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EDUCATIONAL PHILOSOPHY

The educational objectives of the USC- Female Pelvic Medicine and Reconstructive Surgery (FPMRS) program align with the six ACGME competencies. These goals are to improve the health care of women by: a) Practice-Based Learning and Improvement—Providing high standards of education and training related to Female Pelvic Medicine and Reconstructive Surgery; b) Patient Care and Procedural Skills & Interpersonal and Communications Skills—Improving the recruitment of qualified physicians to this subspecialty and encouraging the development of academicians as well as clinicians who are able to provide consultation and comprehensive management of women with complete benign pelvic conditions, lower urinary tract disorders and pelvic floor dysfunction; c) Medical Knowledge—Providing basic science and clinical knowledge regarding female pelvic disorders; d) System-based Practice—Obtaining the understanding of the basic role of a physician in a healthcare organization by improving the organization, distribution and cost-effectiveness of patient care; e) System-based Practice and Professionalism—Establishing a collaboration between urology, gynecologists, colorectal surgeons, and other sub-specialties, including cross-dissemination of clinical experience, research, and teaching.

The primary goal of the Female Pelvic Medicine and Reconstructive Surgery fellowship at USC is to train surgeon scientists by providing fellows with advanced training in both the diagnosis and the medical and surgical treatment of voiding dysfunction and other pelvic floor conditions as well as providing fellows with the necessary training in clinical and/or basic science research in disorders that affect the pelvic floor to become independent investigators. The training will provide an in-depth experience in clinical and investigative work sufficient to allow pursuit of an academic career within Female Pelvic Medicine and Reconstructive Surgery. Fellows will obtain an intensive, comprehensive and ongoing clinical and laboratory research experience in related aspects of Female Pelvic Medicine and Reconstructive Surgery at USC Institute of Urology, an institution not only recognized as a national and international referral center for clinical care, but also respected in research.

The FPMRS fellows will rotate through the urology and gynecology clinics at LAC+USC Medical Center, Norris Comprehensive Cancer Center and Rancho Los Amigos during their first, second and third years. The FPMRS is an integral rotation for the residents in the respective residency program. While on that rotation, they are an integral part of the FPMRS team and participate in all the didactic session. Fellows will lecture fellows during their rotation. All surgical cases will be attended by a resident, fellow and attending faculty with the resident performing portions of the procedure consistent with graduated responsibility and the fellow performing those portions of the procedure appropriate for their training. The fellow will also assist and instruct residents under attending supervision as appropriate. The USC Institute of Urology has a 5 year program and a total of 18 residents (3 for each level of training). The USC Obstetrics and Gynecology Program is a 4 year program with a total of 31 residents. The residents rotate through various disciplines on a rotational basis. The Urology FPMRS Division has a Junior (PGY6) Fellow in the rotation. Residents in the gynecology team are assigned by the chief resident to participate in the urogynecology rotation. More advanced and complicated cases are usually assisted by the chief residents. Appropriate to the level of training the residents provide support for the out-patient clinics and perform basic vaginal and endoscopy examinations under the supervision of the fellows. As the fellows progress in independence throughout their training they will also serve in supervisory role for the residents in the operating room and clinics. Provided the very large clinical volume and presence of 6 full-time female FPMRS faculty, the combined working of the fellow and residents do not cause any competition. The fellows are also expected to provide the residents with supervision both in the out-patient and in the operating room with intensive exposure to pelvic vaginal and abdominal anatomy during the rotation. In addition, fellows participate with the residents in weekly departmental grand rounds and are encouraged to participate in the resident’s departmental journal clubs. All resident didactic sessions are open to the fellows. While in the rotation, residents are expected to attend all FPMRS Fellowship didactic sessions but they are welcomed and encouraged to attend all other didactics throughout their residency.
I. ENVIRONMENT

A. To provide an intellectual environment for acquiring the knowledge, skills, clinical judgment, and attitudes which are essential to the practice of FPMRS. The program leadership, the supporting staff, the faculty, and the administration of the institution have a full commitment to the educational program and will provide appropriate resources and facilities. Service commitments will not compromise the achievement of educational goals and objectives.

B. To provide training with a close working relationship with trainees in accredited programs in other disciplines such as pathology, radiology, general surgery, pediatrics, anesthesia, and internal medicine, physical therapy, and all surgical disciplines.

C. To provide instructions of the FPMRS trainees by qualified faculty in these other related disciplines.

D. To provide a healthy and safe work environment for fellows. These include: access to food 24 hours a day; call rooms that are safe, quiet, and private; security and safety measures including parking faculties, on-call quarters, hospital and institutional grounds. We will be providing services that help assure that the fellows do not perform work extraneous to achieving educational goals and objectives.

II. CLINICAL TRAINING

A. To provide advanced training. To produce trainees with expertise as practitioners and consultants in Female Pelvic Medicine and Reconstructive Surgery. The program will emphasize scholarship, self-instruction, development of critical analysis of clinical problems, and the ability to make appropriate decisions. The program will provide adequate opportunities for the trainees to acquire skills in the performance of techniques required for the practice of urology. Education of fellows is accomplished by graduated responsibility.

B. To provide new and follow-up patients ranging from pediatric to geriatric ages of both sexes to assure a wide range of experience for each trainee. All domains of FPMRS are incorporated, including pelvic organ prolapse, urinary tract infection, evaluation of the lower urinary tract, robotic and vaginal surgery, neurourology, reconstruction, pelvic pain, incontinence, and urodynamics.

C. To provide supervised opportunities for trainees to develop skills in consultation in FPMRS and in communicating with colleagues and referring physicians.

D. To provide training in cultural, social, family, behavioral, ethical and economic issues in FPMRS.

E. To provide supervision and documentation of satisfactory attainment of skills of the trainee in technical procedures integral to urologic surgery. This will include a comprehensive understanding of the indications, contraindications, complications, techniques, and interpretation of results of these procedures.

III. DIDACTIC TRAINING

A. To provide as a basis for the program, a structured urologic/female pelvic medicine and reconstructive surgery curriculum with well-defined educational goals and objectives.

B. To provide regularly scheduled clinical conferences, as well as seminars and critical literature review activities pertaining to urology. A carefully organized and effective didactic program has been
developed with constant input from the fellows. A formal educational curriculum has been adopted to integrate the educational activities and include involvement of all active program faculty. This curriculum includes weekly clinical conference (urodynamics, indications conference or clinical subject) within the specific clinical rotation (urology, urogynecology or colorectal), weekly didactic conference which includes clinical, surgical and research topics, an multidisciplinary meeting with Colorectal, a quarterly Journal Club and Morbidity and Mortality conference. Furthermore, the fellows will participate in all conferences, seminars and lectures of the Urology Department, Obstetric and Gynecology Department and/or Colorectal Surgery Division when on those specific rotations. In addition, on a quarterly basis the faculty and fellows of USC FPMRS fellowship will meet on Tuesday evening at 5pm to discuss M&M cases of the previous 3 months. Fellows will also be invited to participate in Departmental journal clubs and teaching conferences. Fellows are asked to present discussion of cases and/or didactic discussion on each specific case. Specific didactic teaching sessions will occur on Tuesday evenings. These are conducted by faculty from the FPMRS Program, fellows, and from other disciplines mentioned in I B. The teaching sessions follow a schedule arranged far in advance to meet educational needs that are the most important. Collateral reading material is supplied in advance of the meetings and discussed during the sessions, which last from 1½ to 3 hours. Journal Club is held quarterly and is organized by the fellows and specific faculty mentors. One faculty member is assigned to each Journal Club.

C. To provide for the participation of trainees in planning and conducting the conferences. FPMRS fellows help organize and participate in all conferences.

D. To provide for attendance and participation of trainees in multidisciplinary conferences. Attendance at all conferences is monitored closely and is required. A sign in sheet is provided and recorded.

E. To provide trainees with opportunities to teach FPMRS to residents, medical students, fellow physicians, and other professional personnel.

IV. RESEARCH TRAINING

A. To provide research training in urologic surgery and FPMRS. This will include instruction in study design, data collection, and statistical analysis.

B. To provide opportunities for trainees to conduct research under faculty supervision. A major commitment of the USC Institute of Urology and the Department of Obstetrics and Gynecology has been to train FPMRS fellows in research. We have made training of academic FPMRS fellows our priority and have structured our laboratory research program accordingly. While we recognize that not every fellow will be able to remain in an academic environment, the intellectual gain and emphasis on clinical and basic research is a vital part of our educational philosophy. This combined emphasis on broad and extensive clinical experience through understanding of the pathophysiology of disease in the literature relating to pelvic medicine diseases, and a basic research environment are equally important to elements of our educational program.

C. To provide opportunities for advanced research training leading to an academic appointment at a major university. The fellow will be required to take two advanced graduate student course, one of which will include a Biostatistics course.

D. All FPMRS Fellows will complete a research specific project, thesis, thesis presentation, and manuscript submission prior to the end of their training.

V. FELLOW PROMOTION
A. Each fellow must successfully complete the preceding year before proceeding to the following year in the two/three year program. Advancement to the next year of a fellowship program must be based on evidence of satisfactory performance in the six general competencies including demonstrated ability to assume graded and increasing responsibility for patient care as outlined in the Institutional, Common and Specialty program requirements. Daily attendance in each rotation must be adequate to learn the skills and knowledge of that rotation. Prolonged absence due to illness, or other personal matters must be documented in writing to the appropriate division chief, the residency program director, and chair of the department. Failure to promote based on absenteeism must be unanimously approved by the chair of the department, residency program director, and assistant residency program director.

B. Identification and policy regarding fellows with preliminary less than satisfactory overall evaluation.

C. Faculty who identify a fellow whose preliminary overall evaluation is less than satisfactory is required to verify that observation with at least one other faculty member associated with that or a prior rotation. An urgent specific discussion must then be held with the program director. Specific problems and potential solutions should be identified and discussed with the fellow in a constructive manner. Continued poor overall performance unresponsive to above remedial measures requires a second round of discussions which should also involve the assistant director of the residency program, department chair, and the fellow’s faculty mentor or a faculty member of the fellow's choosing. Discussion of further remedial measures should be established at that time. Lack of positive response in fellow performance would lead to consideration of denial of promotion recommendation from the department chair, program director, and assistant program director to a faculty vote. Appropriate counseling will be provided to the fellow regarding long-term alternative career pathways.

D. Determination of promotion is the responsibility of the Program Director. The program director should have a representative faculty committee or Clinical Competency Committee (CCC) that objectively and fairly evaluates the performance of all fellows on an annual basis. Minutes of the evaluation proceedings must be protected by peer review statute.

VI. ACCOUNTABILITY OF FACULTY AND TRAINEES

A. To provide appropriate accountability by means of written evaluation, the faculty will evaluate the trainees and the trainees will evaluate the faculty at regular intervals. These evaluations will be discussed with those individuals being evaluated. The written evaluations are anonymous and do not identify the individual trainee or faculty evaluator. The trainees will also evaluate each specific rotation, conference, research experience, the program director, and the overall program with written evaluations (See Forms).

B. To provide appropriate accountability by means of training and faculty input, each aspect of the fellowship training program and each rotation is discussed at an annual faculty meeting of the faculty and trainees devoted to the fellowship-training program. Each trainee is asked to actively participate in providing feedback and suggested improvements. Minutes and the action plan from this retreat are distributed to all faculty and fellows. To provide appropriate accountability the department faculty meet quarterly to monitor the evaluation of trainees. (Comprised of the Residency Program Director, Department Chairman and all fulltime faculty members.) Evaluations are discussed quarterly to assure that assessment of and feedback to trainees occur regularly. It is the responsibility of this committee to assure that trainees are meeting with the Program Director, that faculty understand evaluation responsibilities, that an annual summary evaluation of each fellow is completed and that individual training issues are appropriately addressed. A written copy of the USC FPMRS Goals and Objectives are given to each of the faculty and trainees to make them aware of the goals, objectives, teaching
methods, accountability, and evaluation process. Fellows are given a copy of the program requirements for residency education in FPMRS supplied by the ACGME. Requirements for tracking procedures and requirements for procedure logs is also provided.

VII. SUPERVISION AND FELLOW RESPONSIBILITY

A. The USC Institute of Urology is completely committed to the concept that the essential learning activity is the interaction of the fellow with patients under the guidance and supervision of faculty members who give value, context, and meaning. It is a core tenet of the Department that in order for the fellow to develop his/her skills, knowledge, and attitude the fellow have graded and progressive responsibility. The purpose of the graded and progressive responsibility to transform the fellow to an independent practitioner had excellent clinical surgeon who is also capable of accomplished scientific investigation and effective teaching.

Fellows are accorded progressive surgical responsibility based on individual assessment of expertise. With experience the fellow becomes the primary surgeon, teaching the junior fellow or urology fellow; the faculty member acts as an assistant in these cases. When other consultants are required to assure optimal patient care or when combined cases are being performed, the fellow continues their surgical participation at the discretion of either the Colorectal, Gynecologic or Urologic consultant.

B. All fellow-patient encounters must be supervised by a senior fellow or Attending who is in the same room as the encounter, available, on campus, or be immediately available by electronic communication. The supervising surgeon must insure that the treatment is compassionate and safe, appropriate for the fellow and the patient, and effective.

C. All patients in the hospital are the direct responsibility of an attending member of the Medical Staff. Each patient is assigned a primary attending physician, although other attending physicians may, at times be delegated responsibility for the care of a patient and provide supervision instead of or in addition to the assigned practitioner.

D. Progression of Responsibility

Attending Staff supervise participants in professional graduate medical education programs in their patient care responsibilities in a manner commensurate with the Fellow’s level of training and experience. The Department Chair together with the Program Director is responsible for ensuring that the degree of professional responsibility accorded to each Fellow is progressively increased through the course of training, commensurate with his or her skill, training and experience. The respective Department Chair together with the Program Director makes decisions about individual fellow graded responsibility and progressive involvement and independence in specific patient care activities. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. In some cases, the supervising physician may be a more advanced fellow or fellow. The attending physician is also responsible for determining in an individual case the degree of fellow independent functioning.

Program is designed specifically to insure progressive responsibility for each year of advancement in the two/three-year program. Within each rotation faculty surgeons will supervise an increasing role in each repetitive operation based on daily attending evaluations of individual performance, regular written evaluations of each Fellow, results of internal or external examinations, and program director fellow evaluation meetings.

E. Level of Supervision and Availability of Attending Physicians:
Supervising Attending physicians have the responsibility to enhance the knowledge of the Fellow and to ensure the quality of care delivered to each patient by any Fellow. This responsibility is exercised by observation, consultation and direction. It includes the imparting of the practitioner’s knowledge, skills and attitudes by the practitioner to the Fellow and assuring that the care is delivered in an appropriate, timely and effective manner. Fulfillment of such responsibility requires personal involvement with each patient and each Fellow who is providing care as part of the training experience. Supervising attending physicians should act professionally and as a role model for trainees. Supervisors will direct the care of the patient and provide the appropriate level of supervision based on the complexity of care, and the experience, judgment and level of training of the Fellow being supervised. To ensure oversight of fellow supervision and graded authority and responsibility, the following classifications of supervision are used:

Direct Supervision – The supervising physician is physically present with the fellow and patient.

Indirect Supervision with Direct Supervision Immediately Available - The supervising physician is physically within the hospital and immediately available to provide Direct Supervision.

Indirect Supervision with Direct Supervision Available – The supervision physician in not physical present but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Supervision in the majority of clinical situations is direct, but in certain clinical situations, supervision might be indirect with immediate availability of the attending physician. At home call is done under indirect supervision with supervision available. PGY5 fellows will be supervised either directly or indirectly with direct supervision immediately available. Fellows must communicate with the supervising faculty member regarding all major changes and decisions in patient care, including all transfers of a patient to an intensive care unit and all end-of-life decisions or need for emergent care and surgical intervention.

F. Program is designed specifically to insure progressive responsibility for each year of advancement in the two/three-year program. Within each rotation faculty surgeons will supervise an increasing role in each repetitive operation based on daily attending evaluations of individual performance, regular written evaluations of each Fellow, results of internal or external examinations, and program director fellow evaluation meetings.

G. With each year of training, the degree of responsibility accorded to a fellow, both professional and administrative, is progressively increased consonant with skill and experience. This includes responsibility in patient care, leadership, teaching, organization, and administration. Senior fellows supervise and act as consultants to junior fellows.

VIII. EVALUATIONS AND DUE PROCESS

A. Fellows are evaluated by a combination of the faculty, patients, peers and other professionals during or at the end of each rotation. Items to be evaluated include patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice. The Program Director will discuss the evaluations with each fellow twice each year at the semi-annual review to evaluate his or her performance for the entire year.
B. Appointment or promotion of fellows occurs when the fellow’s medical knowledge, attitudes and clinical performance meet minimum standards necessary for trainees at their level. (See also V. Fellow Promotions) Fellow evaluations are performed on a quarterly basis and copies of evaluation summaries are available to the fellows. Each fellow should expect to progress to the next level of residency unless he or she is given adequate notification and informed of the reasons for not advancing. If the performance of a fellow is in question, the fellow will receive timely and progressive verbal and written notification and have the opportunity to learn why it is in question.

C. Fellows will be asked to participate in the annual faculty review, which will include an evaluation of teaching ability, commitment, clinical knowledge and scholarly activities. Fellows are also asked to play a significant role in the annual evaluation of the FPMRS Program. This covers all training sites and includes evaluation of satisfactory completion of educational goals and attention to the needs of the fellows, especially regarding the balance between educational and service components of the program.

IX. COMMUNICATION

In providing supervision to Fellows supervising attending physicians should provide advice and support and should encourage trainees to freely seek their input. Fellows are expected to make liberal use of the supervisory resources available to them and are encouraged to seek advice and input from their supervisors. The clinical environment should maximize effective communication including the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty. Each fellow must know the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence.

Mail should be picked up at regular intervals in the mailboxes at the USC Institute of Urology, Norris Cancer Hospital, 7th Floor Topping Tower and email should be checked on a regular basis.

X. MONITORING COMPLIANCE

The quality of Fellow supervision and adherence to supervision guidelines and policies shall be monitored through annual review of the Fellow’s evaluation of their supervisors and rotations. The Program Director shall evaluate each fellow’s ability by specific criteria included in the rotation evaluations. The fellow’s evaluations and progress will be discussed by all participating faculty during the quarterly faculty meetings.

XI. RELATIONSHIPS WITH VOLUNTARY CLINICAL FACULTY - On rare occasion, clinical faculty is involved in clinics and operative rooms. In these instances, they will provide direct supervision of the fellow. The FPMRS faculty, is ultimately responsible to ensure that this interaction is in accordance to our the ACGME accredited fellowship.
PROGRAM COMPONENTS

A. Sponsoring Institution
   UNIVERSITY OF SOUTHERN CALIFORNIA/LAC+USC MEDICAL CENTER PROGRAM

B. Participating Institutions
   LAC+USC Medical Center
   LAC-Rancho Los Amigos National Rehabilitation Center
   Kenneth Norris Jr Cancer Hospital and Research Institute
   Keck Hospital of USC

C. Format
   **Gynecology Track**
   Year 1: 60% clinical and 40% research time allocation.
   Year 2: 65% clinical and 35% research time allocation.
   Year 3: 75% clinical and 25% research time allocation.

   **Urology Track**
   Year 2: 80% clinical and 20% research time allocation, with one day a week reserved for research.
   Year 3: 80% research and 20% clinical time allocation.

Total Complement: 1 PGY5, 2PGY6, 2 PGY7- **Total # of Fellows-5**
DEFINITIONS

ATTENDING PHYSICIAN - An appropriately credentialed and privileged member of the medical staff who accepts full responsibility for a specific patient's medical/surgical care.

CLINICAL SUPERVISION - A required faculty activity involving the oversight and direction of patient care activities that are provided by fellows.

CONDITIONAL INDEPENDENCE - Graded, progressive responsibility for patient care with defined oversight.

FACULTY - Any individuals who have received formal assignment to teach fellows/fellow physicians. At some sites, appointment to the medical staff of the hospital constitutes appointment to the faculty.

GRADUATED RESPONSIBILITY - A progressive increase in the clinical patient care and supervisory roles within the training environment commensurate with appropriate education, competence, experience attained during the course of training. This process is intended to culminate in the development of a high level of individual responsibility to be achieved prior to graduation.

PROGRAM DIRECTOR - The one physician designated with authority and accountability for the operation for the residency program.

PROGRAM YEAR - Refers to the current year of education within a specific program; this designation may or may not correspond to the fellows' graduate year level.

FELLOW - A physician in an accredited graduated medical education specialty program.

SITE - An organization (or entity) that assumes the ultimate financial and academic responsibility of a program of GME. The sponsoring institution has the primary purpose of providing educational programs and/or health care services (e.g. a university. A medical school, a hospital, a school of public health, health department a public health agency, an organized health care delivery system, a medical examiners office, a consortium, an education foundation).

SUPERVISING PHYSICIAN - A physician, either faculty member or more senior fellow designated by the program director as the supervisor of a junior fellow. Such designation must be based on demonstrated medical and supervisory capabilities of the physician.

VOLUNTARY CLINICAL FACULTY - A community physician who volunteers to help educate residents and fellows and serves as a designated supervisor.
LEVELS OF SUPERVISION

DIRECT SUPERVISION – the supervising physician is physically present with the fellow and patient.

INDIRECT SUPERVISION - with direct supervision immediately available – The supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

OVERSIGHT – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
JOB RESPONSIBILITIES BY PROGRAM YEAR

I. FPMRS GYN PGY5 Responsibilities
FPMRS PGY 5 fellows are responsible for all pre-op and post-op inpatient care including H&P and dictated discharge summaries on all patients. Rotation schedules are dictated by the Program Director. FPMRS PGY 5 fellows are responsible for rotating through the FPMRS Urogynecology, and Research rotations. In addition, fellows begin their training as consulting physicians to both the hospital wards and the hospital emergency room. FPMRS PGY 5 fellows are under close supervision by faculty at all times. This particular year is designed to give each fellow an adequate sample of all areas of clinical areas of FPMRS had to offer as a long term career. FPMRS PGY 5 fellows are also responsible for maintaining a record of every complication with patient name, number, date, attending, diagnosis, procedure, complication, treatment and outcome at LAC + USC Medical Center. These data are used at quarterly morbidity and mortality conferences. In addition, the FPMRS PGY 5 fellow is responsible for preparation of the case list and journal clubs for our FPMRS conferences as needed. The FPMRS PGY 5 fellows call responsibilities are limited to at home call on nights and weekends; fellows are free from call duty completely at least 4 days a month. FPMRS PGY 5 fellows will evaluate patients in the office setting that will come to surgical treatment. This offers an element of continuity of care.

II. FPMRS GYN PGY 6, FPMRS URO PGY 6 Responsibilities
FPMRS GYN PGY 6, FPMRS URO PGY 6 fellows are responsible for maintaining a record of every complication with patient name, number, date, attending, diagnosis, procedure, complication, treatment and outcome at all facilities pertaining to their assigned rotations.

From a clinical perspective, FPMRS PGY6 fellows gain increasing independence in terms of managing hospital ward and emergency room consultations. In addition, these fellows begin to have more autonomy in the operating room. During this year they will be exposed to full rotations in the other specialty (i.e. urology trainees rotate with urogynecology, and gynecology trainees rotate with urology) as well as exposure to colorectal surgery at the Norris Cancer Hospital and Keck Hospital of USC. These fellows also gain more autonomy (with attending staff back-up) in managing outpatient urologic complaints. The FPMRS PGY 6 fellows call responsibilities are limited to at home call on nights and weekends fellows are free from call duty completely at least 4 days a month. FPMRS PGY 6 fellows will evaluate patients in the office setting that will come to surgical treatment. This offers an element of continuity of care.

FPMRS PGY 6 fellows are asked to deliver and arrange all equipment at Journal Clubs and Teaching Conferences; to be responsible for audio-visual equipment and to operate the slide projector and LCD projector. They are asked to circulate the attendance list, ensure that everyone present signs in, and to maintain records of case presentations and morbidity and mortality statistics.

The FPMRS PGY 6 fellow is asked to submit an equitable consultation "on call" schedule to the Academic Affairs Coordinator by the 20th of each month.

III. FPMRS GYN PGY 7, FPMRS URO PGY 7 Responsibilities
FPMRS PGY 7 fellows are senior fellows and as such will have graduated responsibility that may include supervision of junior fellows. In the urology rotation, they will have get to choose surgical cases (based on complexity of cases and/or index numbers needed) to satisfy 20% of their time. It is at this level of training that the fellow becomes more independent with major open surgical cases (bladder augmentations, hysterectomies and sacrocolpopexies). Adequate faculty supervision is always provided and utilization of this support is dictated by the comfort level of the fellow and faculty team.
The FPMRS PGY 7 fellows call responsibilities are limited to at home call on nights and weekends fellows are free from call duty completely at least 4 days a month. The urology fellow spends 80% of her/his time in research. FPMRS PGY 7 fellows will evaluate patients in the office setting that will come to surgical treatment. This offers an element of continuity of care.

- At all levels, fellows will be involved in supervising and teaching residents and medical students.
LEGEND FOR COMPETENCIES

Patient Care
• Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Medical Knowledge
• Fellows must demonstrate knowledge of establishing and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

Practice-based Learning and Improvement
• Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

Interpersonal and Communication Skills
• Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

Professionalism
• Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

System-based Practice
• Fellows must demonstrate an awareness of responsiveness to the large context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.
Overall Educational Goals for the
UCLA Female Pelvic Medicine & Reconstructive Surgery Fellowship

The educational objectives of the USC- Female Pelvic Medicine and Reconstructive Surgery (FPMRS) program are to improve the healthcare of women by: a) Providing high standards of education and training related to Female Pelvic Medicine and Reconstructive Surgery; b) Improving the recruitment of qualified physicians to this subspecialty and encouraging the development of academicians; c) Providing basic science and clinical knowledge regarding female pelvic disorders; d) Improving the organization, distribution and cost-effectiveness of patient care; e) Establishing a collaboration between urology, gynecologists, colorectal surgeons, and other sub-specialties, including cross-dissemination of clinical experience, research, and teaching.

The primary goal of the Female Pelvic Medicine and Reconstructive Surgery fellowship at USC is to train surgeon scientist by providing fellows with advanced training in both the diagnosis and the medical and surgical treatment of voiding dysfunction and other pelvic floor conditions as well as providing fellows with the necessary training in clinical and/or basic science research in disorders that affect the pelvic floor to become independent investigators. The training will provide an in-depth experience in clinical and investigative work sufficient to allow pursuit of an academic career within Female Pelvic Medicine and Reconstructive Surgery. Fellows will obtain an intensive, comprehensive and ongoing clinical and laboratory research experience in related aspects of Female Pelvic Medicine and Reconstructive Surgery at USC Institute of Urology, an institution not only recognized as a national and international referral center for clinical care, but also respected in research.

The major strength of this program is the strong research and clinical experience gained at an institution renowned for combining patient care, research, and education. The fellow will benefit from a strong clinical program marked by high quality and complex patient care. The fellow will also benefit from a great research opportunity provided by the close relationship and research laboratories in our Departments, the CTSI, the Medical School, and outside the Medical School including the Departments of Gerontology, the Stem Cell Institute, and the Department of Biomedical Engineering at the School of Engineering.

Since opening its doors in 1885, USC Medical Center has consistently been a healthcare innovator. The Keck School of Medicine of the University of Southern California (renamed 1999) was established in 1885 as the region’s first medical school and the second professional school founded at USC. The Keck School of Medicine of the University of Southern California is located on the 79-acre Health Sciences Campus, three miles northeast of downtown Los Angeles and seven miles from the USC University Park Campus. Located on the university's 30.8-acre (125,000 m2) Health Sciences campus three miles (5 km) northeast of downtown Los Angeles, California, the Keck School of Medicine is adjacent to the Los Angeles County+USC Medical Center—one of the largest teaching hospitals in the U.S.

Keck’s faculty, students, fellows, and residents staff neighboring Keck Hospital of USC, USC Norris Comprehensive Cancer Center and Hospital, Los Angeles County+USC Medical Center, Children’s Hospital Los Angeles, and an extended network of USC-affiliated hospitals throughout Southern California. The affiliated Children’s Hospital Los Angeles is currently the best children’s hospital on the West Coast according to U.S. News and World Report. In addition, U.S. News & World Report’s 2014 edition ranked the Keck School of Medicine of USC at No. 31 in research among the top 135 U.S. medical schools.

The Health Sciences Campus (HSC) is a focal point for students, patients and scientists from around the world. The many clinical, classroom and laboratory resources of the campus combine to form a dynamic, interactive environment for learning, collaboration and scientific discovery. The Health Sciences Campus lies adjacent to the Los Angeles County+University of Southern California (LAC+USC) Medical Center, a primary affiliate of the Keck School of Medicine and one of the nation’s largest teaching hospitals. HSC is also home to the Keck Medical Center of USC - a state-of-the-art academic medical center comprised of the Keck Hospital of USC.
(formerly USC University Hospital) and the USC Norris Cancer Hospital. The two world-class, USC-owned hospitals are staffed by more than 500 physicians who are faculty at the renowned Keck School of Medicine of USC. USC also partners with the nearby Children’s Hospital Los Angeles.

Creating more opportunities for Keck School faculty and students to work at the forefront of biomedicine while continuing to provide outstanding patient care are among the Keck School’s highest priorities. Los Angeles County+USC Medical Center, a partner of the Keck School of Medicine of USC since 1885, is one of the largest public hospitals in the country. Staffed by more than 450 full-time faculty of the Keck School and over 900 medical residents in training, the facility treats over 800,000 patients annually. Among its specialized facilities and services are a state-of-the-art burn center, Level III neonatal intensive care unit, Level I trauma service, an NIH-funded clinical research center and a HIV/AIDS outpatient center.

Keck Hospital of USC is a private, 400-bed acute care hospital staffed by faculty of the Keck School of Medicine of USC. Among the hospital’s advanced services are neurointerventional radiology, cardiac catheterization and interventional cardiology. Surgical specialties include organ transplantation and neurosurgery, as well as cardiothoracic, bariatric, esophageal, orthopedic, and plastic and reconstructive surgeries.

The USC Norris Comprehensive Cancer Center & Hospital is a leader in cancer research and care, with nearly 200 members investigating the complex origins and progression of cancer, developing prevention strategies, searching for cures and caring for cancer patients. Part of the Keck School of Medicine, USC Norris is designated by the National Cancer Institute as one of the nation’s 40 comprehensive cancer centers. USC Norris Cancer Hospital is a 60-bed inpatient facility affiliated with the USC Norris Comprehensive Cancer Center, where patients benefit from revolutionary treatment provided by the same physicians that conduct leading-edge research at the center. USC Norris medical specialists are particularly trained to treat cancer of the bladder, prostate, kidney, testes, female reproductive system, breast, lung, gastrointestinal tract, melanoma, leukemia, lymphomas and AIDS-related cancers.

A series of strong and stimulating off-service rotations has been arranged. These experiences offer an intensive exposure to allied disciplines. The fellows may work with experienced clinician’s services in Urology, Physical Therapy, Gynecology, and Colorectal Surgery. Outpatient rotations are available on these services providing teaching in vaginal and uterine pathology, urodynamic testing, radiology, vaginal and endoanal ultrasound, pelvic floor rehabilitation, and colonoscopy. The fellows will be directly involved with teaching of junior fellows, residents, and medical students. Our services include residents/fellows in urology and obstetrics and gynecology. Currently these are second-, third-, fourth, and fifth year residents. The fellows will also participate in educational activities for allied medical personnel and nursing staff.

Dr. Rodríguez is an established surgeon-scientist with extensive expertise in the field of female pelvic and reconstructive surgery (FPMRS) in Urology. Dr. Rodríguez serves as the Director of the FPMRS fellowship and oversees the all aspects all aspects of the FPMRS fellowship training. In addition to clinical outcomes research, our basic science research includes among other areas the fields of tissue engineering, stem cells applications for the treatment of urinary incontinence and lower urinary tract reconstruction, the genetics and the role of nitric oxide in the pathophysiology of vaginal prolapse. Dr. Rodríguez has a well-funded and equipped laboratory and is recipient of multiple research grants including NIH grants. Multiple scientific collaborations established with UCLA and USC in the Departments of Genetics (Eric Vilain, M.D., Ph.D), Biomedical Engineering (Benjamin Wu, D.D.S., Ph.D), and Pharmacology (Lou Ignarro, Ph.D), Psychiatry (Daniel Holshnider, MD, PhD), will provide fellows with the opportunity to pursue a diversity of basic science projects. In addition, we have the unique opportunity of being a member of the NIH funded Center of Neuroviceral Science and Women’s Health at UCLA(CNS/WH, NIH P50 DK64539, NIHR24 AT002681). This multidisciplinary center focuses in the pathophysiology of chronic visceral pain including painful bladder syndromes and interstitial cystitis. Another of the goals of the center is to study gender differences in the
manifestation of painful bladder disorders and inflammatory bowel disease. In addition, as part of the center, our fellows will have access to the clinical outcomes core directed by the School of Public Health and the animal and tissue histology cores which are part of the Center’s infrastructure.

In summary, with our faculty experience in training numerous fellows, our large out-patient clinics, our large surgical volume in pelvic reconstruction, our programs of neuromodulation and neurourology, and our strong research program, the USC FPMRS program is uniquely equipped to train fellows for an independent and productive academic career in Female Pelvic Medicine & Reconstructive Surgery and to become future leaders in our field.
Competencies Addressed: PC, MK, PBLI, ICS, P, SBP

Medical Knowledge

**Epidemiology:** The fellow will demonstrate understanding of the epidemiology of urinary incontinence, pelvic prolapse, defecation disorders, including birth, aging and neurologic disease.

**Quality of Life:** The fellow must demonstrate knowledge in the impact of urinary incontinence, pelvic prolapse, and defecation disorders on quality of life.

**Questionnaires:** At the end of the rotation, the fellow must be able to use and interpretation of disease-specific and global health questionnaires to evaluate the impact of pelvic floor disorders.

**Scientific Method:** The fellow must be able to apply the scientific method to problem solving and decision making.

**Diagnostic:** The fellow must be able to demonstrate an understanding of indications, contraindications, complications, techniques and interpretation of results of diagnostic procedures including urine cytology, pad test voiding diary, urodynamics testing, cystoscopy and cystoscopic manipulations including stent placement and retrograde pyelograms.

**Neoplasm:** The fellow must be able to evaluate the lower urinary and genital tract for abnormalities including neoplasms, and interpreting cytology and biopsy results.

Professionalism

The fellow must demonstrate a commitment to carrying out professional responsibility and an adherence to ethical principles and demonstrate compassion, integrity, and respect for to the, responsiveness to patients needs that supersedes self-interest, respect to patient privacy, accountability to patients, society and profession, and sensitivity and responsiveness to a diverse patient population, including diversity of age, culture, gender, race, and religion.

Patient Care and Procedural Skills

**Hematuria:** The fellow must demonstrate competence in the evaluation and management of micro and gross hematuria.

**Pain:** The fellow must demonstrate competence in the evaluation and management of interstitial cystitis and painful bladder syndrome.

**Neurogenic Bladder:** The fellow must demonstrate competence in the evaluation and management of neurogenic bladder.

**Urinary Tract Infections:** At the end of the rotation, the fellow must feel comfortable evaluating and treating uncomplicated and complicated urinary tract infections, evaluate resistance antibiotic patters, differentiate between bacterial persistence or re-infection and evaluate and manage the patient with recurrent infections.

**Pelvic Examination:** The fellow should understand the differences between the different classification systems of pelvic organ prolapse and be able to quantify prolapse.

Practice Based Learning and Improvement

Fellows must demonstrate the ability to investigate and evaluate the care of patients and assimilate scientific evidence by identifying strengths, deficiencies, and limits to the fellow’s expertise, setting learning goals, and use information technology to optimize learning. They must coordinate patient care within the health care system relevant to FPMRS specialty and advocate for quality patient care and optimal patient care systems.

Interpersonal and Communications Skills

Fellows must be able to communicate effectively with patients, families and the public across a
broad range of socioeconomic and cultural backgrounds and communicate effectively with
physicians and other health care professionals.

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<thead>
<tr>
<th>Systems-based Practice</th>
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<tbody>
<tr>
<td>Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care. They should work effectively in various health care delivery settings and coordinate patient care</td>
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Year 2 LAC+ USC Medical Center  
FPMRS GYN Rotation  
Upon completion of the rotation the fellow should be comfortable with the basic and clinical science, clinical presentation and treatment of the following. The fellow should be comfortable with the operative skills listed below.

**Competencies Addressed:** PC, MK, PBLI, ICS, P, SBP

### Medical Knowledge

**Diagnosis of Pelvic Floor Disorders:** Fellow will demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social behavioral sciences, as well as the proper application of this knowledge to patient care.

**Anatomy and Physiology:** The fellow must demonstrate knowledge in the anatomy, physiology, and pathophysiology of the pelvic floor, including the lower urinary tract, colorectal anal, and vaginal functioning.

**Infectious Disease:** The fellow will demonstrate competence in the evaluation and treatment of sexually transmitted and other infectious diseases.

**Psychosocial Aspects of Pelvic Floor Disorders:** The fellow will show understanding of the quality of life and psychosocial aspects of pelvic floor disorders.

**Sexual Dysfunction:** The fellow will show competence in the diagnosis, classification and treatment of patients with sexual dysfunction.

**Pain Management:** The fellow will show understanding of basic pain management of patients with pelvic pain and interstitial cystitis.

### Professionalism

The fellow must demonstrate accountability to patients, society and the profession of FPMRS and medicine.

### Patient Care and Procedural Skills

**Urinary Incontinence:** The fellow will demonstrate the ability to diagnose and manage patients with urinary incontinence including performing surgery for urinary incontinence including the use of native tissues, synthetic slings, and periurethral bulking agents. In addition, the fellow will demonstrate competence in the behavioral, pharmacological, functional, nonsurgical and surgical treatment of incontinence.

**Obstetrical Complications:** The fellow will demonstrate the ability to diagnose and manage patients with obstetric complications including obstetric lacerations.

**Pelvic Organ Prolapse:** The fellow will demonstrate the ability to diagnose and manage patients with pelvic organ prolapse including performing advanced laparoscopic, abdominal, and vaginal surgery for uterovaginal prolapse and post hysterectomy vaginal vault prolapse including reconstructive and obliteratorive procedures.

**Benign Gynecologic Conditions:** The fellow will show competence in the diagnosis and treatment of benign conditions occurring in the female pelvis.

### Practice Based Learning and Improvement

Fellows must demonstrate the ability identify strengths, deficiencies and limits to their own knowledge and expertise, the ability to investigate and evaluate their care of patients, and systemically analyze their practice using quality improvement methods. They should locate, appraise, and assimilate evidence form scientific studies related to their patients’ health problems.

### Interpersonal and Communications Skills

Fellows must be able to work effectively as a member or leader of a health care team, act in a consultative role to other physicians and health professional, and to maintain comprehensive, timely and legible medical records.
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Year 2 Keck Medical Center, Norris Cancer Center

**COLORECTAL Rotation**

*Upon completion of the rotation the fellow should be comfortable with the basic and clinical science, clinical presentation and treatment of the following. The fellow should be comfortable with the operative skills listed below.*

**Competencies Addressed: PC, MK, PBLI, ICS, P, SBP**

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<tr>
<td><strong>Function:</strong> The fellow will demonstrate competence in colorectal-anal function and the pathophysiology of defecatory disorders.</td>
</tr>
<tr>
<td><strong>Fecal Incontinence:</strong> The fellow must demonstrate knowledge in the diagnosis and treatment of defecatory disorders including the use of manometry, transrectal ultrasound and vaginal, perineal and abdominal approaches to its treatment.</td>
</tr>
<tr>
<td><strong>Functional Defecatory Disorders:</strong> The fellow will understand the relationship between painful bladder syndrome and other GI functional disorders such as irritable bowel syndrome and its treatment overlaps.</td>
</tr>
<tr>
<td><strong>Physical Therapy:</strong> The fellow will show proficiency in the use of physical therapy to diagnose and treat pelvic floor disorders including urinary and fecal incontinence, dysfunctional voiding, constipation, pelvic pain and sexual dysfunction.</td>
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<td>The fellow must demonstrate a commitment to carrying out professional responsibility and an adherence to ethical principles and demonstrate compassion, integrity, and respect for to the, responsiveness to patients needs that supersedes self-interest, respect to patient privacy, accountability to patients, society and profession, and sensitivity and responsiveness to a diverse patient population, including diversity of age, culture, gender, race, and religion.</td>
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<tr>
<td><strong>Fecal Incontinence:</strong> The fellow must be able to provide compassionate, appropriate, and effective treatment and care including anal sphincter reconstruction and Interstim for fecal incontinence.</td>
</tr>
<tr>
<td><strong>Disorders of Defecation:</strong> The fellow will demonstrate competence in the behavioral, pharmacological, functional, non-surgical and surgical treatment of defecatory disorders.</td>
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<tr>
<td><strong>Rectovaginal Fistula:</strong> The fellow will demonstrate competence in the diagnosis and surgical treatment of rectovaginal fistula.</td>
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<td>Fellows must demonstrate the ability to investigate and evaluate the care of patients and assimilate scientific evidence by identifying strengths, deficiencies, and limits to the fellow’s expertise, setting learning goals, and use information technology to optimize learning. They must coordinate patient care.</td>
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Upon completion of the rotation the fellow should be comfortable with the basic and clinical science, clinical presentation and treatment of the following. The fellow should be comfortable with the operative skills listed below.

**Competencies Addressed:** PC, MK, PBLI, ICS, P, SBP

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<tr>
<td><strong>Diagnosis of Pelvic Floor Disorders:</strong> The fellow will demonstrate competence in the indication, contraindication, limitations, complications, techniques and interpretation of diagnostic procedures for the evaluation of pelvic organ disorders including, pelvic imaging for the diagnosis of urinary and anal incontinence, pelvic floor dysfunction, prolapse and urodynamic assessment.</td>
</tr>
<tr>
<td><strong>Anatomy and Physiology:</strong> The fellow must demonstrate knowledge in the anatomy, physiology, and pathophysiology of the pelvic floor, including the lower urinary tract and vaginal functioning</td>
</tr>
<tr>
<td><strong>Geriatric Medicine:</strong> The fellow will demonstrate competence in the evaluation and treatment of pelvic floor disorders in the elderly and determine the physiologic changes commonly seen as patients age which might contribute to their urinary symptoms</td>
</tr>
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<td><strong>Psychosocial Aspects of Pelvic Floor Disorders:</strong> The fellow will show understanding of the quality of life and psychosocial aspects of pelvic floor disorders.</td>
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<td><strong>Pain Management:</strong> The fellow will show understanding of basic pain management of patients with pelvic pain and interstitial cystitis.</td>
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<td><strong>Urinary Incontinence:</strong> The fellow will demonstrate the ability to diagnose and manage patients with urinary incontinence including performing surgery for urinary incontinence including the use of native tissues, synthetic slings, and perurethral bulking agents. In addition, the fellow will demonstrate competence in the behavioral, pharmacological, functional, nonsurgical and surgical treatment of incontinence as well as its urodynamics evaluation.</td>
</tr>
<tr>
<td><strong>Micturition:</strong> The fellow will demonstrate the ability to diagnose and manage patients with micturition disorders including competence in the behavioral, pharmacological, functional, nonsurgical and surgical treatment.</td>
</tr>
<tr>
<td><strong>Pelvic Organ Prolapse:</strong> The fellow will demonstrate the ability to diagnose and manage patients with pelvic organ prolapse including performing advanced laparoscopic, abdominal and vaginal surgery for uterovaginal prolapse and post hysterectomy vaginal vault prolapse including reconstructive and obliteration procedures.</td>
</tr>
<tr>
<td><strong>Injuries and Lesions of the lower Urinary tract:</strong> The fellow will diagnose and manage patients with genitourinary fistulae, urethral diverticula, injuries to the genitourinary tract, congenital anomalies, and infection and non-infectious irritative conditions of the lower urinary tract.</td>
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<td>Fellows must demonstrate the ability identify strengths, deficiencies and limits to their own knowledge and expertise, the ability to investigate and evaluate their care of patients, and systemically analyze their practice using quality improvement methods. They should incorporate formative evaluation feedback into daily practice. They should locate, appraise, and assimilate evidence form scientific studies related to their patients’ health problems, identify and perform appropriate learning activities and participate in the education of patients, families, students, fellows and other health professionals.</td>
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FPMRS GYN and Urology Rotation

Upon completion of the rotation the fellow should be comfortable with the basic and clinical science, clinical presentation and treatment of the following. The fellow should be comfortable with the operative skills listed below.

Competencies Addressed: PC, MK, PBLI, ICS, P, SBP

<table>
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<tbody>
<tr>
<td><strong>Anatomy and Physiology:</strong> The fellow must demonstrate knowledge in the anatomy, physiology, and pathophysiology of the lower urinary tract dysfunction secondary to neurologic diseases.</td>
</tr>
<tr>
<td><strong>Medical Indications:</strong> The fellow shall demonstrate proficiency in the indications, contraindications, limitations, complications, techniques, and interpretation of results of screening, diagnostic, and therapeutic procedures including surgery for pelvic organ prolapse, urinary incontinence, and rectovaginal, vesicovaginal and urethrovaginal fistula.</td>
</tr>
<tr>
<td><strong>Research and Quantitative Knowledge:</strong> The fellow will demonstrate dominion of quantitative techniques, including biostatistics, epidemiology, research design, and research methods. In addition, by the end of the fellowship the fellow will have understanding of the peer review system, manuscript preparation, and grantsmanship.</td>
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<tr>
<td><strong>Demonstrate Commitment:</strong> Fellows will demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Additionally, demonstrates leadership in the department.</td>
</tr>
<tr>
<td><strong>Demonstrate Compassion:</strong> Fellows must demonstrate compassion, integrity, and respect for others maintain accountability to patients, society, and the profession as well as be present and prepared for conferences</td>
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<th>Patient Care and Procedural Skills</th>
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<td>Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.</td>
</tr>
<tr>
<td><strong>Diagnosis and Treatment of Pelvic Floor Disorders:</strong> Fellows will show expertise in the recognition, diagnosis and conservative and surgical treatment of patients with urinary and fecal incontinence, pelvic organ prolapse, genitourinary and rectovaginal fistulæ, neurogenic bladder, urethral diverticula, injuries of the genitourinary tract, congenital anomalies and infectious and non-infectious conditions and painful syndromes of the lower urinary tract and pelvis. Fellows will be expected to anticipate, recognize, and manage any potential complication which may result from these treatments.</td>
</tr>
<tr>
<td><strong>Assessment of Effectiveness:</strong> Fellows will be expected to assess the outcomes of treatment options by history, physical exam, use of quantitative and qualitative questionnaires and diagnostic tests</td>
</tr>
<tr>
<td><strong>Diagnosis and Management of Genitourinary Treatment Complications:</strong> Fellows shall anticipate, recognize, and manage any potential complication which may result from treatments and therapies. They will be expected to manage complications after vaginal delivery, spinal cord injury, stroke, multiple sclerosis and similar health events.</td>
</tr>
<tr>
<td><strong>Management of Fistulæ and Urethral Diverticula:</strong> Fellow will demonstrate competence in diagnosing and managing genitourinary and rectovaginal fistulæ, urethral diverticula, injuries to the genitourinary tract, and congenital anomalies.</td>
</tr>
<tr>
<td><strong>Surgical Treatment:</strong> By the end of the rotation, fellows will expertly perform advanced...</td>
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laparoscopic, abdominal, and vaginal surgery for uterovaginal prolapse including reconstructive and obliterative procedures.

**Practice Based Learning and Improvement**

**Demonstrate Knowledge:** Fellows must demonstrate the ability identify strengths, deficiencies and limits to their own knowledge and expertise, the ability to investigate and evaluate their care of patients, and systemically analyze their practice using quality improvement methods.

**Utilize Formative Evaluation:** They should incorporate formative evaluation feedback into daily practice. **Incorporate Scientific Evidences:** They should locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems, identify and perform appropriate learning activities and participate in the education of patients, families, students, fellows and other health professionals. Publishes thesis in peer reviewed journal.

**Interpersonal and Communications Skills**

Fellows must be able to utilize interpersonal and communication skills that result in the effective exchange of information and teaming with patients, their families, and professional associates. To this aim, fellows are expected to communicate effectively with patients and families, communicate effectively with physicians and other health care professionals, work effectively as a member of a health care team, and act in a consultative role to other physicians and health care professionals.

**Systems-based Practice**

**Demonstrate Awareness of Large Health System:** Fellows are expected to demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system.

**Advocate for optimal Care of Patient:** Fellows must advocate to provide optimal health care, work effectively in various health care delivery setting and systems relevant to their clinical specialty, work effectively in multidisciplinary teams to enhance patient safety and improve patient care quality. By understanding how patient care and other professionals work together.

**Consideration of Costs and Risk-benefits:** Fellows should incorporate considerations of cost awareness and risk-benefit analysis in patient and population base care, and participate in identifying system errors and in implement potential system solutions.

| PC: Patient Care | PBLI: Practice-Based Learning and Improvement | P: Professionalism |
| MK: Medical Knowledge | ICS: Interpersonal and Communications Skills | SBP: Systems-Based Practice |
Research Rotation (PGY5-7)

Upon completion of the rotation the fellow should be comfortable with the scientific method of problem solving, study design, data analysis, grant writing, and the integration of career long research and discovery as a tool to improve the health care of women.

Competencies Addressed: PC, MK, PBLI, ICS, P, SBP

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<th>Medical Knowledge</th>
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<tr>
<td><strong>Hypothesis:</strong> The fellow will demonstrate competency in developing a hypothesis to a research question and ill develop this in the form of a thesis. The fellow will demonstrate competency in choosing the appropriate study design to address the research hypothesis, select the and understand the basic statistical analysis and how they apply to particular data sets, determine power calculations and select study populations.</td>
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<td><strong>Quality of Life and Questionnaires:</strong> The fellow must demonstrate knowledge in the impact of urinary incontinence, pelvic prolapse, and defecation disorders on quality of life and the use of questionnaires as qualitative and quantitative tools of assessment.</td>
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<tr>
<td><strong>Basic Science:</strong> The fellow will demonstrate understanding of the basics of basic research and how in vitro and animal studies help us develop and tests hypotheses that cannot be adequately tested in patient populations.</td>
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<td><strong>Scientific Method:</strong> The fellow must be able to apply the scientific method to problem solving and decision making</td>
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<tr>
<td><strong>Quantitative Techniques:</strong> The fellow will demonstrate competence in quantitative techniques including epidemiology, biostatistics, and research design and research methods. The fellow will show competency in discussing different types of study design, and the strengths and limitations of each, identify and apply appropriate measures of central tendency, types of distribution, and statistical analysis.</td>
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<td><strong>Study bias:</strong> The fellow will demonstrate competence in discussing and understanding different types of study bias including selection, information and confounding.</td>
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<td><strong>Error:</strong> The fellow will demonstrate competence in defining and interpreting the meaning of Type I error and Type II error.</td>
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<td><strong>Biostatistics:</strong> The fellow will show competence in the use of appropriate statistical methods to determine if differences in study populations are significant and interpret confidence intervals. Some of those methods will include chi-square test of association, independent and paired student’s test, Mann-Whitney U test, Wilcoxon sign rank test, Pearson and Spearman correlations, logistic and linear regression analysis, odds ratio, risk ratio, and survival analysis.</td>
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<td><strong>Research Findings:</strong> The fellow will show competence in interpreting research findings and discuss potential limitations.</td>
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<th>Professionalism</th>
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<td>The fellow will learn to establish collaborations and appropriate professional conduct as a member of a research team. The fellow must demonstrate accountability to research subjects, will learn how to apply for Institutional Review Board (IRB) or Animal research Committee (ARC) approval. As part of applying for approval for protection of research subjects the fellow will take mandatory required online courses on research ethics, HIPPA compliance, the care of animals, and confidentiality among others.</td>
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<th>Patient Care</th>
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<tr>
<td>The fellow must demonstrate accountability to research subjects, will learn how to apply for Institutional Review Board (IRB) approval. As part of applying for approval for protection of research subjects the fellow will take mandatory required online courses on research ethics, HIPPA compliance, and confidentiality among others. Each of these required modules have a quiz to assess competency and provides a certificate of completion.</td>
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<th>Practice Based Learning and Improvement</th>
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Fellows must demonstrate the ability to identify strengths, deficiencies and limits to their own research and quantitative knowledge and expertise. They will be required to complete a course on biostatistics. They will also seek statistical and study design consultation from services currently provided by the USC department of Biostatistics and the USC Clinical and Translational Science Institute (CTSI). Learn how to develop a hypothesis, learn how to distinguished the types, strengths and benefits of different study designs and how to choose the appropriate design to address a particular hypothesis, understand the basic statistical analysis and how they apply to particular data sets.

**Interpersonal and Communications Skills**

Fellows must be able to work productively as part of a research team. Depending on the specific research project this might include medical students, research coordinators, nurses, biostatistician, technicians, graduate students, and laboratory personnel. Fellows will be expected to maintain comprehensive and accurate laboratory notebooks and research data. In addition, the fellows will meet and present their progress weekly during laboratory or research meeting with the program director and members of the research team. This will culminate in the final thesis presentation and manuscript preparation (year-3)

**Systems-based Practice**

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of women’s health care and how research lead to diagnostic and treatment improvements for patients. Fellows will demonstrate understanding of the research agendas of national and international organizations as they relate to issues of women’s health and pelvic disorders (NIH and its institutes, AUGS, AUA, ABOG, ICS, IUGA, SUFU, etc.). The fellows will demonstrate basic understanding of grant writing and funding sources.

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**FELLOW RESEARCH AND PUBLICATIONS**

I. Research

The Research activities of the fellows are an integral part of their educational experience during the fellowship. It is expected that fellows will enter the program with an interest in research, although a variability of research backgrounds and levels of previous experience with research will be accommodated. The final fellowship year will be spent between 25-80% in research.

The following structure is designed to initiate and further promote the development of research questions, definition of specific aims, design of basic methodology in order to answer the scientific questions proposed, completion of protocols, implementation of a study, collection and analysis of the data, and a preparation of a manuscript.

A. All research must be based at USC or one of its affiliated hospitals.

B. Proposals must be submitted in advance of the intended start of research to allow time for review and approval.

C. Proposals are to be prepared according to a standard scientific research format.

D. Each project should have the sponsorship of a USC faculty member.

E. The biweekly didactic lecture series incorporates lectures discussing development of hypothesis, testing this hypothesis and development of research protocols, quantitative techniques such as statistics, basic epidemiological methodology, data analysis, and manuscript preparation.
F. The fellows are instructed in how to explain research to patients and how research can be applied to patient care. In addition, the research fellows will present their hypothesis, specific aims and planned methodology at the beginning of their research year to the entire faculty and to other fellows. This presentation will familiarize all in the program with the fellow’s proposed research plan but will also provide critique and feedback at the beginning of the fellow’s research year to allow for the ability to incorporate suggestions and ideas.

G. The research fellows will provide a progress report half way through their research year and a final research and thesis presentation. A thesis committee consisting of the Research Director, Dr. Rong Zhang an FPMRS Faculty member and another research scientist outside the fellowship as necessary will evaluate the fellow’s thesis and presentation and provide a written critique. The thesis will be in the form of a comprehensive scholarly paper which complies with the instructions to authors for one of the major journals in our field (J Urology, American Journal Obstetrics and Gynecology, NEJM, Urology, etc.). In addition to the thesis, all fellows will be evaluated in research competencies. Research presentations are held 3 times per year. At the beginning of the year in order to discuss and critique the proposed research project, midyear progress report, and at the end of the academic year to evaluate the research done. Attendance is mandatory for all FPMRS fellows and faculty. This forms part of the rotating didactic lecture series and thus will not involve more than the 2 hour weekly commitment by faculty. In addition, fellows will be required to participate in laboratory or research meeting conducted weekly by research mentors. In addition, Dr. Rodriguez conducts laboratory meetings where methodology, progress and results are discussed and problems identified. These 2 hour meetings happen weekly on Tuesdays at 10 am. All fellows in protected research rotation are required to participate. All other faculty are invited but not required to participate.

H. All fellows must complete two graduate level elective courses with at least one graduate level course in statistics. Courses in the graduate USC curriculum, the CTSI and the K30 program will also be available such as courses in clinical and translational investigation, animal research, grant writing and others, depending on the research interest of the fellow.

I. During the research year fellows participate in weekly laboratory meetings with the Program Director which includes presentations on basic science research, as well as progress reports on all clinical projects, and research journal club. These meetings are designed not only as laboratory meetings, but also as a venue to expose to each other the basic scientists and clinical researchers in order to cross-pollinate ideas and help each other with translational projects. These are truly multidisciplinary meetings involving collaborators and all the FPMRS faculty are invited to these meetings.

J. Papers to be presented at national or regional meetings should first be presented at the research meetings or grand rounds.

Fellows attend a minimum of one meeting per year (or more for research presentations) and will be encouraged to present at two annual meetings. They will have the opportunity to attend the Annual Meetings of the American Urological Association (AUA), Society of Urodynamics and Female Urology (SUFU), The American Urogynecologic Society (AUGS), the International Continence Society and/or the Society of Gynecologic Surgeons. The fellows are provided annual monetary support for meeting participation (1,500 per year). Fellows are encouraged to apply for educational grants in order to supplement this amount. In addition, the fellows will be encouraged to submit abstracts to other national or international meetings, as appropriate, specialty as related to their particular research area such as the American Geriatrics Society or the American Pain Society, among others. Active participation, including presentation, is encouraged at all meetings to promote the fellow’s experience and expertise in scientific meeting participation.
II. Publications

The Department must assure that fellows' publications include complete and accurate information concerning reprint requests, funding source, faculty status, etc. To assist fellows, all papers must be approved by the Program Director before submission. This includes papers reporting work done at any affiliate institution.

CURRICULUM

Anatomy and physiology of the pelvic floor
Physical Exam of the Patient with Pelvic Floor Disorders and POP-Q
Neurophysiology of the urinary tract
Surgical management of fecal incontinence *
Outcome Measures in Pelvic Floor Disorders#
Effects of Delivery in pelvic floor function: roll of vaginal delivery, epistomy, assisted delivery and c-section
Evaluation, treatment and outcomes of physical therapy for pelvic organ disorders: urinary and fecal incontinence, pelvic pain
Diagnosis and Conservative treatment of genitourinary pain disorders: vulvodynea, vestibulitis, and Painful Bladder Syndrome
Pessary and conservative management of Pelvic Floor Disorders
Surgical management of the vault: transvaginal vs. abdominal vs. robotic
Research Study Design#
Management of spinal cord injury and neurogenic bladder
Diagnosis and treatment of vaginal cysts, lesions, and masses^*
The use of graft materials in POP surgery: indications, characteristics, outcomes, and complications
Diagnosis and treatment of posterior wall prolapse
Treatment of Overactive Bladder: pharmacology, neuromodulation and surgical treatment
Evaluation of fecal incontinence: trans-anal ultrasound, manometry, and defecogram*
Obliterative treatment of POP: indications, techniques and outcomes
Diagnosis and management of vesicovaginal and urethrovaginal fistulas
Research Power Calculation#
Management of recurrent urinary tract infections
Evaluation and treatment of female sexual dysfunction^*
Role of urodynamics in the diagnosis of urinary incontinence (vlpp, upp, DO, etc.): theory and case studies
Diagnosis and treatment of stress urinary incontinence
Management of genitourinary complications of vaginal delivery
Primer to grant writing
Etiology and treatment of rectovaginal fistula
Congenital genitourinary anomalies^*
The role of urinary diversion in FPMRS
Diagnosis and management of chronic pelvic pain
Epidemiology of pelvic organ prolapse including racial variation^*
Hysterectomy and uterine sparing surgeries in uterine prolapse
Management of anti-incontinence complications
How to write and review a scientific manuscript
Management of Chronic Constipation*
Surgical Anatomy of the Retroperitoneum, Kidneys, and Ureters
Anatomy of the Lower Urinary Tract and Female Genitalia
Evaluation of the Urologinecologic Patient: History, Physical Examination, and Urinalysis
Urinary Tract Imaging: Basic Principles
Basic Instrumentation and Cystoscopy
Basics of Laparoscopic Urogynecologic Surgery
Infections of the Urinary Tract
Inflammatory Conditions of the Female Genitourinary Tract
Interstitial Cystitis and Related Disorders
Sexually Transmitted and Associated Diseases
Urological Implications of AIDS and Related Conditions
Cutaneous Diseases of the External Genitalia

Basic Principles of Immunology

Tissue Engineering Perspectives for Reconstructive Surgery

Pathophysiology of Urinary Obstruction
Physiology and Pharmacology of the Bladder and Urethra
Pathophysiology, Categorization, and Management of Voiding Dysfunction
Neuromuscular Dysfunction of the Lower Urinary Tract
Urinary Incontinence: Epidemiology, Pathophysiology, Evaluation, and Overview of Management
Pharmacologic Management of Storage and Emptying Failure
Conservative Management of Urinary Incontinence: Behavioral and Pelvic Floor Therapy, Urethral and Pelvic Devices
Electrical Stimulation and Neuromodulation in Storage and Emptying Failure
Retropubic Suspension Surgery for Incontinence in Women
Vaginal Reconstructive Surgery for Sphincteric Incontinence
Pubovaginal Slings
Tension-Free Vaginal Tape Procedures
Injection Therapy for Urinary Incontinence
Additional Treatment for Storage and Emptying Failure
Geriatric Voiding Dysfunction and Urinary Incontinence
Urinary Tract Fistulae
Bladder and Urethral Diverticula
The Artificial Genitourinary Sphincter
Use of Intestinal Segments in Urinary Diversion
Cutaneous Continent Urinary Diversion
Orthotopic Urinary Diversion
Genital and Lower Urinary Tract Trauma
Lower Urinary Tract Calculi
Normal and Anomalous Development of the Genital and Urinary Tract

Sexual Differentiation: Normal and Abnormal

Key
* Multi-disciplinary Defecatory Disorders Conference
^ Fellow Lecture
# Research Didactic
PATIENT CARE AND MEDICAL RECORDS

I. Consults
Junior and senior fellows see inpatient consults at LAC + USC and Keck Hospitals of USC (Norris, Keck) and RLARC. The residents on the service are consulted and they will include the FPMRS fellow. It is essential that the attending FPMRS faculty see the consult patients on consult rounds each day and sign the necessary patient notes. This can most effectively be done by adding these patients to the regular afternoon ward rounds. Regular and personal communication with the primary physician is encouraged. After seeing an inpatient on a consultation basis, fellows must write a brief and legible consultation note in the patient's chart. Signatures must be legible.

A. Guidelines for Consults
1. The resident assigned to consults must be available at all times when on call. If the resident is on page status "In Surgery; Not Available", the fellow will act as backup for FPMRS cases and the ER should be notified to call the OR Front Desk to contact the fellow.
2. The fellow on the consult service is expected to present all consults to the attending urologist for review and signature of consult notes in timely fashion.
3. It is left to the Fellows judgment whether to personally see a patient in the ER (i.e. for placement of a catheter at 3 a.m.)

II. Private Patient Care at LAC + USC, Keck Hospital of USC and Norris Cancer Hospital
While the fellow staff has responsibility for routine work-ups and orders on private patients, any special procedures and tests should be done only with the concurrence of the private staff physician, with whom the patient has made a contract. Good judgment must be maintained at all times in dealing with private patients, especially in regard to the amount of responsibility to be assumed by the fellow. It is always safest to check with the attending physician if any question exists.

Participation by the fellow staff in operative procedures performed on private patients is necessary for the safe conduct of the operation and is congruous with the institution's teaching obligations. The private physician will determine the extent of the fellow's participation in each case. Clearly, the fellows who will be first and second assistants must be thoroughly familiar with all aspects of the individual patient's history and physical examination, and with the planned operative procedure.

III. FPMRS Ambulatory Care Services
The USC Institute of Urology faculty and fellows see patients in the Norris Cancer Center Clinics, Keck Hospital, Beverly Hills clinics, RALRC outpatient clinics, and the LAC/USC urogynecology outpatient clinics. The fellow is responsible for maintaining the quality of the educational experience for residents and medical students assigned to the Service. All patients seen by the fellows must be treated as if they were private patients and extended all the courtesies inherent in the relationship between a patient and his physician.

IV. Same Day Admissions/Outpatient Surgeries
The majority of surgical patients in our institution are either treated as outpatients or admitted as inpatients on the morning of surgery. Fellows are responsible to guarantee the timely and appropriate evaluation of Same Day Admission (SDA) and outpatient surgery patients on the FPMRS GYN and URO Services. Faculty (and/or their fellows) are primarily responsible for work-ups on their private patients. Patients should be seen by the FPMRS fellow for routine history, physical and pre-operative evaluation who will be the primary assistant in surgery. The traditional Department requirement that fellows know the details of
the patient's history and medical problems holds for these patients as much as for patients admitted the night before surgery.

V. Handover/Transfer

Inpatient care of severely ill and/or postoperative patients is a 24 hour a day-365 days a year ongoing commitment. It is impossible and undesirable for a fellow surgeon to provide ongoing continuous care to all of his or her patients throughout their entire admission. Thus handover or transfer of the responsibility of patient care from one fellow surgeon to another is inevitable. The Department recognizes that such transfers or handover introduce the increased possibility of errors in patient care and subsequent iatrogenic complications. The situation is analogous to the exchange of the "baton" between runners in a relay race. The Institute of Urology is committed to minimizing the number of such transfers or handovers, optimizing the exchange of accurate and timely information, and thus reducing number of errors in patient care.

1. Transfer of Patient Information and Documentation

Transfer of information must be both written and verbal. Every transferred patient to be identified by name hospital number date of birth or age and sex. The transferring fellow surgeons written note tabulated within the last 24 hour's and preferably within the last 8 hours to include the date patient's name and number date of birth, diagnoses, operation performed, and importance pre-existing or postoperative type of analgesia, intravenous access, antibiotic coverage, and loss status, catheters utilized, drains utilized, dressing, postoperative activity, and planned postoperative course should be included. Current temperature, vital signs, urine output, examination findings, recent laboratory data, and recent images should be included. Pre-transfer written notes regarding preoperative or non-operative patient's should include admission problem, differential diagnosis, findings on physical examination, laboratory values, imaging results and other pertinent information. Proposed management plan should be included.

The accepting fellow surgeon must write a post acceptance progress report within 24 hours preferably within 8 hours to tabulated similar information. “Walk Around Rounds” by both the accepting and transferring fellow surgeons and introduction to the patients is to be strongly encouraged. It is extremely important for the transferring fellow surgeon bring to the attention of the accepting fellow surgeon performed or critical pending laboratory results or images. Supervising faculty surgeon must be identified. Transferring surgeons should be aware of patients with identical last names or very similar clinical diagnoses.

2. Minimal Number of Transition in Patient Care

There will be two clinical fellows per year who work closely. During the clinical year the fellow will spend weekly rotations alternating between particular attending rotations. One fellow will primarily be involved in inpatient/complex surgical learning and outpatient/clinic based learning while fellow #2 will be involved in outpatient surgical and outpatient learning. The fellow involved in the primarily outpatient rotation (fellow#2 in this example), will also spend time during the week in the urodynamic suite, learning outpatient procedures, in consultation and evaluations in the clinic, and spending one day a week in clinical research and training in manuscript writing. The fellow covering the primarily inpatient service, will be on call. At the end of the week, prior to switching weekly rotations, the fellows will provide a detail report on the inpatient service. Given that both fellows will be in clinics at the same time and that they will round as a team, this will minimize the number of transitions and ensure continuity of care. This scheme will provide a continuity of the care and follow-up of the patients during the clinical year.

3. The fellows will not have any in house calls. They will be in a rotational base on call at home. Vacations and other academic duties are factored into the completion of the at home call lists. Our urology fellows are on call in the hospital and can communicate to our fellows any issues with our inpatients or any
emergency. It will be extremely rare for a fellow to be required to visit the hospital while on call (perhaps once every 3 months).

VI. Common Circumstances Requiring Faculty Involvement
   A. Coverage of Fellow-Patient Interaction by Faculty
      Each fellow-patient interaction must be covered by direct faculty supervision, indirect on campus faculty supervision, or availability of indirect supervision by electronic communication. Identification of supervising faculty member must be provided by monthly call schedules or revisions. Each fellow at each of our teaching hospitals in each of the rotations has “back up” by an attending faculty member. Every fellow is aware of who the “back up faculty member” is and how they can be reached by telephone and/or pager. In a situation where a clinical problem exceeds the fellow’s capability the fellow contacts the faculty member and the problem is addressed by telephone consultation and/or in person hospital visit by the faculty member. Fellows are constantly encouraged to seek such a back up consultation. The indication for initiating the process is “if the fellow deems it to be necessary”. Fellows are constantly reassured that they will never be criticized for “unnecessary usage of such a back up system”. All surgical care requires an attending to be present in the operating room.

   B. Notification of Faculty
      Faculty must be notified and communicated with by the fellow in the following circumstances:
      1. once a day communication regarding all inpatients
      2. emergency admission of the patient from the emergency ward, clinic, or office
      3. development of a significant complication.
      4. unexpected transfer of the patient to the intensive care unit.
      5. unexpected emergency return of the patient to the operating room.
      6. discussion of end-of-life issues and concern by the family that they do not wish the patient to be resuscitated (DNR issues)
      7. serious concern and/or dissatisfaction by the family regarding the quality of overall medical care and/or quality or frequency of communication.
      8. serious concern by consulting physicians or nurses regarding a patient's overall progress
      9. patient admission to the emergency ward who is in a serious condition.
      10. death
      11. any clinical situation in which the fellow’s clinical intuition tells him/her that something is seriously wrong

   C. Indications for Indirect Faculty Supervisor To Go to the Patient's Bedside
      1. any of the above circumstances at the fellow staff does not feel qualified to handle a problem technically or, emotionally,
      2. any of the above circumstances as requested by the family.
      3. in any of the above circumstances after suitable mutual discussion between the fellow and supervising faculty member.

VII. Medical Records

      The fellows' management of medical records must comply with hospital regulations. Consultation notes must be discussed with and signed by the attending urologist on call.
RESOURCES

The department provides dedicated office space in the USC Institute of Urology department location which has computer terminals with internet access that can be used for word processing, image processing and analysis. There is similar space in the Department of Obstetrics and Gynecology for the fellow. The fellows also have direct access to the USC Healthcare Internal website, with access to: PubMed Medline, Harrison’s Online, MD Consult, STAT! Medical Online Database, CRL On-line, the Norris Medical Library, LAC+USC Medical Library as well as the Keck Hospital of USC Library. The department has a digital projector and computer laptop available to fellows for PowerPoint presentations.

The fellow office space is located at the USC Institute of Urology, located in Norris Cancer Hospital, seventh floor Topping Tower.

Clinic General Descriptions- Consultations, outpatient visits, outpatient procedures, and some diagnostic imaging services are provided in this setting.

Research laboratories & Collaborations- The research activities of the fellows are an integral part of their educational experience during the fellowship. It is expected that fellows will enter the program with an interest in research, although a variability of research backgrounds and levels of previous experience with research will be accommodated. The Urology Division of FPMRS has 1,000 sq. feet of dedicated wet research space under the supervision of the Fellowship Director. PhDs and graduate students participate in the laboratory which focuses in animal models or pelvic floor disorders and will help train and supervise fellows. In the laboratory, Fellows will be directly supervised by Dr. Rodríguez and Dr. Zhang, Assistant Professor of Urologic Research and director of the FPMRS laboratory and Dr. Chang, Assistant Professor of Urologic Research. Fellows will also be able to participate with a number of collaborators including investigators in the Eli and Edythe Broad Center for Regenerative Medicine and Stem Cell research at USC with over 10,000 sq. feet of laboratory space and cores including the Flow Cytometry, Microscopy, and Stem Cell core facilities and directed by Dr. Andrew McMahon, the Laboratory of Vertebral Brain Mapping directed by Dr. Daniel Holschneider, and the USC Clinical and Translational Science Institute (CTSI) a 56.8 million dollar effort to advanced urban health and its expert consultation services at every stage of the translational process. CTSI provides services in human studies and trials, statistical support and REDCap, a free and secure web based application designed to support data capture and surveys for clinical research. Fellows will also have access to the CTSI KL2 post-doctoral training program, a twelve month training program leading to a Master of Science in Clinical, Biomedical, and Translational Investigations (CBTI) as well as to participate in a less formal fashion in particular areas of its curriculum. Laboratories on the nearby medical school campus are also available. A variety of workshops/seminars on grant writing, manuscript preparation, and conduct of research are available through the Center for Excellence in Research. The urology and gynecology departments have developed a surgical patient database for online tracking of operative cases of outcomes, and the FPMRS division is also working on a data base for urodynamic and clinical findings. Fellows will also have access to work with the Multidiciplinary Approaches to Chronic Urologic Pelvic Pain (MAPP) data base, a multicenter NIDDK sponsored research network studying interstitial cystitis and chronic urologic pelvic pain via the Program Director who serves as Multi-PI of the UCLA-USC site.
The Urology department employ a statistician to provide statistical support for fellows’ research projects. In addition, fellows will have full access to medical records in both electronic and paper chart forms, provided that the appropriate IRB, HIPPA safeguards, and patient consents are maintained. Our Health Services collaborators also maintain a number of clinical databases available to the fellows.

The Department computer system is available for fellows’ use. Fellows are required to become proficient with Microsoft Word and PowerPoint software. Instruction is available. Additionally, various data base systems are available for data analysis. Publication and photography costs should be anticipated when a research project is designed, and included in the research grant budget.
LIBRARY AND JOURNALS

Keck Hospital of USC Library - Keck Hospital of USC library is a small reference library located on the first floor and used primarily by hospital medical residents/fellows, faculty and staff. The library has fewer than 500 volumes, including medical references, textbooks and major medical journals. Two computer terminals allow for searches of the collection. The library does not allow borrowing of materials. However, access to a photocopy machine can be arranged. For further information, call (323) 442-8686.

Norris Medical Library - This library is the largest of the medical libraries on the Health Sciences Campus and is the main USC library for the health sciences. It has an extensive collection on all aspects of biomedicine and health care, as well as books for leisure reading. The Norris Library offers a number of services beyond its extensive collection of health sciences books and journals, including its own Web site that provides access to online electronic journals and books, a computer lab and classroom, videoconferencing, and instruction on use of information resources for research (such as bioinformatics resources), education and clinical care.

LAC + USC Medical Library - The Inpatient Tower houses a lending and reference library on medical sciences for students, house staff and physicians. The LAC+USC Medical Center Library located in the Inpatient Tower (Room 3K111), provides services and resources in support of patient care. The Library subscribes to 290 journals, has 10,000 bound journals, and maintains 6300 books in basic science, clinical medicine and consumer health. The Library is open to Health Sciences Campus students, interns, residents, fellows and medical staff with LAC+USC Medical Center identification badges. The Library’s web site is restricted to access from within the LAC+USC Medical Center and computers in the Norris Medical Library. Hours are: Monday – Friday, 8:30 a.m. – 6:00 p.m.

Recommended Reading
OTHER FELLOW SUPPORT

A. DEA License – Currently fellows are require to provide a State of California license, DEA license and NPI registration.

B. CA State Fluoroscopy Licensure and Renewal (if necessary)
CONFERENCES, MEETINGS AND EXAMINATIONS

It is the obligation of the faculty to assure that fellows receive appropriate education in keeping with standards of the Department and national certifying bodies. Attendance at Department conferences is mandatory for all fellows. Attendance will be monitored and appropriate action will be taken for unexcused absences.

I. CONFERENCES

A. Didactics
   A formal educational curriculum has been adopted to integrate the educational activities and include involvement of all active faculty. This curriculum includes clinical conferences (urodynamics, indications conference or clinical subject), didactic conference and multi-disciplinary meetings with Colorectal, Urology, and Physical Therapy service or Journal Club. On a rotational basis the conferences will be devoted to: case presentation, didactic lectures, journal clubs, and research.

B. Research Presentations
   Research presentations are held four times per year in order to discuss and critique the proposed research project. The 5th scheduled date will be at the end of the academic year to evaluate the research done and/or the thesis presentation. Attendance is mandatory for all FPMRS fellows and faculty.

C. Rounds
   1. Grand Rounds
      a. Urology Grand Rounds take place from September through June on Friday mornings from 7:30am to 8:30am. On a rotation basis, chief fellows are responsible for organizing the conference and securing cases. The Chief Fellows are responsible for arranging for cases to be presented. Attendance is required for the entire session. Morbidity and Mortality Conference is an essential component the FPMRS program curriculum. The senior fellow is responsible for reporting "statistics" from all hospitals for the period since the last Grand Rounds. The "statistics" must include the number of major cases, endoscopic majors, minor procedures, complications and deaths.

      b. OBGYN- Grand Rounds take place from September through June on Friday mornings from 8:30am to 10:00am

      Grand Rounds attendees are granted one credit of Continuing Medical Education units for each session.

   3. Affiliated Hospital Rounds
      The attendance of our fellows on the scheduled rounds at the affiliated hospitals is expected.

D. Journal Club
   The FPMRS Clinical Journal Club meets three times per year. Its purpose is to discuss pertinent literature in the urology/gynecology/FPMRS field. Readings are assigned and discussions led by a member of the faculty. The majority of assigned articles will be from the journals listed in the “recommended reading” list (above). It is assumed that all fellows have subscriptions therefore these articles will not be photocopied. Assigned articles from other journals will be photocopied and distributed to each fellow. When articles are available via WWW link, this link will be provided to the fellows via email.
E. Teaching Conferences
Teaching Conferences provide didactic instruction to the fellows and attendance is mandatory. The goal is to provide instruction in all areas of Urology with the specific aim of preparing fellows for the FPMRS subspecialty in-service Examination and FPMRS Boards.

FPMRS topics presented include but are not limited to: anatomy and physiology of the pelvic floor, neurophysiology of the urinary tract, obliterator treatment of POP, urodynamics, and diagnosis and treatment of stress urinary incontinence. In addition, since clinical problems frequently involve multidisciplinary care beyond standard urologic training, faculty from other medical fields are often invited as speakers particularly in the areas of internal medicine, general surgery, pediatrics, obstetrics and gynecology, pathology and radiology.

The fellows will participate in all conferences, seminars and lectures of the FPMRS Fellowship.

In addition to the didactic conference, journal clubs and M&M conferences, faculty will participate in clinical conference (urodynamics, indications conference or clinical subject) weekly, once a week.

II. Educational Meetings

A. General Policy
The Department supports and encourages fellow attendance at local and national medical and scientific meetings. However, owing to the needs of the clinical services and the limitation of travel funds the guidelines set forth in this section must be followed.

Permission to attend any meeting, regardless of whether funding is requested, must be granted by the Program Director before submitting the abstract. Fellows who submit abstracts without prior approval may be denied permission to present the paper if the abstract is accepted. Written approval by the service chief and must be obtained before submitting the request to Program Director.

Fellow should work with Program Administrator to plan time off. In order to obtain the most economical airfares, it may be necessary for fellows to adjust their travel schedules, e.g. stay over a Saturday night. Every effort will be made to house fellows in a hotel within walking distance of the meeting headquarters. Fellows may be required to share rooms. The Department will determine the maximum rate of reimbursement for hotel rooms. If a fellow elects to stay at a more expensive hotel, the additional costs, including transportation expenses, must be paid by the fellow.

B. Registration for Local Meetings
Local and regional meetings that do not require travel or housing are often attractive and convenient for the fellows. Request for academic leave and registration fee payment must be submitted in writing to the Program Director.

C. Travel Reimbursement
The general rule is that travel advances are not available, however, airline tickets can be charged on a Department account. Fellows must retain all receipts for meals, lodging and other expenses and to submit these at the conclusion of the trip. Reimbursement is usually available within three weeks after proper documentation is submitted to the Business Office. A total of $1,500 per year is provided.

Guidelines for Reimbursement:

Travel-no travel packages especially ones that are purchased on the internet. They usually do not provide itemized bill.

Airfare-only use coach and try to use the travel Center to buy
your airfare so this way you do not have to put out your money and get reimbursed later on.

Registration Fees- You can use a purchase order to register to a conference.

Hotel rooms – don’t go beyond $400 per night. Always go with the most economical one. Spa, movies, alcohol, and insurance are not reimbursable.

Rental Cars- avoid putting gas where you rent your car since they usually cost a lot more than filling up the tank outside the rental place. We do not pay for insurance on rental cars.

Limousines- are not reimbursable

Meal allowance- not to exceed $69 per day. Keep all your itemized receipts from the first to the last day of travel.

Flying vs driving - - choose whichever is less expensive.

Travel reimbursement form- must be signed by traveler and PI.

III. Examinations

A. Subspecialty Certification in Female Pelvic Medicine and Reconstructive Surgery is encouraged for each fellow successfully completing the program.

- **For OB/Gyns** interested in FPMRS Certification, ABOG Bulletins for FPMRS Subspeciality Certification information for Senior is available at the ABOG website ([www.abog.org](http://www.abog.org))

- **For Urologists** interested in FPMRS Certification, the FPM-RS handbook is available on the Board's website, [www.abu.org](http://www.abu.org)
COMPETENCIES AND EVALUATION OF OUTCOMES

The goals and objectives define the ways in which the competencies are may be accomplished. Fellows are evaluated by the faculty at the end of each rotation using the Myevaluations.com system. Five days prior to the due date, the faculty receives an electronic reminder to complete the evaluation. Subsequent reminders are sent in the event of any delay in a timely submission. Failure to complete the evaluation within two weeks of the end-of-the-rotation will be reported to the Program Director who will meet with the faculty member and/or to the Chairman for appropriate action.

DUTY HOURS AND WORKING ENVIRONMENT

I. Duty Hours and On-Call Schedule

Fellows must have a keen sense of personal responsibility for continuing patient care, and must recognize that their obligation to patients is not automatically discharged at any given hour of the day or any particular day of the week. Duty hours and night and weekend call for fellows reflect the concept of responsibility for patients and provide for adequate patient care. However, it is the philosophy of the Urology Department that fellows must not be required regularly to perform excessively difficult or prolonged duties. Rotation schedules are prepared in compliance with the following guidelines:

A. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting. Fellows at all levels should have the opportunity to spend at least one full day out of seven free from all educational and clinical responsibilities. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities. At-home call cannot be assigned on these free days. These guidelines are based on an average over a four-week period. PGY6 and PGY7 fellows must not spend more than 24 continuous hours on duty. Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. It is essential for patient safety and fellow education that effective transitions in care occur. For this reason, fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

B. In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the fellow must: appropriately hand over the care of all other patients to the team responsible for their continuing care; and, document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. The program director will review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.

C. PGY5 fellows should have 10 consecutive hours, but must have 8 consecutive hours, free of duty between scheduled duty periods. Intermediate-level fellows should have 10 hours free of duty, and must have eight hours between scheduled. They must have at least 14 hours free of duty after the rare event of 24 hours of in-house duty. The aim of these policies is to ensure that senior fellows are prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80-hour, maximum duty period length, as explained above.

D. Urology residents and FPMRS fellows take call from home; however, on-call rooms permitting adequate rest and privacy are available for each resident on night duty in the hospital in the rare event they are
needed. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00pm and 8:00am, is strongly suggested.

E. There should be adequate backup support if the volume of patient care required jeopardizes the quality of patient care during or following assigned periods of duty.

F. Time spent in the hospital by residents/fellows on at-home call must count towards 80-hour maximum weekly hour limit.

In addition to specific duty hours, residents/fellows and faculty need to be cognizant and concerned about fatigue. Fellows will be encouraged to use alertness management strategies. Any fatigue concerns should be addressed with the supervising attending. Strategic naps are encouraged prior to driving home and especially after 16 hours of continuous duty. Nap rooms are provided in the House Staff Sleep Quarters.

Residents/fellows are required to report and log all duty hours on University online monitoring system-My evaluations. Resident/fellows must log in at least once every week. The Program coordinator will run reports on a weekly basis to review each resident’s/fellows reported duty hours to ensure compliance and address potential violations. Residents/fellows having concerns about duty hours should report them to the Program Director or Designated Institutional Official (DIO).

II. Alertness Management/Fatigue Mitigation

As part of the didactic lectures, faculty and fellows will be educated to recognize the signs of fatigue and sleep deprivation, manage fatigue and learn mitigation processes, and to adopt fatigue mitigation processes to manage the potential negative effects of fatigue in patient care and learning, such as naps. Adequate on call facilities and facilities to rest or take naps are available to the fellows at all times. In the event that a fellow is too fatigued to perform his/her duties, in order to ensure continuity of patient care, the fellow will sign off care to another fellow or resident on duty under the supervision of the attending physician.

III. Vacations

Fellows are entitled to four weeks (20 days) of vacation annually, not including educational leave for conference attendance. No other vacation time is permissible. Vacation days must be taken for employment or fellowship interviews.

Permission for time off must be granted from immediate rotation attending or supervisor then approved by Program Directors. Vacation time in July is not permitted. Specific vacation guidelines have been established and are delineated in Appendix A - GUIDELINES FOR FELLOW VACATION TIME.

IV. Leaves of Absence

Fellows planning parental leaves should consult with human resources to discuss USC benefits for maternity and paternity leaves. See benefit highlights in Appendix B- MATERNITY/PATERNITY LEAVE. In accordance with board certification regulations, absences from training longer than six weeks within one academic year (including vacation time) will delay time to completion of the fellowship. It is essential that all leaves of absence be discussed with the Program Director as soon as a fellow deems such a leave necessary. Leaves of absence will be approved on a case-by-case basis.

V. Moonlighting

Moonlighting by fellows is not permitted. Upon matching into the USC FPMRS program, all fellows signed a contract stating, "Employment outside USC or its affiliated hospitals (i.e. moonlighting) is not permitted and is possible cause for termination of your contract".
In cases of extreme hardship or under special circumstances detailed below, the Department may permit moonlighting during a fellow’s research year with written authorization from the Program Director and approval of the Service Chief of the affected hospital. Moonlighting must not interfere at any time with the ability of the fellow to achieve the goals and objectives of the program.

A. Fellows must demonstrate a true financial need and receive written permission from Program Director.

B. Moonlighting must be limited to 24 hours a week, and only on weekends during which there are no scheduled conferences.

C. Time spent by fellows in internal and external moonlighting must be counted toward the 80-hour weekly limit on duty hours.

D. Permission to moonlight will be revoked if it causes discord or conflicts with resident/fellow responsibilities.

E. All fellows engaged in moonlighting must be licensed for unsupervised medical practice.

F. Fellows must present a statement indicating their place of work and a list of the exact days and hours they will be working. They must also provide the Department with the name of a contact person at the hospital for verification of the assigned hours.

Fellows wishing to moonlight during vacation must clear that with the Program Director, again indicating the place and number of hours.
SURGICAL LOGS

The USC FPMRS Program is fully accredited by the Residency Review Committee (RRC) of the Accreditation Council for Graduate Medical Education (ACGME). The RRC has specified a number of requirements for continued accreditation of the Program. A major requirement is the maintenance of fellows’ surgical logs.

Fellows are required to enter their cases in the ACGME database on a daily basis. This database is accessible from any computer through the World Wide Web. Access codes and data entry instruction are available from the Academic Affairs Office. Each week, the Academic Affairs Coordinator will review the surgical logs to ensure that proper reporting by the fellows. Monthly review of the fellows’ surgical logs by the Program Director will include assessment of adequacy of common cases and volume for each fellow. As the cases are reviewed, graded responsibility of fellows is monitored so that adjustments can be made if necessary. If case logs indicate insufficient volume in any area, the fellow will be unable to advance to the next PGY level until the case number is sufficient.

The Program Director and Department Chairman will review surgical logs with the fellows individually at the time of the semi-annual review to ensure sufficient progress.

At the completion of the residency program, a final surgical log must be signed by the fellow as well as the Program Director and provided to the RRC. Fellows will not be provided with a diploma of program completion until final surgical logs are submitted to the Program Director.
ACGME Program Requirements for Graduate Medical Education in Female Pelvic Medicine and Reconstructive Surgery

ACGME-approved: June 10, 2012; effective: June 10, 2012
Revised Common Program Requirements effective: July 1, 2013
ACGME approved categorization: September 29, 2013; effective: July 1, 2014
Revised Common Program Requirements effective: July 1, 2015
Revised Common Program Requirements effective: July 1, 2016

ACGME Program Requirements for Residency Education in Female Pelvic Medicine and Reconstructive Surgery

COMMON PROGRAM REQUIREMENTS ARE IN BOLD
(Resident is same as fellow for FPMRS)

Introduction
Int.A. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident. The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept--graded and progressive responsibility--is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int.B. Female pelvic medicine and reconstructive surgery physicians provide consultation services and comprehensive management of women with pelvic floor disorders, including urinary incontinence, lower urinary tract disorders, pelvic organ prolapse, and childbirth-related injuries. Comprehensive management includes the preventive, diagnostic, and therapeutic procedures necessary for the total care of the female patient with these conditions, complications, and sequelae resulting from pelvic floor disorders.

Int.C. The educational program in female pelvic medicine and reconstructive surgery must be 36 months in length. (Core)*

I. Institutions
I.A. Sponsoring Institution
One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to fellow assignments at all participating sites. (Core)
The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her Female Pelvic Medicine and Reconstructive Surgery 2
I.A.1. The sponsoring institution must also sponsor Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs in either obstetrics and gynecology or urology. (Core)
I.A.1.a) The program must function as an integral part of an ACGME-accredited residency program in either obstetrics and gynecology or urology. (Core)
I.A.1.b) The female pelvic medicine and reconstructive surgery fellowship program must be affiliated with a Liaison Committee on Medical Education (LCME)-accredited medical school. (Detail)

I.B. Participating Sites
I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years. (Core)

The PLA should:
I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for fellows; (Detail)
I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document; (Detail)
I.B.1.c) specify the duration and content of the educational experience; and, (Detail)
I.B.1.d) state the policies and procedures that will govern fellow education during the assignment. (Detail)

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS). (Core)

II. Program Personnel and Resources
II.A. Program Director
II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution’s GMEC must approve a change in program director. (Core)
II.A.1.a) The program director must submit this change to the ACGME via the ADS. (Core)
II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability. (Detail)

II.A.3. Qualifications of the program director must include:

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee; (Core)

II.A.3.b) current certification in the subspecialty by the American Board of Obstetrics and Gynecology or the American Board of Urology, or subspecialty qualifications that are acceptable to the Review Committee; (Core)

II.A.3.c) current medical licensure and appropriate medical staff appointment; (Core)

II.A.3.d) completion of a female pelvic medicine and reconstructive surgery fellowship at least five years prior to appointment as the program director; and, (Core)

II.A.3.e) documented clinical and scholarly expertise in female pelvic medicine and reconstructive surgery. (Core)

II.A.4. The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas. (Core)

The program director must:
II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program; (Core)

II.A.4.b) approve a local director at each participating site who is accountable for fellow education; (Core)

II.A.4.c) approve the selection of program faculty as appropriate; (Core)

II.A.4.d) evaluate program faculty; (Core)

II.A.4.e) approve the continued participation of program faculty based on evaluation; (Core)

II.A.4.f) monitor fellow supervision at all participating sites; (Core)

II.A.4.g) prepare and submit all information required and requested by the ACGME; (Core)

II.A.4.g).(1) This includes but is not limited to the program

Female Pelvic Medicine and Reconstructive Surgery 4
application forms and annual program updates to the ADS, and ensure that the information submitted is accurate and complete. (Core)

II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution; (Detail)

II.A.4.i) provide verification of fellowship education for all fellows, including those who leave the program prior to completion; (Detail)

II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for fellow duty hours and the working environment, including moonlighting, (Core)

and, to that end, must:

II.A.4.j).1) distribute these policies and procedures to the fellows and faculty; (Detail)

II.A.4.j).2) monitor fellow duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements; (Core)

II.A.4.j).3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and, (Detail)

II.A.4.j).4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue. (Detail)

II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged; (Detail)

II.A.4.l) comply with the sponsoring institution’s written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of fellows, disciplinary action, and supervision of fellows; (Detail)

II.A.4.m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures; (Detail)

II.A.4.n) obtain review and approval of the sponsoring institution’s GMEC/DIO before submitting information or requests to the ACGME, including: (Core)

II.A.4.n).1) all applications for ACGME accreditation of new programs; (Detail)

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II.A.4.n).(2) changes in fellow complement; (Detail)
II.A.4.n).(3) major changes in program structure or length of training; (Detail)
II.A.4.n).(4) progress reports requested by the Review Committee; (Detail)
II.A.4.n).(5) requests for increases or any change to fellow duty hours; (Detail)
II.A.4.n).(6) voluntary withdrawals of ACGME-accredited programs; (Detail)
II.A.4.n).(7) requests for appeal of an adverse action; and, (Detail)
II.A.4.n).(8) appeal presentations to a Board of Appeal or the ACGME. (Detail)

II.A.4.o) obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses:
II.A.4.o).(1) program citations, and/or, (Detail)
II.A.4.o).(2) request for changes in the program that would have significant impact, including financial, on the program or institution. (Detail)
II.A.4.p) dedicate at least eight hours per week of his or her professional effort to the administrative and educational activities of the female pelvic medicine and reconstructive surgery program. (Core)

II.B. Faculty
II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows at that location. (Core)

The faculty must:
II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of fellows, and (Core)
II.B.1.b) administer and maintain an educational environment conducive to educating fellows in each of the ACGME competency areas. (Core)

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II.B.2. The physician faculty must have current certification in the subspecialty by the American Board of Obstetrics and Gynecology or Urology, or possess qualifications judged acceptable to the Review Committee. (Core)

II.B.2.a) The Review Committee accepts only current ABMS specialty certification in either obstetrics and gynecology or urology. (Core)

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment. (Core)

II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Detail)

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b).(1) peer-reviewed funding; (Detail)

II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks; (Detail)

II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, (Detail)

II.B.5.b).(4) participation in national committees or educational organizations. (Detail)

II.B.5.c) Faculty should encourage and support fellows in scholarly activities. (Core)

II.B.6. In addition to the program director, there must be at least one other full-time program faculty member who is certified in female pelvic medicine and reconstructive surgery by either the American Board of Obstetrics and Gynecology or the American Board of Urology. (Core)

II.B.7. For fellowship programs functioning as part of an ACGME-accredited obstetrics and gynecology residency, there should be one core faculty member who is a urologist certified by the American Board of Urology in female pelvic medicine and reconstructive surgery, or who possesses other qualifications acceptable to the Review Committee. (Core)

II.B.8. For programs functioning as part of an ACGME-accredited urology residency, there should be one core faculty member who is an
obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology in female pelvic medicine and reconstructive surgery, or who possesses other qualifications acceptable to the Review Committee. (Core)

II.B.9. Other faculty members must include qualified colorectal surgeons and gastroenterologists or other physicians who possess qualifications acceptable to the Review Committee. (Detail)

II.C. Other Program Personnel
The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program. (Core)

II.D. Resources
The institution and the program must jointly ensure the availability of adequate resources for fellow education, as defined in the specialty program requirements. (Core)

II.D.1. The primary clinical site must include operating rooms, ambulatory clinic facilities, recovery rooms, intensive care units, blood banks, diagnostic laboratories, and imaging services. (Core)

II.D.1.a) Access to these resources must be available at all times for the management of complications. (Core)

II.D.2. The program must have clinical and laboratory research facilities that are equipped to allow fellows to engage in scholarly activities. (Core)

II.E. Medical Information Access
Fellows must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available. (Detail)

III. Fellow Appointments
III.A. Eligibility Criteria
The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements. (Core)

III.A.1. Eligibility Requirements – Residency Programs
III.A.1.a) All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, or in Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians Female Pelvic Medicine and Reconstructive Surgery
of Canada (CFPC)-accredited residency programs located in Canada. Residency programs must receive verification of each applicant’s level of competency in the required clinical field using ACGME or CanMEDS Milestones assessments from the prior training program. (Core)

III.A.1.b) A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. (Core)

III.A.1.c) A Review Committee may grant the exception to the eligibility requirements specified in Section III.A.2.b) for residency programs that require completion of a prerequisite residency program prior to admission. (Core)

III.A.1.d) Review Committees will grant no other exceptions to these eligibility requirements for residency education. (Core)

III.A.2. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC-accredited residency program located in Canada. (Core)

[See Program Requirements III.A.2.d) and III.A.2.e)]

III.A.2.a) Fellowship programs must receive verification of each entering fellow’s level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program. (Core)

III.A.2.b) Fellow Eligibility Exception

A Review Committee may grant the following exception to the fellowship eligibility requirements: An ACGME-accredited fellowship program may accept an exceptionally qualified applicant**, who does not satisfy the eligibility requirements listed in Sections III.A.2. and III.A.2.a), but who does meet all of the following additional qualifications and conditions: (Core) Female Pelvic Medicine and Reconstructive Surgery 9
III.A.2.b).(1) Assessment by the program director and fellowship selection committee of the applicant’s suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and (Core)

III.A.2.b).(2) Review and approval of the applicant’s exceptional qualifications by the GMEC or a subcommittee of the GMEC; and (Core)

III.A.2.b).(3) Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and; (Core)

III.A.2.b).(4) For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and, (Core)

III.A.2.b).(5) Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant’s Milestones evaluation conducted at the conclusion of the residency program. (Core)

III.A.2.b).(5).(a) If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training. (Core)

** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program. Female Pelvic Medicine and Reconstructive Surgery 10
III.A.2.c) The Review Committees for Obstetrics and Gynecology and Urology do not allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A.2. (Core)

III.A.2.d) To be eligible for appointment at the F1 level, a fellow must have satisfactorily completed an obstetrics and gynecology or urology residency accredited by the ACGME or an obstetrics and gynecology or urology program located in Canada and accredited by the RCPSC. (Core)

III.A.2.e) To be eligible for appointment at the F2 level, a fellow must have satisfactorily completed a urology residency accredited by the ACGME or a urology residency located in Canada and accredited by the RCPSC. (Core)

III.A.2.f) Prior to entering the program, each fellow must be informed of the requirements for completing the program, including the criteria to qualify for the subspecialty board examination. (Core)

III.B. Number of Fellows
The program’s educational resources must be adequate to support the number of fellows appointed to the program. (Core)

III.B.1. The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. (Core)

III.B.2. There should be at least two fellows in the program at all times. (Detail)

III.C. Fellow Transfers
III.C.1. Before accepting a fellow who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring fellow. (Detail)

III.C.2. A program director must provide timely verification of fellowship education and summative performance evaluations for fellows who may leave the program prior to completion. (Detail)

III.D. Appointment of Fellows and Other Learners
The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed fellows’ education. (Core)

III.D.1. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines. (Detail)
IV. Educational Program
IV.A. The curriculum must contain the following educational components:
IV.A.1. Overall educational goals for the program, which the program must make available to fellows and faculty; (Core)

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to fellows and faculty at least annually, in either written or electronic form; (Core)

IV.A.2.a) At the beginning of the program, each fellow must have an individual educational plan that includes a monthly block rotation diagram displaying the clinical, didactic, and research activities by rotation. (Detail)

IV.A.3. Regularly scheduled didactic sessions; (Core)

IV.A.3.a) There must be regularly scheduled journal clubs, seminars, didactics, and morbidity and mortality conferences. (Core)

Topics must include:
IV.A.3.a).(1) anatomy and physiology of the pelvic floor, including the lower urinary tract, and colorectal-anal and vaginal function; (Detail)

IV.A.3.a).(2) behavioral, pharmacological, functional, and surgical treatment of urinary incontinence, anal incontinence, and pelvic floor dysfunction, including micturition and defecation disorders, and pelvic organ prolapse; (Detail)

IV.A.3.a).(3) diagnosis and evaluation of pelvic floor dysfunction, including urinary incontinence, voiding dysfunction, pelvic organ prolapse, defecation disorders, and sexual dysfunction; (Detail)

IV.A.3.a).(4) diagnosis and management of genitourinary and rectovaginal fistulae, urethral diverticula, injuries to the genitourinary tract, congenital anomalies, and infectious and non-infectious irritative conditions of the lower urinary tract and pelvic floor; (Detail)

IV.A.3.a).(5) management of genitourinary complications of vaginal delivery, spinal cord injuries, and medical, psychiatric, and geriatric conditions related to pelvic floor disorders; (Detail)

IV.A.3.a).(6) pathophysiology of pelvic floor dysfunction including urinary incontinence, anal incontinence, voiding dysfunction, pelvic organ prolapse, defecation disorders

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and sexual dysfunction; and, (Detail)

IV.A.3.a).(7) research design, grant writing, research methodology, scientific writing, and presentation skills. (Detail)

IV.A.4. Delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and supervision of fellows over the continuum of the program; and, (Core)

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: (Core)

IV.A.5.a) Patient Care and Procedural Skills

IV.A.5.a).(1) Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (Outcome)

IV.A.5.a).(2) Fellows must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Fellows: (Outcome)

IV.A.5.a).(2).(a) must demonstrate competence in:

IV.A.5.a).(2).(a).(i) assessing the effects of treatment, and recognizing and managing the complications of therapy; (Outcome)

IV.A.5.a).(2).(a).(ii) diagnosing and managing patients with urinary incontinence, pelvic organ prolapse, genitourinary and rectovaginal fistulae, anal incontinence, urethral diverticula, injuries to the genitourinary tract, congenital anomalies, and infectious and non-infectious irritative conditions of the lower urinary tract and pelvic floor; (Outcome)

IV.A.5.a).(2).(a).(iii) evaluating the lower urinary and genital tract for abnormalities including neoplasms, and interpreting cytology and biopsy results; (Outcome)

IV.A.5.a).(2).(a).(iv) performing advanced laparoscopic, abdominal, and vaginal surgery for uterovaginal prolapse and post-hysterectomy vaginal vault prolapse including reconstructive and obliterate
procedures. (Outcome)

IV.A.5.a).(2).(a).(v) performing cystoscopy and cystoscopic manipulations, including stent placement retrograde pyelograms and ureteral stent placement; (Outcome)

IV.A.5.a).(2).(a).(vi) performing urodynamics testing; (Outcome)

IV.A.5.a).(2).(a).(vii) performing surgery for urinary incontinence including native tissue and synthetic slings and periurethral bulking agents; and, (Outcome)

IV.A.5.a).(2).(a).(viii) performing surgery for complicated obstetric lacerations and treatment of related benign conditions occurring in the female pelvis. (Outcome)

IV.A.5.a).(2).(b) completing the F1 year must demonstrate competence in:

IV.A.5.a).(2).(b).(i) evaluating and managing hematuria; (Outcome)

IV.A.5.a).(2).(b).(ii) evaluating and managing painful bladder, including interstitial cystitis; (Outcome)

IV.A.5.a).(2).(b).(iii) evaluating and managing neurogenic voiding dysfunction; (Outcome)

IV.A.5.a).(2).(b).(iv) evaluating and treating urinary tract infections; and, (Outcome)

IV.A.5.a).(2).(b).(v) performing a female pelvic exam, including quantification of pelvic organ prolapse. (Outcome)

IV.A.5.a).(2).(c) completing the F2 year must demonstrate competence in the behavioral, pharmacological, functional, non-surgical, and surgical treatment of:

IV.A.5.a).(2).(c).(i) micturition and defecation disorders; (Outcome)

IV.A.5.a).(2).(c).(ii) pelvic organ prolapse; and, (Outcome)

IV.A.5.a).(2).(c).(iii) urinary incontinence. (Outcome)

IV.A.5.a).(2).(d) completing the F3 year must demonstrate competence in:

IV.A.5.a).(2).(d).(i) diagnosing and managing genitourinary and
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rectovaginal fistulae, urethral diverticula, injuries to the genitourinary tract, and congenital anomalies; and,

(Outcome)

IV.A.5.a).(2).(d).(ii) managing genitourinary complications following vaginal delivery, spinal cord injuries, and similar health events.  (Outcome)

**IV.A.5.b) Medical Knowledge**

**Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows:**

(Outcome)

IV.A.5.b).(1) completing the F1 year must demonstrate competence in their knowledge of:

IV.A.5.b).(1).(a) the epidemiology of urinary incontinence, pelvic organ prolapse, and defecation disorders, including birth, aging, and neurologic disease;  (Outcome)

IV.A.5.b).(1).(b) the impact of urinary incontinence, pelvic organ prolapse, and defecation disorders on quality of life;  (Outcome)

IV.A.5.b).(1).(c) the use and interpretation of disease-specific and global health questionnaires to evaluate the impact of pelvic floor disorders on quality of life;  (Outcome)

IV.A.5.b).(1).(d) the scientific method of problem solving and evidence-based decision making; and,  (Outcome)

IV.A.5.b).(1).(e) indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline, to include:  (Outcome)

IV.A.5.b).(1).(e).(i) the indications for and use of screening tests and procedures including urinalysis, urine cytology, and pad test; and,  (Outcome)

IV.A.5.b).(1).(e).(ii) use and interpretation of a voiding diary.  (Outcome)

IV.A.5.b).(2) completing the F2 year must demonstrate competence in their knowledge of:

IV.A.5.b).(2).(a) the anatomy, physiology, and pathophysiology of the pelvic floor, including the lower urinary tract,
and colorectal-anal and vaginal functioning; (Outcome)

IV.A.5.b).(2).(b) clinically pertinent areas of pathology, infectious disease, geriatric medicine, physical therapy, pain management, sexual dysfunction, and psychosocial aspects of pelvic floor disorders; and, (Outcome)

IV.A.5.b).(2).(c) indications, contraindications, limitations, complications, techniques, and interpretation of results of screening, diagnostic, and therapeutic procedures for the treatment and evaluation of pelvic floor disorders, to include: (Outcome)

IV.A.5.b).(2).(c).(i) pelvic imaging studies for the diagnostic evaluation of urinary and anal incontinence, pelvic floor dysfunction, and prolapse; and, (Outcome)

IV.A.5.b).(2).(c).(ii) urodynamic assessment. (Outcome)

IV.A.5.b).(3) completing the F3 year must demonstrate competence in their knowledge of:

IV.A.5.b).(3).(a) assessment and treatment of lower urinary tract dysfunction secondary to neurologic diseases; (Outcome)

IV.A.5.b).(3).(b) indications, contraindications, limitations, complications, techniques, and interpretation of results of screening, diagnostic, and therapeutic procedures including surgery for: (Outcome)

IV.A.5.b).(3).(b).(i) pelvic organ prolapse; (Outcome)

IV.A.5.b).(3).(b).(ii) urinary incontinence; (Outcome)

IV.A.5.b).(3).(b).(iii) rectovaginal fistula related to obstetric trauma; and, (Outcome)

IV.A.5.b).(3).(b).(iv) vesicovaginal and urethrovaginal fistula. (Outcome)

IV.A.5.b).(3).(c) quantitative techniques, including biostatistics, epidemiology, research design, and research methods. (Outcome)

IV.A.5.c) Practice-based Learning and Improvement

Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care Female Pelvic Medicine and Reconstructive Surgery 16
based on constant self-evaluation and life-long learning. (Outcome)
Fellows are expected to develop skills and habits to be able to meet the following goals:

IV.A.5.c).(1) identify strengths, deficiencies, and limits in one’s knowledge and expertise; (Outcome)

IV.A.5.c).(2) set learning and improvement goals; (Outcome)

IV.A.5.c).(3) identify and perform appropriate learning activities; (Outcome)

IV.A.5.c).(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; (Outcome)

IV.A.5.c).(5) incorporate formative evaluation feedback into daily practice; (Outcome)

IV.A.5.c).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems; (Outcome)

IV.A.5.c).(7) use information technology to optimize learning; and, (Outcome)

IV.A.5.c).(8) participate in the education of patients, families, students, fellows and other health professionals. (Outcome)

IV.A.5.d) Interpersonal and Communication Skills

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Outcome)
Fellows are expected to:

IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Outcome)

IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies; (Outcome)

IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group; (Outcome)

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IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; and, (Outcome)

IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable. (Outcome)

IV.A.5.e) Professionalism

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Fellows are expected to demonstrate:

IV.A.5.e).(1) compassion, integrity, and respect for others; (Outcome)

IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest; (Outcome)

IV.A.5.e).(3) respect for patient privacy and autonomy; (Outcome)

IV.A.5.e).(4) accountability to patients, society and the profession; and, (Outcome)

IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. (Outcome)

IV.A.5.f) Systems-based Practice

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. (Outcome)

Fellows are expected to:

IV.A.5.f).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty; (Outcome)

IV.A.5.f).(2) coordinate patient care within the health care system relevant to their clinical specialty; (Outcome)

IV.A.5.f).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; (Outcome)

IV.A.5.f).(4) advocate for quality patient care and optimal patient care.
care systems; (Outcome)

IV.A.5.f).(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and, (Outcome)

IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions. (Outcome)

IV.A.6. Curriculum Organization and Fellow Experiences

IV.A.6.a) Fellows must have both inpatient and outpatient experiences. (Core)

IV.A.6.a).(1) Fellows should have supervised responsibility for the total care of the patient, including initial evaluation, establishment of diagnosis, selection of appropriate therapy, and management of complications. (Core)

IV.A.6.a).(2) Fellows must participate in continuity of patient care through pre-operative and post-operative clinics and inpatient contact. (Core)

IV.A.6.a).(3) Fellows must record all surgical procedures in which they have a significant role in the ACGME Case Log System. (Core)

IV.A.6.a).(4) The total time devoted to these experiences should not exceed 24 months. (Detail)

IV.A.6.b) The 12 months of the program not devoted to inpatient and outpatient experiences should be devoted to research and/or other elective experiences. (Detail)

IV.A.6.c) A fellow must not spend more than 10 percent of his or her time, when averaged over a four-week period, performing duties outside of female pelvic medicine and reconstructive surgery. (Detail)

IV.A.6.d) Fellows should participate in the diagnosis and management of clinically pertinent areas of pathology, infectious disease, geriatric medicine, physical therapy, pain management, pre- and post-operative care, sexual dysfunction, and psychosocial aspects of pelvic floor disorders. (Detail)

IV.B. Fellows’ Scholarly Activities

IV.B.1. The curriculum must advance fellows’ knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)

IV.B.2. Fellows should participate in scholarly activity. (Core)

IV.B.2.a) Each fellow, under the direction of a faculty mentor, must

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complete a comprehensive written scholarly paper or quality improvement project (thesis) during the program that demonstrates the following: (Outcome)

IV.B.2.a).(1) utilization of advanced research methodology and techniques, including research design and quantitative analysis; (Outcome)

IV.B.2.a).(2) collection and statistical analysis of information obtained from a structured basic laboratory and/or clinical research setting; and, (Outcome)

IV.B.2.a).(3) synthesis of the scientific literature, hypothesis testing, and description of findings and results. (Outcome)

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate fellow involvement in scholarly activities. (Detail)

V. Evaluation
V.A. Fellow Evaluation
V.A.1. The program director must appoint the Clinical Competency Committee. (Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. (Core)

V.A.1.a).1) The program director may appoint additional members of the Clinical Competency Committee.

V.A.1.a).1).(a) These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program’s fellows in patient care and other health care settings. (Core)

V.A.1.a).1).(b) Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee. (Core)

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee. (Core)

V.A.1.b).1) The Clinical Competency Committee should:

V.A.1.b).1).(a) review all fellow evaluations semi-annually; (Core)
V.A.1.b).(1).(b) prepare and ensure the reporting of Milestones evaluations of each fellow semi-annually to ACGME; and, (Core)

V.A.1.b).(1).(c) advise the program director regarding fellow progress, including promotion, remediation, and dismissal. (Detail)

V.A.2. Formative Evaluation

V.A.2.a) The faculty must evaluate fellow performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment. (Core)

V.A.2.a).(1) Each fellow’s scholarly activity must be monitored by a faculty member and confirmed by a competency assessment committee that includes at least one physician scientist not affiliated with the program. (Detail)

V.A.2.b) The program must:

V.A.2.b).(1) provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; (Core)

V.A.2.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); (Detail)

V.A.2.b).(3) document progressive fellow performance improvement appropriate to educational level; and, (Core)

V.A.2.b).(4) provide each fellow with documented semiannual evaluation of performance with feedback. (Core)

V.A.2.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy. (Detail)

V.A.3. Summative Evaluation

V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure fellows are able to practice core professional activities without supervision upon completion of the program. (Core)

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V.A.3.a).(1) Each fellow must give an oral presentation of his or her scholarly project (thesis), which must be formally assessed by the faculty, including a written evaluation. (Outcome)

V.A.3.b) The program director must provide a summative evaluation for each fellow upon completion of the program. (Core)

This evaluation must:
V.A.3.b).(1) become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy; (Detail)
V.A.3.b).(2) document the fellow's performance during the final period of education; and, (Detail)
V.A.3.b).(3) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision. (Detail)

V.B. Faculty Evaluation
V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program. (Core)
V.B.2. These evaluations should include a review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities. (Detail)
V.B.3. This evaluation must include at least annual written confidential evaluations by the fellows. (Detail)

V.C. Program Evaluation and Improvement
V.C.1. The program director must appoint the Program Evaluation Committee (PEC). (Core)
V.C.1.a) The Program Evaluation Committee:
V.C.1.a).(1) must be composed of at least two program faculty members and should include at least one fellow; (Core)
V.C.1.a).(2) must have a written description of its responsibilities; and, (Core)
V.C.1.a).(3) should participate actively in:
V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; (Detail)
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V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; (Detail)

V.C.1.a).(3).(c) addressing areas of non-compliance with ACGME standards; and, (Detail)

V.C.1.a).(3).(d) reviewing the program annually using evaluations of faculty, fellows, and others, as specified below. (Detail)

V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation. (Core)

The program must monitor and track each of the following areas:
V.C.2.a) fellow performance; (Core)

V.C.2.b) faculty development; (Core)

V.C.2.c) graduate performance, including performance of program graduates on the certification examination; (Core)

V.C.2.c).(1) At least 70 percent of the program’s graduates from the preceding five years must have taken the subspecialty certification examination of the American Board of Obstetrics and Gynecology or American Board of Urology. (Outcome)

V.C.2.c).(2) At least 70 percent of the program’s graduates from the preceding five years who took the certifying examination for female pelvic medicine and reconstructive surgery for the first time must have passed. In those programs with fewer than five graduates in the past five years, at least 70 percent of the five most recent graduates must have passed. (Outcome)

V.C.2.d) program quality; and, (Core)

V.C.2.d).(1) Fellows and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and (Detail)

V.C.2.d).(2) The program must use the results of fellows’ and faculty members’ assessments of the program together with other program evaluation results to improve the program. (Detail)

V.C.2.e) progress on the previous year’s action plan(s). (Core)

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V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. (Core)

V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. (Detail)

VI. Fellow Duty Hours in the Learning and Working Environment
VI.A. Professionalism, Personal Responsibility, and Patient Safety
VI.A.1. Programs and sponsoring institutions must educate fellows and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients. (Core)
VI.A.2. The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational environment. (Core)
VI.A.3. The program director must ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. (Core)
VI.A.4. The learning objectives of the program must:
VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and, (Core)
VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill non-physician service obligations. (Core)
VI.A.5. The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. (Core)
VI.A.6. Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:
VI.A.6.a) assurance of the safety and welfare of patients entrusted to their care; (Outcome)
VI.A.6.b) provision of patient- and family-centered care; (Outcome)
VI.A.6.c) assurance of their fitness for duty; (Outcome)
VI.A.6.d) management of their time before, during, and after clinical assignments; (Outcome)
VI.A.6.e) recognition of impairment, including illness and fatigue, in themselves and in their peers; (Outcome)
VI.A.6.f) attention to lifelong learning; (Outcome)
VI.A.6.g) the monitoring of their patient care performance improvement indicators; and, (Outcome)
VI.A.6.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data. (Outcome)

VI.A.7. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. They must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider. (Outcome)

VI.B. Transitions of Care

VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care. (Core)
VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)
VI.B.3. Programs must ensure that fellows are competent in communicating with team members in the hand-over process. (Outcome)
VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient’s care. (Detail)

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:
VI.C.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation; (Core)
VI.C.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and, (Core)
VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules. (Detail)

VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her Female Pelvic Medicine and Reconstructive Surgery 25
patient care duties. (Core)
VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home. (Core)
VI.D. Supervision of Fellows
VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient’s care. (Core)
VI.D.1.a) This information should be available to fellows, faculty members, and patients. (Detail)
VI.D.1.b) Fellows and faculty members should inform patients of their respective roles in each patient’s care. (Detail)
VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients. (Core)
Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback as to the appropriateness of that care. (Detail)
VI.D.3. Levels of Supervision
To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision: (Core)
VI.D.3.a) Direct Supervision – the supervising physician is physically present with the fellow and patient. (Core)
VI.D.3.b) Indirect Supervision:
VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. (Core)
VI.D.3.b).(2) with direct supervision available – the supervising
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physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. (Core)

VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. (Core)

VI.D.4.a) The program director must evaluate each fellow’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria. (Core)

VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows. (Detail)

VI.D.4.c) Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)

VI.D.5. Programs must set guidelines for circumstances and events in which fellows must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions. (Core)

VI.D.5.a) Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. (Outcome)

VI.D.5.a)(1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. (Core)

VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility. (Detail)

VI.E. Clinical Responsibilities

The clinical responsibilities for each fellow must be based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services. (Core)

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VI.F. Teamwork

Fellows must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty. (Core)

VI.F.1. The interprofessional team may include: physicians from other specialties such as colorectal surgery and gastroenterology, credentialed registered nurses (RNs), certified nurses, certified nurse specialists (CNSs), certified dieticians, mental health providers, nurse practitioners (NPs), other advanced practice nurses, other advanced practice providers, pharmacists, physical and occupational therapists, physician assistants (PAs) and social workers should be integrated into both the didactic and clinical experience of the fellow as clinically relevant. (Detail)

VI.G. Fellow Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting. (Core)

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale. (Detail)

The Review Committee will not consider requests for exceptions to the 80-hour limit to the fellows' work week.

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures. (Detail)

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution’s GMEC and DIO. (Detail)

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program. (Core)

VI.G.2.b) Time spent by fellows in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be
Female Pelvic Medicine and Reconstructive Surgery 28
counted towards the 80-hour Maximum Weekly Hour Limit. (Core)

VI.G.2.c) PGY-1 residents are not permitted to moonlight. (Core)

VI.G.3. Mandatory Time Free of Duty

Fellows must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)

VI.G.4. Maximum Duty Period Length

VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration. (Core)

VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. (Core)

VI.G.4.b).(1) Programs must encourage fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested. (Detail)

VI.G.4.b).(2) It is essential for patient safety and fellow education that effective transitions in care occur. Fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours. (Core)

VI.G.4.b).(3) Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. (Core)

VI.G.4.b).(4) In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. (Detail)

VI.G.4.b).(4).(a) Under those circumstances, the fellow must:

VI.G.4.b).(4).(a).(i) appropriately hand over the care of all other patients to the team responsible for their continuing care; and, (Detail)

Female Pelvic Medicine and Reconstructive Surgery 29
VI.G.4.b).(4).(a).(ii) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. (Detail)

VI.G.4.b).(4).(b) The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty. (Detail)

VI.G.5. Minimum Time Off between Scheduled Duty Periods

VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. (Core)

VI.G.5.b) Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. (Core)

VI.G.5.c) Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. (Outcome)

Female pelvic medicine and reconstructive surgery fellows are considered to be in the final years of education.

VI.G.5.c).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these fellows must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. (Detail)

VI.G.5.c).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director. (Detail)

VI.G.5.c).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the fellow has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. (Detail)

Female Pelvic Medicine and Reconstructive Surgery 30
VI.G.6. Maximum Frequency of In-House Night Float

Fellows must not be scheduled for more than six consecutive nights of night float. (Core)

VI.G.7. Maximum In-House On-Call Frequency

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period). (Core)

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by fellows on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. (Core)

VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow. (Core)

VI.G.8.b) Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”. (Detail)

***

“Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

Osteopathic Recognition

For programs seeking Osteopathic Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable.

(http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf)
Appendix A
GUIDELINES FOR FELLOW VACATION TIME

GENERAL GUIDELINES

- Fellows are entitled to four calendar weeks (20 days) of vacation annually.
- No vacation time may be taken during the months of June or July.
- Vacations must be taken in one-week or two-week blocks. Fellows in their clinical rotations can only take a one-week block vacation. Two-week block vacations and small blocks (less than 5 days) will only be approved during research rotations.
- Fellows in their last year of training (3rd year fellows) may also use small blocks of vacation time for the purpose of job or fellowship interviews only.
- Job or fellowship interview days must be counted as vacation days.
- Request time off with immediate rotation supervisor or attending. When pre-approved, submit requested days off to FPMRS administrator for record-keeping and formal approval from Director or Co-Director a minimum of 4 weeks in advance of requested vacation. Once formal approval is granted, log your time off on WorkDay site. (If rotation supervisor is one of the directors, please inform administrator nonetheless for our program records.)

I. 4 weeks of vacation per academic year.

For Gyn Track Fellow

a. Year 1
   i. 2 week on FPMRS-GYN rotation.
   ii. 2 weeks on Research rotation.

b. Year 2
   i. 2 weeks on FPMRS-GYN rotation.
   ii. 2 weeks on Research rotation.

c. Year 3
   i. 3 weeks on FPMRS-GYN rotation.
   ii. 1 week on Research rotation.
For Urology Track Fellow

a. Year 2
   i. 4 weeks on FPMRS-UROLOGY rotation.

b. Year 3
   i. 4 weeks on Research rotation.

II. Scientific Meetings

- Approved educational leave for meeting attendance will not be counted as vacation time.
- Fellows are encouraged to submit their research work and attend 1-2 national meetings per year.
- A total stipend of $1,500 per year will be provided to fund these educational experiences.
- Fellows must submit original research work in order to qualify to attend a particular meeting.
- As the vacation time, requests to attend meetings must follow the general guidelines above.

Presentations at scientific meetings, attendance at other educational courses.
   b. Encouraged during R3 year.
   c. During clinical rotations, vacation time should be used, to be coordinated with point person for each site:
      i. FPMRS-Gynecology, LAC + USC Medical Center: Dr. Ozel
      ii. FPMRS-Urology, Rancho Los Amigos-RLANRC: Dr. Ginsberg
      iii. FPMRS-Urology, Keck Hospital of USC/Norris Cancer Hospital: Dr. Rodriguez
      iv. Colorectal rotation, Keck Hospital of USC/Norris Cancer Hospital: Dr. Cologne

Authorized By:
Larissa Rodriguez, MD
Program Director
________________________________________________

Inderbir Gill, MD
Chairman, Department of Urology
____________________________________________________

Original Effective Date: 10/1/2017
# TIME OFF REQUEST FORM

Your request for time off must be submitted and approved by program Director or Co-Director.

<table>
<thead>
<tr>
<th>NAME:</th>
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<tbody>
<tr>
<td>TODAY’S DATE:</td>
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</tr>
<tr>
<td>VACATION DAYS AVAILABLE:</td>
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<td>AS OF (DATE):</td>
<td></td>
</tr>
<tr>
<td>NUMBER OF DAYS REQUESTED:</td>
<td></td>
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<tr>
<td>STARTING ON:</td>
<td></td>
</tr>
<tr>
<td>ENDING ON:</td>
<td></td>
</tr>
<tr>
<td>RETURN TO WORK ON:</td>
<td></td>
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</table>

## FELLOW CERTIFICATION

I understand that time away from work is subject to management approval and company policies.

Employee Signature: ___________________________ Date: __________

## DIRECTOR APPROVAL

<table>
<thead>
<tr>
<th>APPROVED:</th>
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<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Begum Ozel, MD</td>
<td>Approval: ___________________</td>
<td>Date: ______</td>
</tr>
<tr>
<td>Larissa Rodriguez, MD</td>
<td>Approval: ___________________</td>
<td>Date: ______</td>
</tr>
</tbody>
</table>

## TYPE OF REQUEST

- [ ] VACATION
- [ ] EDUCATION LEAVE
- [ ] PERSONAL LEAVE
- [ ] FAMILY AND MEDICAL LEAVE
- [ ] BEREAVEMENT LEAVE
- [ ] SICK TIME
- [ ] JURY DUTY
- [ ] TIME OFF TO VOTE

## COMMENTS

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Appendix B
MATERNITY/PATERNITY LEAVES

Whether you’re having a baby or adopting a child, this section will help you determine:

- How much time you can take off
- How and when you’ll get paid
- What you need to do and when
- Resources available for going back to work

Pregnancy (information for Moms)

Time off

Generally speaking, you may take up to 22 weeks off due to the birth of a baby, but it will probably not all be paid time. Here’s how it breaks down for a normal pregnancy (complications will necessitate consultation with a specialized case manager):

Pregnancy disability is a 10-week paid benefit, MINUS a 7-day waiting period (you can use sick leave or vacation leave, during the waiting period, so that you continue to get paid). On day 8 of your leave, benefits are payable for the remaining 9 weeks.

At USC, our guidelines are to start pregnancy disability no sooner than 2 weeks before your estimated delivery date. Many women choose to start on the day of delivery, and have the full 10 weeks after the baby is born.

During your pregnancy disability, your job is protected by the Family Medical Leave Act (FMLA).

When your pregnancy disability 10 weeks are exhausted, the California Family Rights Act (CFRA) gives you another 12 weeks of job protection, but it is an unpaid leave. CFRA can be tacked on to the end of the 10-week pregnancy disability for a full 22 consecutive weeks off – or you could go back to work after the 10-week disability leave, and then later take the 12 CFRA weeks any other time within the baby’s first year of life.

Whenever you take your CFRA 12 weeks, half of that time CAN be paid, through the Paid Family Leave (PFL) program, which offers 6 weeks of paid “bonding” time with your child that can also be used anytime within his or her first year of birth.

Of course, during the other “half” of the CFRA time – the part this is unpaid – you may be able to use sick or vacation time in order to get paid. Obviously, that depends on how much sick or vacation leave you have.

The leave availabilities mentioned here may vary if you already took FMLA or CFRA leave for another reason within the past 12 months. Talk to your HR Partner or HR/Payroll Analyst if you’re not sure.

If your healthcare provider takes you off work prior to your delivery date due to complications, that is considered a “regular” disability claim. See the Disability section on the Benefits site. Your 10 weeks of maternity leave will begin on your delivery date. Be sure to notify USC’s third party administrator

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1 Online source, https://employees.usc.edu/new-baby/
(Broadspire), your manager, and the USC Disability Management office of your delivery date, and make sure you complete all steps listed below.

**Getting paid**

**Pregnancy disability period**

Your payment depends on which disability plan you chose. Calculations are based on your gross wages prior to leave.

- **Basic Plan only** – You receive 70% of gross pay, with a weekly maximum cap.
- **Supplemental Plan (if already enrolled)** – You receive 100% of gross pay for up to 10 weeks – you get 1 week of full pay for each year of USC service. After that, you’re paid at 80%. No weekly maximum cap like the Basic Plan.

The timing of disability payments depends on when your healthcare provider submits paperwork. Ideally, we hope to disburse disability funds on your regular payroll schedule using your regular method of payment. However, sometimes paperwork misses cutoff deadlines, in which case your disability payments may be sent to you by check, even if you normally use direct deposit, and you may receive them later than your normal paydays.

One exception – if all of your paycheck is regularly direct deposited into your checking account at the USC Credit Union, all disability benefit checks will be direct deposited into your account, even if they are too late for your regular payroll schedule. If you have direct deposits at any other institution other than USCCU, and the information is too late for your payroll schedule, then you will be mailed a check instead.

**Paid Family Leave period**

Payment is based on your most recent annual earnings. The state of California considers the highest quarter of that year’s earning and then pays you 55% of that amount. Payment schedules vary as these funds come directly from the state.

Since the 55% amount can be a hardship for some employees, some departments will supplement the other 45% by allowing the employee to use sick and/or vacation time to supplement that pay; the difference is calculated into hours and that amount is deducted from their accruals. Not all departments offer this option.

**What to do when**

**Early in pregnancy**

Visit the Disability section on the Benefits site, which explains how disability payments work. Also read USC’s Pregnancy-Related Medical Leave policy.

Because it will affect how much you’re paid in disability, you’ll want to verify which disability plan you’ve chosen – you can see that information in Workday or eTrac.

In order to aid schools and departments in academic and business planning, please file for relevant leaves as early as possible. No later than a month before your due date.

5-6 weeks before your due date (or immediately if you experience complications that will take you off work earlier), call Broadspire at (800) 495-2315. Broadspire administers all USC disability claims. Within 24
hours of your call, they’ll ship you a claims packets, which you should receive within a week. Return all requested items to Broadspire as quickly as possible to avoid delaying benefits.

Broadspire will work with your healthcare provider to obtain all information needed to evaluate your claim. It is helpful if you know the name of the individual, at your healthcare provider’s office, who will transmit information to Broadspire, to expedite handling of delays.

**Once your baby has arrived**

As soon as possible notify Broadspire (which administers USC’s disability plans) of the exact delivery date.

For new mothers, this is the date your 10 weeks of disability will begin (unless you opted to begin your leave 2 weeks pre-delivery, in which case you may only have 8 weeks left). Broadspire will notify USC’s disability office, which will initiate the disability payment process. After your disability is exhausted, you can use your FMLA/CFRA/PFL leave (see Pregnancy section for details).

New fathers are also entitled to the 12 weeks of unpaid FMLA/CFRA leave, and the concurrent 6 weeks of Paid Family Leave, at any time within the baby’s first year of life, provided the leaves weren’t used for some other purpose within the past 12 months. See Pregnancy section for explanation of FMLA/CFRA.

All paid parental leaves must be concluded within one year of the birth or adoption date.

**Within 30 days of your delivery date**

To add your new baby to your medical, dental, or other insurance coverage—or start or change the amount of a flexible spending account—you must provide Benefits with acceptable provisional documentation within 30 days of the birth of the baby.

Because we know that official certificates can take several months to arrive, Benefits will accept the provisional documentation, like a letter from the healthcare provider or hospital or other provisional documentation in order to temporarily enroll your child.

To finalize the enrollment you must submit the official state certificate within three months of the effective date of coverage or your baby’s coverage will be cancelled. The effective date of the coverage will be the date of birth.

Because enrolling a dependent requires a social security number, and most newborns have not received one, contact the HR Service Center for assistance or call them at (213) 821-8100.

Be aware that because it takes two to three weeks from the time you submit documentation to the time your new baby shows active in the insurance provider’s system, you may need to pay for services used during that period and file a claim for reimbursement after the child’s enrollment is finalized.

How to submit documentation – contact the HR Service Center.

This is a good time to review your beneficiary designations on insurance policies or retirement plans. These changes must be made on the Minnesota Life website (for union employees whose coverage is through UNUM, you must complete a change form).
Adoption

If you are adopting or becoming a legal guardian, generally speaking, you may take up to 12 weeks off to bond with your new child, but it will probably not all be paid time. Here’s how it breaks down:

Under the Family Medical Leave Act (FMLA) and the California Family Rights Act (CFRA), your job is protected during 12 weeks of unpaid leave that may be taken any time during the first year in which the new child is placed in your family.

Whenever you take your 12 weeks off, half of that time CAN be paid, through the Paid Family Leave (PFL) program, which offers 6 weeks of paid “bonding” time with your child that can also be used anytime within his her first year of birth.

Of course, during the other “half” of your 12 weeks—the part that is unpaid—you may be able to use sick or vacation time in order to get paid. Obviously, that depends on how much sick or vacation leave you have.

The leave availabilities mentioned here may vary if you already took FMLA or CFRA leave for another reason within the past 12 months. Talk to your HR Partner or HR/Payroll Analyst if you’re not certain.

An important note regarding Paid Family Leave benefits—they come from the state, and so are subject to varying schedules which may not match your current payroll schedule.

What to do

Contact your HR Partner or HR/Payroll Analyst for information on accessing the FMLA/CFRA leave.

Contact Broadspire, which administers all USC Paid Family Leave claims, at (800) 495-2315.

Within 30 days of your new child’s placement in your family, provide the Benefits office with a copy of the official court signed adoption/placement documentation in order to add him or her onto your medical, dental, and other insurance policies, and to start or change the amount of a flexible spending account. You will eventually receive a state certified birth certificate, a copy of which must also be provided to the Benefits office; otherwise, the child’s benefits enrollment will be cancelled.

Because enrolling a dependent requires a social security number, if your child is a newborn who has not yet received one, contact the HR Service Center for assistance or call them at (213) 821-8100.
Appendix C
FPMRS Block Diagram and Detailed Rotation Schedule
Monthly Rotation Block Diagram for Gynecology & Urology Track

Attached in separate File