SUBSPECIALTY FELLOWSHIP IN **UROGYNECOLOGY AND PELVIC RECONSTRUCTIVE SURGERY**

2019


بسم الله الرحمن الرحيم

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CHAPTER 1

1. INTRODUCTION

The specialty education of physicians to practice independently is practical and certainly occurs within the framework of the healthcare delivery system. Developing the skills, knowledge, and attitudes leading to expertise in all areas of clinical competency requires the physician to be personally responsible for the care of all patients. For the fellow, the essential learning activity is the interaction with the patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions.

As fellows gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater competence. Supervision in the setting of Postgraduate Medical Education (PGME) is designed to provide safe and effective care to the individual patient and ensures that each fellow develops the skills, knowledge, and attitude required to enter the consultancy practice of medicine as well as establishing a foundation for continued professional growth**.**

The Subspecialty Fellowship Training Program in Urogynecology and Pelvic Reconstructive Surgery consists of three years of full-time structured and supervised postgraduate fellowship training and will include scientific research leading to peer-reviewed publication. It encompasses education in the basic sciences, training in cognitive and technical skills, development of clinical knowledge, and acquisition of sound surgical judgment. The program provides an opportunity for fellows to learn the fundamentals of basic sciences in-depth as applied to clinical urogynecology and pelvic reconstructive surgery.

Upon successful completion of the program, the trainee will be awarded the **Certificate of Subspecialty Fellowship in Urogynecology and Pelvic Reconstructive Surgery**.

1.1 Rationale

The Subspecialty Fellowship in Urogynecology Reconstructive Pelvic Surgery (U-RPS), which is supervised by SCFHS, is committed to a competency-based curriculum that provides the highest level of clinical training, education, and research for the development of future U-RPS consultants.

1.2 Mission

To graduate competent, safe, skilled and knowledgeable specialists capable of functioning independently in the fields of Urogynecology and Pelvic Reconstructive Surgery.

1.3 Overall Goals and Objectives

At the end of the training, fellows will have a broad-based understanding of the core knowledge, skills, and attitudes in U-RPS. Each fellow will be capable of functioning independently as a consulting physician in all matters relating to the diagnosis and medical and surgical management of U-RPS patients. They will be responsible individuals with the highest commitment to their patients, fulfilling all CanMEDS domains in the role of a consultant while demonstrating a commitment to their profession, life-long learning, and to society in general.

Our objectives are to:

1. Provide adequate training in consultation services and comprehensive management of women with pelvic floor disorders, including urinary incontinence, lower urinary tract disorders, pelvic organ dysfunction, and childbirth-related injuries.
2. Improve quality of care through comprehensive management including preventive, diagnostic, and therapeutic procedures necessary for the total care of the female patients with these conditions and complications resulting from pelvic floor disorders.
3. Foster practices that improve knowledge, teaching, and research in female pelvic health.
4. Improve the quality of care for patients with pelvic floor disorders by growing and promoting the U-RPS specialty and expertise, as well as ensuring the coordinated management and availability of special facilities and clinical materials.
5. To encourage interdisciplinary collaboration between varied professionals working in this field.

1.4 Background

Several Boards and Colleges around the world have established guidelines for the sub-specialization of Urogynecology/FMP-RPS in order to improve the care given to women with disorders of the pelvic floor and to enhance medical knowledge and research.

Guidelines for this sub-specialization of the following Boards and Colleges were used in this paper: The Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Physicians and Surgeons of Canada, International Urogynecological Association (IUGA), the Core Curriculum in Obstetrics and Gynecology by the American College of Obstetricians and Gynecologists (ACOG), and the American Board of Urology (ABU).

1.5 Definitions/ Abbreviations

Blueprint: A tool that identifies the content areas covered on the examination. For each content area, the blueprint outlines the weighting of the area, domains, and sections examined. The blueprint also provides details of the assessment tools used in the examination.

Case-Based Discussion (CBD): An encounter that involves a comprehensive review of clinical cases between a trainee and an evaluator. The candidate is given feedback by an evaluator across a range of areas relating to clinical knowledge, clinical decision-making, and patient management.

Competence: Possession of a satisfactory level of relevant knowledge and the acquisition of a range of relevant skills, including interpersonal and technical components, at a certain point in the educational process.

Continuous Evaluation Report (CER): An annual report on the fellow's skills prepared for each fellow at the end of each academic year.

Direct Observation of Procedural Skills (DOPS): A structured checklist for assessing competence in performing diagnostic and interventional procedures. It facilitates feedback in order to develop behaviors and performance related to operative, decision-making, communication, and teamwork skills.

Training Capacity: The maximum number of fellows approved by the UGPSC per year based on the availability of adequate resources.

Female Pelvic Reconstructive Surgery (FMP-RPS)

Final In-Training Evaluation Report (FITER): A summative evaluation prepared at the end of the training program, which grants the fellow the full range of competencies (knowledge, skills, and attitudes) required for a specialist and who is ready to sit for the Saudi certification examinations. The FITER is not a composite of the regular in-training evaluations; rather, it is a testimony of the evaluation of competencies at the end of a training program.

Mini-Clinical Evaluation Exercise (Mini-CEX): A direct observation assessment or "snapshot" of a candidate-patient interaction. To be most useful, the evaluator should provide timely and specific feedback to the candidate after each encounter.

Multiple Choice Questions (MCQ)

Objective Structured Clinical Examination (OSCE): A standardized way of assessing clinical competencies. It provides a mean to assess the "shows how" of physical examination and history taking skills, communication skills with patients and family members, breadth and depth of knowledge, ability to summarize and document findings, and ability to make a differential diagnosis or plan treatment.

Portfolio: A systematic and organized collection of a candidate's work that exhibits to others the direct evidence of said candidate's efforts, achievements, and progress over a period of time.

Contract: A contract between the program and each training site for providing any required assignments.

Saudi Commission for Health Specialties (SCFHS)

Short-Based Answers (SBA)

Structured Oral Examination (SOE): A performance assessment method using realistic patient cases with trained physician examiners questioning a candidate in a structured and standardized manner. This exam format assesses the "know-how" of clinical decision-making and the application or use of medical knowledge with realistic patient scenarios.

Urogynecology and Pelvic Floor Dysfunction Scientific Committee (UGPSC)

Urogynecology and Pelvic Reconstructive Surgery (U-PRS)

CHAPTER 2

2. INSTITUTIONS AND REQUIREMENTS

2.1 Primary training site

The primary training site will assume ultimate responsibility for the program that extends to fellow assignments at all participating sites, and it will conduct the interview and selection of the fellow.

Scheduled rotations between the participating sites will be given to the fellow at the beginning of the fellowship, and a copy will be sent to the Urogynecology Pelvic Floor Fellowship Scientific Committee (UGPSC).

2.1.1 Requirements for primary training site:

2.1.1.a Financial requirement: The primary training site and the program will ensure that the program director has sufficient protected time and financial support for his/her educational and administrative responsibilities to the program. Fees for the fellowship will be paid according to the SCFHS requirements.

2.1.1.b Have a PGME Board who will handle responsibilities for the Subspecialty Fellowship Program.

2.1.1.c Have a commitment to generate written training program standards with a mission of establishing advanced education and patient care.

2.1.1.d Ensure that all resources are available for both the faculties and fellows to complete the requirements for education and research.

2.1.1.e Fulfill the criteria for major training sites (refer to 2.3.2 below).

2.1.1.f Allocate adequate educational resources to facilitate fellow involvement in scholarly activities.

2.1.1.g Training committee representative will be from other participating training sites.

2.1.1.h The fellow must do at least 50 percent of his/her rotation within the primary training site.

2.2 The Sponsoring Site is responsible for the financial requirements for the fellow.

2.3 Participating Training Sites

2.3.1 The participating training site is responsible for:

2.3.1.a Teaching

2.3.1.b Supervision

2.3.1.c Formal evaluation of fellows (as specified later in this document)

2.3.2 Training sites can be divided into major and minor sites.

- Major training sites will have:
  1. At least three certified urogynecologists who will assume both educational and supervisory responsibilities for fellows.
  2. Four or more days of Urogynecology OR per month.
  3. One Urodynamic session per week.

❖ Minor training sites will have:
1. One or two certified urogynecologists who will assume both educational and supervisory responsibilities for fellows.
2. One to three of Urogynecology OR per month.
3. One to two days of Urodynamic sessions per month.

2.3.3 There will be a contract between the program and each training site to provide any required assignments.
- **2.3.3.a** Specify the duration and content of the educational experience.
- **2.3.3.b** State the policies and procedures that will govern the education of fellows during the assignment.

2.3.4 The program director can add or remove minor participating sites as necessary upon approval of the Saudi Commission with clear reasons for addition or removal as long as it is beneficial to the fellows.

2.3.5 Accreditation Criteria

All accredited training centers in the same city or province should be combined in a Subspecialty fellowship training program run by UGPSC and SCFHS. Hospital accreditation requirements are as follows:

1. Will meet the requirements for accreditation as detailed in the general accreditation bylaws of SCFHS.
2. Have a minimum of three qualified subspecialty consultants classified by SCFHS, with satisfactory experience in teaching and commitment to carry out the approved teaching and training program as stipulated by the Saudi Commission for Health Specialties.
3. Have an inpatient subspecialty service, as required by the primary training site.
4. Ensure adequate clinical exposure and professional supervision, and a minimum ratio of one fellow in each year per four subspecialty inpatient beds is required.
5. Curriculum-based teaching activities as approved by the SCFHS will be designed so that each fellow will develop high-quality practical and academic expertise.
6. Research-oriented activities that allow the fellow sufficient exposure and participation are encouraged.
7. The program will allow the fellow to perform not less than the minimum number of procedures required for the subspecialty.
8. The minimum duration of the training should be fulfilled and met (at least three years).
9. The establishment of the subspecialty should not adversely affect an existing specialty in the same center.
10. The accredited hospital will be reviewed regularly by the General Fellowship Scientific Board/Committee, and accreditation will be renewed periodically according to the SCFHS accreditation bylaws.

CHAPTER 3

3.0 PROGRAM PERSONNEL AND RESOURCES

3.1 Urogynecology and Pelvic Floor Dysfunction Scientific Committee (UGPSC)

3.1.1 UGPSC is the review committee that is part of the SCFHS formed by:

1. The Fellowship Program Director of all primary training sites;
2. Two to three recommended members by the UGPSC;
3. The founding chairman will be elected by members; and
4. Re-election of new chair among members will be conducted every three years.

3.1.2 Duties and Responsibilities of the UGPSC:

1. Approval of fellow selection and rotation schedule, which will be provided by the primary training site;
2. Monitor fellows' assessments and approve promotions;
3. Organize the fellowship exams and certificates;
4. Evaluate and approve new training sites;
5. Nominate new members;
6. Review and approve the number of fellows accepted each year;
7. The appeals process, which includes but is not limited to: evaluations, assessments, abuse, examination results, requests to reattempt exams, etc.;
8. Review and update the U-PRS curriculum; and
9. Appoint examiners to proctor fellow examinations.

3.2 Program Director

3.2.1 There will be a single program director with authority and accountability for the operation of the program. The primary training site's PGME Board must approve any selection or change in the program director.

3.2.2 The program director should continue his/her position for a length of time adequate to maintain continuity of leadership and program stability (a minimum of four years).

3.2.3 Qualifications of the program director must include:

- **3.2.3.a** Requisite specialty expertise and documented educational and administrative experience acceptable to the UGPSC.
- **3.2.3.b** Current certification in the subspecialty by the SCFHS or subspecialty qualifications that are acceptable to the UGPSC.
- **3.2.3.c** Current medical licensure and appropriate medical staff appointment.
- **3.2.3.d** Completion of U-RPS or female pelvic medicine and reconstructive surgery (FPM-RPS) fellowship at least three years prior to appointment as the program director.
- **3.2.3.e** Documented clinical and scholarly expertise in U-RPS/or FPM-RPS.

3.2.4 The program director administers and maintains an educational environment conducive to educating the fellows in each of the competency areas. The program director's responsibilities include:

- **3.2.4.a** Overseeing and ensuring the quality of didactic and clinical education in all sites that participate in the program.
- **3.2.4.b** Approving a local director at minor participating sites who are accountable for fellow education.

3.2.4.c Evaluating program faculty.

3.2.4.d Approving the continued participation of program faculty based on evaluation.

3.2.4.e Monitoring fellow supervision at all participating sites.

3.2.4.f Preparing and submitting all information required and requested by the PGME Board, including the program application forms and annual program updates, and ensuring that the information submitted is accurate and complete.

3.2.4.g Ensuring compliance with procedures as set forth and implemented by the primary training site.

3.2.4.h Providing timely verification of fellowship education and summative performance evaluations for all fellows, including those who leave the program prior to completion.

3.2.4.i Implementing policies and procedures consistent with the institutional and program requirements for fellow duty hours and the working environment, including:

1. Distributing these policies and procedures to the fellows and faculty;
2. Monitoring fellow duty hours according to the primary training site's policies, with a frequency sufficient to ensure compliance with PGME requirements; and
3. Adjusting schedules as necessary to relieve excessive service demands and/or fatigue.

3.2.4.k Ensuring provision for back-up support systems when patient care responsibilities are unusually difficult or prolonged.

3.2.4.l Complying with the primary training site's written policies and procedures for selection, evaluation, and promotion of fellows' disciplinary action and supervision of fellows.

3.2.4.m Being familiar and complying with all committee policies and procedures as outlined in the PGME Manual of Policies and Procedures.

3.2.4.n Obtaining review and approval of the primary training site's committee before submitting information or requests to the SCFHS, including:

1. All applications for accreditation of the programs;
2. Changes in fellow complement;
3. Major changes in program structure or length of training;
4. Progress reports requested by the UGPSC;
5. Requests for increases or any change to fellow duty hours; and
6. Requests for appeal of an adverse action or poor assessment.

3.2.4.o Dedicate ample time and professional effort to the administrative and educational activities of the U-RPS program.

3.2.5 The program director of each primary training site will be a member of the UGPSC, which is part of the SCFHS.

3.3 Faculty

3.3.1 At each participating site there must be a sufficient number of faculty, as stated in the contract, with documented qualifications to instruct and supervise all fellows at that location. The faculty must ensure that they:

3.3.1.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.

3.3.1.b Administer and maintain an educational environment conducive to educating fellows in each of the competency areas.

3.3.2 The physician faculty must have current certification in the Urogynecology or Pelvic Reconstructive Surgery subspecialty by the SCFHS or possess qualifications acceptable to the SCFHS.

3.3.3 The physician faculty must possess current medical licensure and appropriate medical staff appointment.

3.3.4 All non-physician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.

3.3.5 The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

3.3.5.a The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

3.3.5.b Some members of the faculty should also demonstrate scholarship by one or more of the following:

1. Publication of original research or review articles in peer-reviewed journals or chapters in textbooks;
2. Publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; and/or
3. Participation in national committees, societies, or educational organizations.

3.3.5.c Faculty should encourage and support fellows in scholarly activities.

3.3.6 In addition to the program director, there will be at least two other full-time program faculty members or three-part time faculty who are certified in U-RPS/or FMP-RS by SCFHS.

3.3.7 Other faculty members may include qualified colorectal surgeons, urologists, gastroenterologists, gynecologists specializing in minimally invasive techniques, endourologists, or female pelvic physiotherapists who possess qualifications acceptable to the UGPSC to ensure that fellows acquire well-rounded experience.

3.4 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.

3.5 Scientific Resources:

- American Urogynecologic Society (augs.org)
- British Society of Urogynecology (bsug.org.uk)
- International Urogynecological Association (www.iuga.org)
- International Continence Society (www.ics.org)
- European Association of Urology (uroweb.org)

3.6 Resources

The institution and the program must jointly ensure the availability of adequate resources for fellows' education, as defined below:

1. The primary training site must include operating rooms, ambulatory clinic facilities, recovery rooms, intensive care units, blood banks, diagnostic laboratories, and imaging services.

Access to these resources must be available at all times for the management of complications.

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

3.7 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.

3.8. Fellow Appointments

3.8.1 Admission/Acceptance Requirements

3.8.1.1 Medically fit

3.8.1.2 Holding active registration status with SCFHS

3.8.1.3 To be admitted to the subspecialty program, the candidate must possess a Saudi Specialty Certificate in the OB-GYNE or an equivalent recognized degree classified by the SCFHS.

3.8.1.4 Successfully pass the interview for the subspecialty program conducted at the primary training site.

3.8.1.5 Provide three letters of recommendation, addressed to the program director, from consultants with whom the candidate has recently worked with for a minimum period of three (3) to six (6) months.

3.8.1.6 Provide written permission from the candidate's primary training site institution allowing him or her to participate on a full-time basis for the entire period of the program.

3.8.1.7 Pay the annual registration fee according to the SCFHS rules and regulations.

3.8.2 Number of Fellows

The program's educational resources will be adequate to support the number of fellows appointed to the program.

3.8.2.1 The program director may not appoint more fellows than are approved by the UGPSC.

3.8.2.2 The minimum required is one fellow.

3.8.2.3 The number of accepted fellows should not affect the residency training.

3.8.2.4 Fellows will be accepted every one to two years.

3.8.2.5 The rotation of the fellows will be coordinated between the primary site by the UGPSC.

3.8.3 Fellow Transfers

3.8.3.1 Before accepting a fellow who is transferring from another program, the program director must obtain written or electronic verification (if available) of previous educational experiences and a summative competency-based performance evaluation of the transferring fellow.

CHAPTER 4

4.0 TEACHING AND LEARNING OPPORTUNITIES

4.1 General Principles

Teaching and learning are designed for delivery through various methods by mixing formal didactic lectures and self-learning processes through a structured and programmatic core education program.

I. Formal Teaching and Learning Activities

1. Core specialty topics will be delivered as basic science lectures and specialty topics
2. Universal/General topics

II. Practice-Based Learning

1. Morning report case presentations
2. Morbidity and mortality review
3. Journal club
4. Case presentation
5. Grand round/guest speakers on core specialty topics
6. Simulation/standardized patients and workshops

III. Work-Based Learning

1. Daily round-based learning
2. On-call based learning
3. Clinic-based learning
4. Workshops and courses
5. Tutorials

IV. General Based Topics (FY1/FY2)

1. Acute Pain Management (FY1)

a. Review the physiological basis of pain perception
b. Proactively identify a patient who might be in acute pain
c. Assess patients with acute pain
d. Apply pharmacological and non-pharmacological modalities for acute pain management
e. Provide adequate pain relief

2. Management of Fluid in a Hospitalized Patient (FY1)

a. Review physiological basis of water balance in the body
b. Assess patients for hydration
c. Recognize patients with over- and under-hydration
d. Order fluid therapy as oral and IV treatments
e. Monitor fluid status and response to therapy

3. Management of Electrolyte Imbalance (FY1)

a. Review physiological basis of electrolyte and acid-base balances in the body
b. Identify diseases and conditions that are likely to cause electrolyte imbalances
c. Correct electrolyte and acid-base balances

d. Perform careful calculations, checks, and other safety measures while correcting acid-base and electrolyte imbalances
e. Monitor response to therapy

4. **Safe drug prescription (FY2).** At the end of the learning unit the fellows should be able to:
   a. Recognize the importance of prescribing safe drugs in healthcare
   b. Describe the various adverse drug reactions with examples of commonly prescribed drugs that can cause such reactions
   c. Apply the principles of drug-drug interaction, drug-disease interactions, and drug-food interactions to common situations
   d. Apply the principles of prescribing drugs in special situations such as renal failure and liver failure
   e. Apply appropriate principles when prescribing drugs to the elderly, the pediatric age group, and pregnant or lactating patients
   f. Promote evidence-based, cost-effective prescriptions
   g. Discuss the ethical and legal frameworks governing safe-drug prescription in Saudi Arabia

5. **Blood Transfusion (FY2)**
   a. Review the different components of blood products available for transfusion
   b. Recognize the indications and contraindications of blood transfusion
   c. Discuss the benefits, risks, and alternatives to transfusion
   d. Undertake consent for specific blood product transfusions
   e. Perform the steps necessary for safe transfusions
   f. Develop an understanding of special precautions and procedures necessary during massive transfusions
   g. Recognize transfusion-associated reactions and immediate management

6. **Sepsis, SIRS, DIVC (FY2)**
   a. Explain the pathogenesis
   b. Identify patient and non-patient related predisposing factors of sepsis
   c. Describe the complications of sepsis
   d. Apply the principle of management of the patient
   e. Describe the prognosis

7. **Ethical Issues: Treatment Refusal, Patient Autonomy (FY2)**
   a. Predict situations where the patient and family are likely to decline treatment
   b. Describe the concept of rational adults in relation to patient autonomy and treatment refusal
   c. Analyze key ethical, moral, and regulatory dilemmas in treatment refusal
   d. Recognize the importance of patient autonomy in the decision-making process
   e. Counsel patients and families declining medical treatment in the light of best interests of the patient

V. Clinical Competencies (FY3)

1. **Pre-Operative Assessment.** At the end of the learning unit, fellows should be able to:
   a. Describe the basic principles of pre-operative assessment

b. Perform pre-operative assessments in uncomplicated patients with special emphasis on:
    1. General health assessment;
    2. Cardiorespiratory assessment;
    3. Medications and medical device assessment; and
    4. Drug allergies.
c. Categorize patients according to risks.

2. **Post-Operative Care**
    a. Devise a post-operative care plan including monitoring vitals, pain and fluid management, medications, and laboratory investigations
    b. Hand over the patients properly to an appropriate facility
    c. Describe the process of post-operative complications
    d. Identify common post-operative recovery signs in patients
    e. Monitor patients for possible post-operative complications
    f. Institute immediate management for post-operative complications

3. **Acute Pain Management**
    a. Review the physiological basis of pain perception.
    b. Proactively identify patients who might be in acute pain.
    c. Assess patients with acute pain.
    d. Apply various pharmacological and non-pharmacological modalities available for acute pain management.
    e. Provide adequate pain relief for uncomplicated patients with acute pain.
    f. Identify and refer patients who can benefit from specialized pain services.

4. **Chronic Pain Management**
    a. Review the bio-psychosocial and physiological bases of chronic pain perception
    b. Discuss various pharmacological and non-pharmacological options available for chronic pain management
    c. Provide adequate pain relief for uncomplicated patients with chronic pain
    d. Identify and refer patients with chronic pain who can benefit from specialized services

5. **Care of the Elderly**
    a. Describe the factors that need to be considered while planning care for the elderly
    b. Recognize the needs and well-being of caregivers
    c. Identify the local and community resources available in care for the elderly
    d. Develop, with input from other healthcare professionals, individualized care plans for elderly patients

6. **Ethics and Healthcare**
    a. Define ethics and healthcare
    b. Recognize ethics and healthcare as a core value governing medical practice
    c. Describe the role of patient advocates in the care of the patients
    d. Develop a positive attitude towards patient advocacy
    e. Be a patient advocate in conflicting situations

4.2 Learning Resources

4.2.1 Mandatory Workshops and Simulation Skills Program

1. Perineal Trauma course and workshop – FY1
2. Basic Laparoscopic Skills workshop – FY1
3. Hands-on Urodynamic workshop – FY1
4. Pelvic Anatomy course – FY1/FY2
5. Basic and Advanced Research Methodology course – FY1/FY3
6. Pelvic Floor and Anorectal Ultrasound – FY2
7. Biostatistics and Epidemiology course – FY2
8. Advanced Laparoscopic Skills workshop – FY3

4.2.2 Reference Textbooks

- *Urogynecology and Reconstructive Pelvic Surgery* by Mark D. Walters
- *Pelvic Floor Disorders* by Alain P. Bourcier
- *Textbook of Female Urology and Urogynaecology* by Linda Cardozo
- *Atlas of Pelvic Anatomy and Gynecologic Surgery* by Baggish Karram
- *Urodynamics* by Paul Abrams

4.2.3 Optional Supplementary Textbooks

- *Female Urinary Incontinence in Practice* by Linda Cardozo
- *Urogynecology and Pelvic Floor Dysfunction* by Alfred B. Bent
- *Urodynamics Made Easy* by Christopher R. Chapple
- *Female Pelvic Reconstructive Surgery* by Stuart L. Stanton
- *Atlas of Urodynamics* by Jerry Blaivas
- *Urogynecology and Female Pelvic Reconstructive Surgery: Just the Facts* by Sam Siddighi
- *Female Genital Plastic and Cosmetic Surgery* by Michael P. Goodman
- *Complications of Female Incontinence and Pelvic Reconstructive Surgery* by Howard B. Goldman
- *Current Clinical Urology* by Eric Klein
- *Office Urogynecology (Practice Pathways Series)* by Anne Weber
- *Urogynecology and Pelvic Reconstructive Surgery* by Manidip Pal

4.2.4 Online Courses

Every fellow should register and have access to the following online courses:

- Mint Medical Education (mintmedicaleducation.com) online course and finish the Introduction to Pelvic Ultrasound course
- International Academy of Pelvic Surgery (academyofpelvicsurgery.com)
- Fundamental Use of Surgical Energy (fuseprogram.org)

4.2.5 Journals

- *Female Pelvic Medicine and Reconstructive Surgery (FPMRS)*
- *Neurourology and Urodynamics Journal*
- *International Urogynecology Journal*

4.3 EDUCATIONAL PROGRAM

4.3.1 Curriculum

4.3.1.1 Regularly scheduled didactic sessions, journal clubs, seminars, and morbidity and mortality conferences. Topics will include:

4.3.1.1a Anatomy and physiology of the pelvic floor, including the lower urinary tract, lower gastrointestinal tract, and genital viscera.

4.3.1.1b Behavioral, pharmacological, functional, and surgical treatment for complex benign pelvic conditions, pelvic floor dysfunction, and lower urinary tract disorders, including but not limited to: urinary incontinence, anal incontinence, and including micturition and defecation disorders, etc.

4.3.1.1c Diagnosis and evaluation of complex benign pelvic conditions, pelvic floor dysfunction, and lower urinary tract disorders, including but not limited to: urinary incontinence, voiding dysfunction, pelvic organ prolapse, defecation disorders, and sexual dysfunction, etc.

4.3.1.1d 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.

4.3.1.1e Management of genitourinary complications of vaginal delivery, spinal cord injuries, and medical, psychiatric, and geriatric conditions related to pelvic floor disorders.

4.3.1.1f Pathophysiology pertaining to the effects of:

- Pregnancy, parturition, and menopause and ageing upon the pelvis and its organs, including but not limited to: urinary incontinence, anal incontinence, voiding dysfunction, pelvic floor dysfunction, defecation disorders, and sexual dysfunctions;
- Disease, both mental and physical, upon the pelvic organs; and
- Surgery, trauma, and radiotherapy upon the pelvic organs.

4.3.1.1g Research design, grant writing, research methodology, scientific writing, and presentation skills.

4.3.1.2 Delineation of fellows' responsibilities for patient care, progressive responsibility for patient management, and supervision of fellows over the continuum of the program.

CHAPTER 5

5. ROTATIONS

5.1 Components

This section details the structure and competencies to be achieved and the methods of achievement. Educational components and goals in the curriculum that will be made available to the fellows and faculty include:

5.1.1 Competency-based goals and objectives for each assignment, at each educational level, will be distributed to the fellows and faculty at least annually, in either written or electronic format.

5.1.2 In the beginning of the program, each fellow will have an individual educational plan that includes a weekly block rotation diagram displaying the clinical, didactic, and research activities by rotation.

5.1.3 Written goals and objectives for each rotation or major learning experience.

- **5.1.3.a** Includes the educational purpose, teaching methods, types of clinical settings, other educational resources to be used, and the method for evaluation of fellows' competencies.
- **5.1.3.b** Defines the level of fellows' supervision by faculty members (refer to 7.4).
- **5.1.3.c** To be reviewed and revised periodically, but not less frequently than every five years, by faculty members and fellows to keep the goals and objectives current and relevant.

5.2 Required Rotations

Required rotations will include the didactic and practical experiences necessary for the fellow to become a professional urogynecologist.

1. Year one: Clinical urogynecology and procedures, including: colorectal, physiotherapy, and research.
   - Urogynecology (five months)
   - Urology (two months)
   - Minimally Invasive Gynecologic Surgery (one month)
   - Plastic Surgery (one month)
   - Colon and Rectal Surgery (one month)
   - Research (one month)
   - Physiotherapy (one month)
2. Year two: Clinical urogynecology and procedures, including: physiotherapy, research and elective(s).
   - Urogynecology (6 months)
   - Physiotherapy (1 month)
   - Research and Participation in the training program (3 months)
   - Female Medical Imaging (1 month)
   - Electives (1 month)
3. Year three: Clinical urogynecology and procedures, including: physiotherapy, research, and elective(s).
   - Urogynecology (8 months)
   - Research (1 month)
   - Electives (3 months)

Fellows are required to satisfactorily complete all assigned rotations for each academic year. Successful completion of rotations requires approval by the fellow's direct supervisor(s) and the program director. For a general framework, refer to Appendix A1: Required Rotations.

5.3 Elective Rotations

Fellows will have elective rotations during their three years of training. Total elective rotations will not exceed four months of the total training period of the fellowship. Some of mentioned rotations stated below are mandatory rotations that may be extended.

Fellows are encouraged to participate in the selection of their elective rotations according to their needs and areas of their training to be strengthened. Examples of elective rotations may include but are not limited to the following:

Urology Rotation	
The fellow will understand and demonstrate the following objectives: • Urodynamic stress incontinence and detrusor over activity • Fistula management and urethral diverticula treatment • Principles of ureteric re-implantation, anastomosis, and nephrostomy • Ureteric problems • Cystoscopy, normal and abnormal findings, and bladder biopsy	Four-week rotation
Urology Rotation continued	
Clinical Competencies: • Determine correct indications for referral for urodynamic stress incontinence and detrusor over activity • Undertake investigations and council patients • Diagnose fistulae and order appropriate investigations • Diagnose and treat urethral diverticula and insert appropriate ureteric stents	Four-week rotation
Colorectal Rotation	
The fellow will understand develop the knowledge, skills, and methods of investigation of the following objectives: • Incontinence: Anal sphincter repair, bulking agents, pelvic floor exercises, and use of constipating agents • Emptying problems: Use of laxatives, transperineal repair of rectocele, transanal repair of rectocele, transanal resection (STARR) • Urgency: biofeedback, drug treatment, and behavioral modification (i.e., diet)	Four-week rotation

The fellow will understand develop the knowledge, skills, and methods of investigation of the following objectives: • Incontinence: Anal sphincter repair, bulking agents, pelvic floor exercises, and use of constipating agents • Emptying problems: Use of laxatives, transperineal repair of rectocele, transanal repair of rectocele, transanal resection (STARR) • Urgency: biofeedback, drug treatment, and behavioral modification (i.e., diet) Clinical Competencies: • Fistulae, including rectovaginal • Demonstrate the appropriate use of intraoperative handling of colorectal system • Recognition of potential areas of complications during reconstructive female pelvic surgery and appropriate post-operative care in the case of bowel injuries • Appropriate counseling	Four-week rotation
Geriatric Rotation	
Each fellow will understand and classify the following objectives: • The natural history and mechanism of pelvic floor dysfunction in aged women • The aging process plays a negative role in either the function or the structure of the pelvis in women. Aging may either add to the deterioration of the pelvic floor dysfunction during the lifespan of a woman or interrupt with other potential predisposing factors (such as parity, mode of delivery, menopausal estrogen deficiency, high body mass index, previous pelvic surgery, and comorbidites, including diabetes mellitus, hypertension, and poor cognitive function) to cause major pelvic floor failure • Incontinence and bladder dysfunction in recognized categories such as urge, stress, and mixed causes in geriatric age • Describe the basic interventions and neurotransmitters involved with bladder function and normal micturition	Four-week rotation
Geriatric Rotation continued	
• Identify medication commonly associated with incontinence and mechanisms by which they influence continence	Four-week rotation

Neurology	
The fellow will understand and have knowledge of the principles of the following objectives: • Effects of neurological conditions on the lower urinary tract • Assessment and treatments for bladder dysfunctions • Effectively carry out neurological examinations and order appropriate investigations • Interpret pelvic floor electromyogram results • Manage patients with neurological conditions affecting the bladder	Four-week rotation
Gynecology Oncology Rotation	
The objective is to ensure extensive exposure to retroperitoneal pelvic organ anatomy during cancer surgery.	Four- to eight-week rotation
Physiotherapy of Pelvic Organs Malfunction Rotation	
Each fellow will understand and have knowledge of the principles of the following objectives: • The principles and possible indications for treatment of overactive bladder symptoms, such as: biofeedback, acupuncture, hypnotherapy, psychotherapy • Therapy modalities and recent advances in this field and female patients' perceptions of and compliance with such treatments Clinical Competencies: • Take history (including standardized questionnaires), carry out appropriate examinations, and analyze charts (frequency, frequency/volume, input/output), and give appropriate advice • Assess pelvic floor strength • Insert catheters (suprapubic, permanent, and nonpermanent) and teach intermittent self-catheterization • Fit and change pessaries • Demonstrate the ability to apply knowledge of anatomy, physiology, and function to the clinical situation and tailor treatment while taking the underlying condition into consideration • Be able to perform appropriate general, pelvic, and neurological exams and implement drug management for incontinence	Four-week rotation

Female Medical Imaging Rotation	
The objectives are: Practicing different modalities of diagnostic medical imaging concerning various urogynecological conditions, which may include: ultrasound imaging (transrectal, transvaginal/introital, and transperineal/translabial methods), reading of simple fluoroscopy for the urinary system, pelvic CT, CT cystogram, MRI and dynamic MRI, defecography, and cysto-colonography	Four-week rotation

These electives will be organized by the program director based on the primary training site requirements.

5.4 Curriculum Organization and Fellow Experiences

5.4.1 Fellows will have both inpatient and outpatient experiences.

5.4.1.a Fellows will have supervised responsibility for the total care of the patient, including initial evaluation, establishment of diagnosis, selection of appropriate therapy, and management of complications.

5.4.1.b Fellows will participate in continuity of patient care through pre- and post-operative clinics and inpatient contact.

5.4.1.c Fellows will record all surgical procedures in which they have a significant role. A logbook is required for final certification (refer to Appendix 3: Logbooks).

5.4.2 The 6 to 12 months of the program not devoted to inpatient and outpatient experiences will be devoted to research and/or other elective experiences.

5.4.3 A fellow must not spend more than 10 percent of his/her time (such as general obstetrics and gynecology work), when averaged over a four-week period, performing duties outside of U-RPS.

5.4.4 Fellows will 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 dysfunctions, and psychosocial aspects of pelvic floor disorders.

5.4.5 The fellow will be familiar with the basics of epidemiology and statistics in order to interpret scientific literature and have the ability to design research trials to encourage evidence-based medicine.

5.4.6 The fellows will have opportunities to attend scientific meetings and present their own research at a national and international level.

5.4.7 The fellows will gain experience in teaching, which will include:

- Responsibility for medical staff from juniors as medical students and nursing staff to core residents in their subspecialty area.
- Administrative responsibility for the organization of teaching in their subspecialty to include scheduled teaching rounds and journal clubs.
- Gain experience in appraisal and assessment techniques.

5.4.8 The fellow will be exposed to administration experiences and responsibilities that will sharpen the skills relevant to the ethical and legal aspects of the clinical practice of this subspecialty within the scope of the national law and regulations.

5.5 Program Structure

5.5.1 The three-year training program in the subspecialty of urogynecology and pelvic reconstructive surgery is divided into two levels:

1. **Junior** level of training: fellow years one and two
   - Designed to provide training in core U-RPS practice
2. **Senior** level of training: fellow year three
   - After successful completion of the junior level, fellows will advance to the senior level, where they will take on more responsibilities and independence as chief fellows.

5.5.2 Chief Fellows

Within the final 12 months of training, fellows will serve six to 12 months as a chief fellow (appointed by the program director). The clinical and academic experience gained while serving as a chief fellow fosters effective leadership skills.

5.6 Competency Outcomes

By the end of the program the fellows will have acquired the following competencies that link to our major learning objectives:

1. Medical Expert (ME)
2. Scholar (S)
3. Collaborator (COLLAB)
4. Communicator (COMM)
5. Professional (P)
6. Leader (L)
7. Health Advocate (HA)
8. Research (R)

5.6.1 Medical Experts

Fellows will skillfully:

5.6.1.a Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

5.6.1.b Competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.

5.6.1.c Demonstrate competence in:

- Assessing the effects of treatment, recognizing, and managing the complications of therapy
- Diagnosing and managing patients with different urinary and pelvic problems
- Evaluating the lower urinary and genital tract for abnormalities
- Performing advanced procedures
- Performing urodynamic testing
- Performing surgery for urinary incontinence
- Performing surgery for complicated obstetric lacerations and treatment of related benign conditions occurring in the female pelvis
- Evaluating and managing hematuria
- Evaluating and managing painful bladder, including interstitial cystitis
- Evaluating and managing neurogenic voiding dysfunction

- Evaluating and treating urinary tract infections
- Performing a female pelvic exam, including quantification of pelvic organ prolapse

5.6.1.d Demonstrate competence in the behavioral, pharmacological, functional, non-surgical, and surgical treatment of:
- Micturition and defecation disorders
- Pelvic organ prolapse
- Urinary incontinence

5.6.1.e Demonstrate competence in diagnosing and managing genitourinary problems, congenital anomalies, and managing genitourinary complications following vaginal delivery, spinal cord injuries, and similar health events.

5.6.2 Communicator

Fellows will be able to demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Fellows will be able to:

5.6.2.a Effectively and appropriately communicate with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds.

5.6.2.b Effectively communicate with physicians, other health professionals, and health-related agencies.

5.6.2.c Maintain comprehensive, timely, and legible medical records.

5.6.2.d Demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

5.6.2.e Demonstrate responsiveness to patient needs that supersedes self-interest.

5.6.2.f Demonstrate respect for patient privacy and autonomy.

5.6.2.g Demonstrate sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

5.6.2.h Demonstrate the ability to convey bad news appropriately and professionally to patients and family members.

5.6.3 Collaborator

Fellows will be able to:

5.6.3.a Coordinate patient care within the health care system relevant to their clinical specialty.

5.6.3.b Work effectively as a member or leader of a health care team or other professional group.

5.6.3.c Act in a consultative role to other physicians and health professionals.

5.6.3.d Effectively call on other resources in the system to provide optimal health care.

5.6.3.e Resolve conflicts or provide feedback where appropriate.

5.6.4 Leader

Fellows will be able to:

5.6.4.a Set learning and improvement goals.

5.6.4.b Systematically analyze practice using quality improvement methods and implement changes with the goal of improving practice.

5.6.4.c Incorporate formative evaluation feedback into daily practice.

5.6.4.e Locate, appraise, and assimilate evidence from scientific studies related to a patient's health problems, using information technology to optimize learning.

5.6.4.f Demonstrate the ability to investigate and evaluate patient care to appraise and assimilate scientific evidence.

5.6.4.g Continuously improve patient care, based on constant self-evaluation and life-long learning.

5.6.4.h Demonstrate an awareness of and responsiveness to the larger context and system of health care.

5.6.4.i Work effectively in various healthcare delivery settings and systems relevant to their clinical specialties.

5.6.4.j Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate.

5.6.4.k Work in inter-professional teams to enhance patient safety and improve patient quality of care.

5.5.4.l Participate in identifying system errors and implementing potential system solutions.

5.6.5 Health Advocate

Fellows will skillfully:

5.6.5.a Advocate for quality patient care and optimal patient care systems, including but not limited to: hazards in the work place environment for patients, other care professionals, and hospital administration, as applicable.

5.6.5.b Participate in the education of patients, families, students, fellows, and other health professionals.

5.6.6 Scholar

Fellows will be able to skillfully:

5.6.6.a Demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care.

5.6.6.b Identify the strengths, deficiencies, and limits in their own knowledge and expertise.

5.6.6.c Identify and perform appropriate learning activities.

5.6.6.d Demonstrate knowledge of the basic principles of research, including how research is conducted, evaluated, explained, and applied to patient care.

5.6.6.e Be a research advocate who actively participates in scholarly activities. Each fellow, under the direction of a faculty mentor, will complete a comprehensive written scholarly paper or quality improvement project (research) during the program that demonstrates the following:

- Utilization of advanced research methodology and techniques, including research design and quantitative analysis;
- Collection and statistical analysis of information obtained from a structured basic laboratory and/or clinical research setting; and
- Synthesis of the scientific literature, hypothesis testing, and descriptions of findings and results. The research must be published or presented at international meetings.

5.6.6.f The fellow must annually participate and will be encouraged to present abstracts at national and international conferences and symposia (at least once a year internationally) related to pelvic floor dysfunctions and Reconstructive female Pelvic surgery.

5.6.7 Professional

Fellows will be able to:

5.6.7.a Demonstrate accountability to patients, society, and the profession.

5.6.7.b Demonstrate compassion, integrity, and respect for others.

5.6.7.c Fulfill the ethical and legal aspects of patient care.

5.6.7.d Accept constructive feedback and criticism, and implement appropriate advice.

5.6.7.e Recognize personal limits through appropriate consultation (with staff supervisors, other physicians, and other healthcare professionals) and show appropriate respect for those consulted.

5.7.7.f Review personal and professional abilities and demonstrate a pattern of continued development of skills and knowledge through education.

5.6.8 Research

The UGPSC views research as an essential part of the fellowship and expects each fellow to finish a minimum of one research peer-reviewed publication during his/her fellowship.

5.6.8.a. In the first year of fellowship we expect the fellow to learn the basics of research design, including the choice of study, type, power analysis, and varying statistical analysis.

5.6.8.b. In addition to the required coursework in biostatistics, the fellow is required to read several textbooks on research design.

5.6.8.c. The fellow is expected to select one or more general topics related to the subspecialty for his/her research during the first three months of the fellowship and select a mentor for his/her project.

5.6.8.d. The fellow will then develop a hypothesis and do background research during the assigned time for the research rotation and begin implementation of the project thereafter.

5.6.8.e. The research rotation and work should be monitored by a designated mentor working at the primary training site.

5.6.8.f. This research should be completed by the end of the fellow's senior year and will be presented at a national meeting and published in a peer-reviewed journal.

During the fellowship, most of the fellows will be participating in several ongoing trials (two or more) in which he or she will be the primary author.

5.7. Levels of Proficiency

Within the subspecialty program there are three levels of knowledge and proficiency. These are referred to as:

5.7.1 Junior year

5.7.1.1 Urogynecology (urinary incontinence and pelvic support defects)

5.7.1.1.a Normal anatomy and general considerations:

1. Explain the normal anatomic supports of the vagina, rectum, bladder, urethra, and uterus (or vaginal cuff in the setting of prior hysterectomy), including the bony pelvis, pelvic floor nerves and musculature, and connective tissue. (S)
2. Describe the static and dynamic interrelationships and function of the pelvic organs and support mechanisms. (S)
3. Describe the principal etiologies of pelvic support defects, urinary incontinence, and fecal incontinence. (S)
4. Summarize the potential psychological, social, and sexual consequences of urogynecological disorders. (S)

5. Describe the symptoms that may be experienced by a patient with pelvic support defects, urinary incontinence, or fecal incontinence. (S)
6. Obtain a pertinent history of a patient with a suspected pelvic support defect, urinary incontinence, or fecal incontinence. (ME)

5.7.1.1.b Pelvic support defects:

1. Identify the anatomic defects associated with various aspects of pelvic support disorders. (S)
2. Perform a focused physical examination to identify the pelvic organs, a prolapse grading system, pelvic floor tone and strength, and appropriate neurological examination, mobility and mental state assessments, and characterize specific pelvic support defects, including the following: (ME)
   a. Anterior compartment;
   b. Urethral hypermobility;
   c. Posterior compartment;
   d. Apical compartment (cervix/uterus or vaginal cuff); and
   e. Levator ani trauma and genital-hiatus-related conditions.
   f. Clinical knowledge: (S)
   g. Pelvic floor problems in the physically or mentally handicapped;
   h. Sexually transmitted diseases;
   i. Defecation disorders;
   j. Emotional and behavioral disorders, and effects on pelvic floor problems; and
   k. Hormone deficiency states.
3. Summarize and counsel patients regarding risks, benefits, and expected outcomes of surgical and nonsurgical approaches to the management of pelvic support disorders. (ME, COMM, P)
4. Subjective assessment, including detailed history and quality of life measurements. (S)
5. Treat urogynecologic disorders by both nonsurgical (e.g., pelvic floor exercise regimens, physical therapy, and pessary) and surgical methods. (ME)
6. Describe the types of injuries or complications that may occur related to medical and surgical treatments of pelvic floor disorders and the approaches to managing them. (ME)
7. Describe appropriate follow-up for a patient who has been treated for a pelvic floor disorder. (ME, COMM, COLLAB)

5.7.1.1.c Continence and incontinence

1. Clinical knowledge in urinary incontinence due to stress incontinence, detrusor overactivity (neurogenic and idiopathic), mixed incontinence, trauma, and congenital abnormalities (ME, S)
2. Clinical knowledge and disorders in childhood. (S)
3. Clinical knowledge of urinary problems secondary to medical disorders and drugs (S)

4. Summarize the normal function of the lower urinary tract during the filling and voiding phases and the mechanisms responsible for urinary continence. (S)
5. Characterize the major types of urinary incontinence. (S)
6. Perform a focused physical examination in a patient with urinary and/or fecal incontinence, including assessment of the following: (ME)
   a. Bladder and urethral support;
   b. Perineal, levator, and anal sphincter trauma and strength; and
   c. Neurologic status.
7. Perform and interpret the results of the following selected tests to characterize urinary incontinence disorders: (ME)
   a. Urinalysis and cytology of urine and the microbiology of the urogenital tract;
   b. Assessment of residual urine volume;
   c. Frequency / volume charts;
   d. Quantification of urine loss by pad or ambulatory studies;
   e. Simple cystometry; and
   f. Swab test.
8. Describe the indications for the implications of the results of other diagnostic tests, such as the following: (ME)
   a. Cystourethroscopy;
   b. Cystometry—filling and voiding phases (simple and subtracted);
   c. Ambulatory cystometry;
   d. Urethral function tests, including urethral pressure profilometry, electrical conductance test, Q tip, and leak pressures;
   e. Perineometry;
   f. Anal sensation and manometry;
   g. Imaging techniques ultrasound (transabdominal including upper tracts, transvaginal, perineal, introital, endoanal, intraurethral, and 3D intraurethral) radiological (micturating cystogram, IVU, video cystourethroscopy, pelvic barium studies (defecography), image intensification, urethrogram, MRI, CT);
   h. Uroflowmetry (simple and pressure/flow/EMG);
   i. Radiologic tests;
   j. Electromyography/physiological studies;
   k. Nerve conductance studies; and
   l. Assessment of anal sphincter integrity (e.g., manometry, radiologic imaging studies, and neurologic testing).
9. Summarize and counsel patients regarding risks, benefits, and expected outcomes of surgical and nonsurgical approaches to the management of incontinence disorders. (ME, COMM, P)
10. Treat incontinence disorders by both nonsurgical (e.g., pelvic floor exercise regimens, physical therapy, and pessary) and surgical methods. (ME)

11. Describe the types of injuries or complications that may occur related to medical and surgical treatments of incontinence disorders and the approaches to managing them. (ME)
12. Describe appropriate follow-up for a patient who has been treated for incontinence. (ME, COMM)

5.7.1.1.d Other urogynecologic conditions:

1. Describe abnormal urethral conditions, including urethral syndrome, urethritis, and diverticulitis. (S)
2. Describe the possible etiologies, diagnostic strategies, and treatment approaches for interstitial cystitis. (S, ME)
3. Describe the various types of urinary voiding disorders, urinary retention, and their possible etiologies, including medical and surgical causes. (S)
4. Describe the etiologies, prevention, diagnostic techniques, and approaches to repairing various fistulae that may involve the pelvic organs. (S)
5. Describe the etiologies, diagnostic strategies, and management of chronic inflammatory conditions of the lower urinary tract (S, ME)
6. Describe the sensory disorders of the lower urinary tract and their diagnostic approach with general information about their management. (S)
7. Clinical knowledge about the effects of pelvic surgery and irradiation on the lower bowel, urinary tract, and pelvic floor. (S)
8. Clinical disorders about urinary disorders in pregnancy. (S)
9. Evaluation and care of the pelvic floor problems in the elderly. (ME, S)
10. Clinical lesions about the central nervous system affecting the urinary system, fecal control, and the pelvic floor. (S)
11. Clinical knowledge about sexual problems related to U-RPS/FPM-RPS. (ME, S)

5.7.1.2 Urinary tract disorders (infection, nephrolithiasis)

5.7.1.2.a Distinguish the types of urinary tract infection, including bacteriuria, urethritis, cystitis, and pyelonephritis. (S)

5.7.1.2.b Describe the pathophysiology related to urinary tract infection, including the organisms commonly implicated in lower and upper urinary tract disorders, and host factors, such as urinary retention, age, and pregnancy. (S)

5.7.1.2.c Describe the pathophysiology of the common forms of nephrolithiasis, including patient risk factors for the development of nephrolithiasis. (S)

5.7.1.2.d Describe typical clinical presentations, and obtain a pertinent history in a patient with a possible urinary tract infection or nephrolithiasis. (ME)

5.7.1.2.e Describe the diagnostic methods and diagnostic criteria for the various types of urinary tract infections. (S)

5.7.1.2.f Summarize the methods used for the diagnosis of nephrolithiasis. (S)

5.7.1.2.g Describe modes of therapy for acute, chronic, and complicated urinary tract infections, including prophylaxis for recurrent infection. (S, ME)

5.7.1.2.h Summarize therapeutic options for nephrolithiasis and strategies to prevent recurrence. (S, ME)

5.7.1.3 Chronic pelvic pain

5.7.1.3.a Define chronic pelvic pain. (S)

5.7.1.3.b Outline the principal gynecologic and non-gynecologic causes of chronic pelvic pain and describe the pathophysiology of each cause. (S)

5.7.1.3.c Obtain a pertinent and detailed medical, menstrual, and sexual history to characterize the patient's chronic pelvic pain, including signs/symptoms emanating from nonreproductive organs. (ME)

5.7.1.3.d Obtain an appropriate social and mental health history in a patient with chronic pelvic pain. (ME)

5.7.1.3.e Perform a focused physical examination, including attempts to localize the pain and an evaluation of neurologic and musculoskeletal components. (ME)

5.7.1.3.f Perform and/or interpret the results of the following selected diagnostic tests to determine the cause of chronic pelvic pain: (ME, COMM)

1. Microbiologic cultures of the genitourinary tract;
2. Radiologic imaging studies;
3. Hysteroscopy;
4. Laparoscopy;
5. Injection of anesthetic agent at a specific trigger point; and
6. Mental health examination, including screening for depressions or dysphoria.

5.7.1.3.g Treat patients with chronic pelvic pain with nonsurgical and surgical methods. (ME)

5.7.1.3.h Summarize indications and approximate success rates for interventions for chronic pelvic pain, such as laparoscopy, etc. (S, ME)

5.7.1.3.i Describe the indication for referral of a patient to a specialist in urology or gastroenterology. (ME, COLLAB)

5.7.1.3.j Describe the indications for referral to a multidisciplinary group, including pain management specialists and behavioral and/or mental health (ME, COLLAB)

5.7.1.3.k Describe the appropriate long-term goals and follow-up for a patient with chronic pelvic pain. (ME, P)

5.7.2 Senior year

The fellow should have received experience in theory, practice, and performance of the procedures listed below. Fellows are not expected to gain expertise in all these techniques but should achieve proficiency in commonly used procedures.

Management options:

- Catheterization (urethral, suprapubic, and clean intermittent self-catheterization)
- Devices (mechanical and electronic)
- Aids, appliances, pants, and pads

Nonsurgical treatment:

- Urinary and GI tract disorders, including incontinence
- Physiotherapeutic techniques and aids, including biofeedback
- Electrical stimulation/modulation therapy
- Behavioral therapy, including bladder and bowel retraining and acupuncture
- Role of pharmacologic agents to treat pelvic floor disorders
- Role of hormonal therapy
- Role of bulking agents (for urinary and fecal incontinence)
- Role of intravesical botulinum toxin
- Role of stem cell therapies
- Pessary fitting and management, surgical procedures
- Urethral dilatation, urethrotomy, and suprapubic cystotomy
- Bladder neck buttress and plication
- Minimally invasive slings
- Vaginal repair of genital tract prolapse, including anterior colporrhaphy, posterior colpoperineorrhaphy, vaginal hysterectomy and repair, enterocele repair, Manchester repair, sacrospinous fixation, iliococcygeus fixation, uterosacral fixation, and paravaginal repairs
- Mesh use in repairs, including use of various graft materials
- Le Fort procedure/colpocleisis
- Abdominal repair of primary and recurrent prolapse, including sacrocolpopexy, rectopexy, uterosacral ligament plication, sacrohysteropexy, Moscowitz and Halban procedure, colposuspension, and similar suprapubic suspension operations (both open and through minimally invasive techniques)
- Laparoscopically assisted vaginal hysterectomy (LAVH) and supracervical hysterectomy (LSH)
- Total and subtotal laparoscopic hysterectomy (TLH, sTLH)
- Sling procedures—retropubic, pubo-vaginal, midurethral, and transobturator, para-, and transurethral injection procedures
- Vaginal plastic surgery
- Implantation of artificial urinary sphincter
- Repair of vesicovaginal, ureterovaginal, urethrovaginal, and recto-vaginal fistulae
- Martius graft technique and gracilis muscle technique
- Augmentation cystoplasty
- Urinary diversion and undiversion
- Urethral diverticulectomy and excision of paraurethral cysts
- Urethral reconstruction
- Urethral closure techniques
- Rectal mucosal prolapse surgery (abdominal Ripstein procedure and rectal approach)
- Anal sphincter repair (primary and secondary)
- Artificial anal sphincter
- Sacral nerve stimulation and implantation
- Dynamic graciloplasty
- Recognition and treatment of intraoperative bladder and bowel injuries
- Robotic surgery
- Operative urethrocystoscopy (removal of mesh/sutures)

5.7.3 Minimum Number of Cases Required in U-PRS

The fellow will be considered for a fellowship of U-PRS only when he/she has performed at least 80 percent of the following cases as a surgeon or first assistant:

1. Perform all urodynamic procedures independently (20 cases);
2. Perform all cystoscopic procedures independently, including stent placement and retrograde pyelography (cystoscopy 40–50, stent 5–10 cases);
3. Place, fit, and remove pessary/incontinence ring (15–20 cases);
4. Female urinary incontinence procedures: Urethral sling, periurethral injections, and retropubic suspensions (40–50 cases);
5. Complication of pelvic organ floor dysfunction surgery: removal/revision of sling and urethrolysis, and removal of eroded mesh (5–10 cases);
6. Neuromodulator (3–5 cases);
7. Colpopexy, uterine suspension, hysterectomy (total and supracervical), colpocleisis (30–40 cases);
8. Insertion of vaginal mesh (1–5 cases);
9. Repair of vesicovaginal, urethrovaginal, rectovaginal, or colovesical fistulae, and urethral diverticulectomy (5–10 cases);
10. Contraction of neovagina (1–3 cases);
11. Repair of anal sphincter laceration (15–20 cases); and
12. Pelvic organ prolapse repair: Cystocele, rectocele, enterocele, or vault prolapse repair (30–40 cases).

5.7.4 Continuum of Learning

Each state of learning will confer specific levels of competency. This is accomplished through a structured, competency-based training program with graded progressive responsibility throughout fellow years one to three, with supervision and monitoring by dedicated consultants. The fellows will be closely monitored (refer to 7.4) and objectively assessed throughout the program using continuous objective assessment tools to ensure the desired training objectives are being met (Refer to Appendix A2: Assessment Tools).

5.8. QUALITY AND SAFETY ASSURANCE

Fellow Duty Hours in the Learning and Working Environment

5.8.1 Professionalism, Personal Responsibility, and Patient Safety

1. Programs and primary training site will 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.
2. The program will be committed to and responsible for promoting patient safety and fellow wellbeing in a supportive educational environment.
3. The program director will ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.
4. The learning objectives of the program will:
   a. Be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching and didactic educational events; and
   b. Will not be compromised by excessive reliance on fellows to fulfill non-physician service obligations.
5. The program director and institution will ensure a culture of professionalism that supports patient safety and personal responsibility.

6. Fellows and faculty members will demonstrate an understanding and acceptance of their personal role in the following:
   - Assurance of the safety and welfare of patients entrusted to their care
   - Provision of patient and family-centered care
   - Assurance of their fitness for duty
   - Management of their time before, during, and after clinical assignments
   - Recognition of impairment, including illness and fatigue in themselves and their peers
   - Attention to lifelong learning
   - Monitoring of their patient care performance improvement indicators
   - Honest and accurate reporting of duty hours, patients, and clinical experience data
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.

5.8.2 Transition of Care

1. The program will design clinical assignments to minimize the number of transitions in patient care.
2. The primary training site and program will ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
3. The program will ensure that fellows are competent in communicating with team members in the transition process.
4. The primary training site will ensure the availability of schedules that inform all members of the healthcare team of attending physicians and fellows currently responsible for each patient's care.

5.8.3 Alertness Management/Fatigue Management

1. The program will:
   a. Educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;
   b. Educate all faculty members and fellows in alertness management and fatigue management processes; and
   c. Adopt fatigue management processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.
2. Have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties.
3. Provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to return home safely.

5.8.4 Supervision of Fellows

5.8.4.1 In the clinical learning environment each patient will have an identifiable, appropriately credentialed, and privileged attending physician (or licensed independent practitioner as approved by each SCFHS) who is ultimately responsible for that patient's care.

a. This information will be available to fellows, faculty members, and patients.
b. Fellows and faculty members will inform patients of their respective roles in each patient's care.

5.8.4.2 The program will demonstrate that the appropriate level of supervision is in place for all fellows who care for patients.

5.8.4.3 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-care review of fellow-delivered care with feedback as to the appropriateness of that care.

5.8.4.4 Levels of Supervision

To ensure oversight of fellow supervision and graded authority and responsibility, the program will use the following classification of supervision:

5.8.4.4.a Direct Supervision: The supervising physician is physically present with the fellow and patient, within the hospital or other site of patient care, and is immediately available to provide direct supervision.

5.8.4.4.b Indirect Supervision: The supervising physician is not physically present, but is immediately available by means of telephonic and/or electronic modalities to provide direct supervision.

5.8.4.4.c Oversight: The supervising physician is available to review procedures/encounters with feedback provided after care is delivered.

5.8.4.5 The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow will be assigned by the program director and faculty members.

- The program director will evaluate each fellow's abilities based on specific criteria. When available, evaluation will be guided by specific national standard-based criteria.
- Faculty members functioning as supervising physicians will delegate portions of care to fellows based on the needs of the patient and the skills of the fellows.
- Senior fellows will supervise junior fellows and recognize their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.
- 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. In particular, a first-year fellow will be supervised either directly or indirectly, with direct supervision immediately available.
- Faculty supervision assignments will 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.

5.8.5 Clinical Responsibilities

The clinical responsibilities for each fellow must be based on the fellow year, patient safety, fellow education, severity and complexity of patient illness/condition, and available support services (refer to Appendix A2 for further details).

5.8.6 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. 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
- Certified mental health providers
- Certified nurse practitioners (NPs) and 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

5.8.7 Fellow Duty Hours

5.8.7.1 The maximum number of duty hours and all other clinical requirements from fellows should be as per SCFHS duty hours policy and the training sites regulations.

5.8.7.2 On-call duties in core training:

5.8.7.2.a The fellow will have on-call duty that will include a minimum of six calls per month for junior trainees and five calls per month for senior trainees, comprising 24 hours. The fellow should cover the urogynecology patients during duties and is also required to facilitate proper endorsements to ensure continuity of patient care.

5.8.7.2.b If the fellow is experiencing fatigue following his/her day of on-call duties, he/she will be allowed to take leave no earlier than noon providing that he/she has finished the endorsements of his/her work, patients, etc.

5.8.7.2.c On-call duty should not interfere with her/his urogynecology training.

5.8.7.2.d Carry out all other clinical requirements and duties as decided and assigned by the primary training site.

5.8.8 Leave

Fellow should comply with SCFHS policy of training on leave, which indicates maximum leave of four weeks per year, in addition to one of the two Eid holiday and a scientific leave.

5.8.9 Fellow Evaluation and Requirement for Graduation

a. Satisfactory clinical and surgical training as outlined by the UGPSC.
b. Completion of a minimum of one research project and preparation of a scientific manuscript suitable for presentation and application by each fellow trainee. The research subject should be on a topic related to the U-PRS subspecialty.
c. Successful completion of the required period of the fellowship training program. If any fellow who has missed the maximum of three months of training of the fellowship program sits for the exam, his/her written and clinical results will be suspended until the missing period is made up.
d. Completion of the logbook, covering the core training program as per the curriculum outline suggested by the UGPSC.
e. The fellow will evaluate his/her education, fellowship experience, and director at the end of their senior year and submit these evaluations to the UGPSC.

CHAPTER 6

Assessment

Assessment plays a vital role in the success of postgraduate training. Assessment will guide trainees and trainers to achieve the targeted learning objectives. On the other hand, reliable and valid assessment will provide excellent means for training improvement as it will inform the following aspects: curriculum development, teaching methods, and quality of learning environment. Assessment can serve the following purposes:

a. **Assessment for learning**: As trainers will use information from trainees' performance to inform their learning for improvement.
b. **Assessment as learning**: As assessment criteria will drive trainees' learning.
c. **Assessment of learning**: As assessment outcomes will represent a quality metric that can improve learning experience.

For the sake of organization, assessment will be further classified into two main categories: *Formative* and *Summative*.

6.1. Formative Continuous Evaluation (refer to Appendix 2, Forms 1–3)

a. General Rules:

Trainees, as an adult learner, should strive for feedback throughout their journey of competency from "novice" to "mastery" levels. Formative assessment (also referred to as continuous assessment) is the component of assessment that is distributed throughout the academic year aiming primarily to provide trainees with effective feedback. Input from the overall formative assessment tools will be utilized at the end of the year to make the decision of promoting each individual trainee from current-to-subsequent training level. Formative assessment will be defined based on the scientific committee recommendations (usually updated and announced for each individual program at the start of the academic year). According to the executive policy on continuous assessment (available online: www.scfhs.org), formative assessment will have the following features:

a. Multisource: minimum four tools.
b. Comprehensive: covering all learning domains (knowledge, skills, and attitude).
c. Relevant: focusing on workplace-based observations.
d. Competency-milestone oriented: reflecting trainee's expected competencies that match trainee's developmental level.

Trainees should play an active role seeking feedback during their training. On the other hand, trainers are expected to provide timely and formative assessment. SCFHS will provide an e-portfolio system to enhance communication and analysis of data arising from formative assessment. The evaluations of fellow performance will be accessible for review by the fellow in accordance with institutional policy.

a. Annual continuous evaluation report **(CER -Refer to Appendix 2: Form 6)**
    - This report is prepared for each fellow at the end of each academic year by the program director to summarize trainee's performance in variable continuous assessment tools in order to make the annual promotion decisions
    - The CER will be based on **five-evaluation components** as per the latest SCFHS policy on promotion and continuous assessment (available on SCFHS website). These components will cover the three main areas for continuous assessment as follows:

a) Knowledge:

1. **Academic Activities:** A weekly protected academic activity should be arranged and moderated by program director as a solo training site or in collaboration with other training sites. Active participation of candidates is expected and should be evaluated. The accumulative average of weekly protected academic activities evaluations will be incorporated in the final yearly CER.
2. **Annual Written Progress Test - once a year**
   The general objective is to assess that the fellow has satisfactorily acquired the theoretical knowledge and clinical competences that he/she should have acquired during the relevant year. A single examination is used for all levels (with adjustment of the passing score to reflect the level difference in fellowship training). This examination shall consist of one paper with 120 questions in the form of multiple-choice questions, SBA, or 20 short notes, or a slide-show examination. Two and a half hours (150 minutes) shall be allowed for this exam. The following **Passing Score will be followed:**

percentage	< 50%	50-59.4%	60-69.4%	>70%
Description	Clear fail	Borderline fail	Borderline pass	Clear pass

b) Skills:

3- OSCE (Objective Structured Clinical Examination)- once a year.

4- **Log Book-** once a year:

Academic and clinical assignments should be documented on an annual basis using the logbook (when applicable). Evaluations will be based on accomplishment of the minimum requirements of the procedures and clinical skills as determined by the program. (Refer to Appendix 3: Logbook)

c) Attitude:

5- **ITERs** (In-training Evaluation Report).

To fulfill the CanMEDS competencies based on the end-of-rotation evaluation, the fellow's performance will be evaluated by ITER jointly by relevant staff for the following competencies: Patient care improvement, procedural skills, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism and systems-based practice. ITER must be completed within two weeks following the end of each rotation (preferably in electronic format) and signed by at least one consultant. The program director will discuss the evaluation with the fellow as necessary. The evaluation form will be submitted to the UGPSC of the SCFHS within four weeks following the end of the rotations. A minimum of three evaluation reports should be submitted by the program director for each candidate based on relevant rotations and training sites. The average of these will be incorporated in the final yearly CER.

- **The CER** should assess the five components of evaluation in order to determine the promotion of candidates to the next level. The evaluation of each component will be based on the following equation:

percentage	< 50%	50-59.4%	60-69.4%	>70%
Description	Clear fail	Borderline fail	Borderline pass	Clear pass

- To achieve unconditioned promotion, the candidate must score a minimum of "borderline pass" in all five components.
- The program director can still recommend the promotion of candidates if the above is not met in some situations:
- In case the candidate scored "borderline failure" in one or two components at maximum, and these scores should not belong to the same area of assessment (for example: both borderline failures should not belong both to skills)
- The candidate must have passed all other components and has scored a minimum of clear pass in at least two components.

* Please refer to the SCFHS policy on promotion and continues assessment (refer to SCFHS website).

- CER is based on **five-evaluation components; however the following components can still be utilized for educational purpose and are not included in the CER. The** UGPSC has the full right to alter/change CER components in future as needed:

1. Case-Based Discussion (CBD). Appendix 2, Form 3:

The purpose of a case-based discussion (CBD) encounter is to evaluate the level of professional judgment exercised in clinical cases by the fellow. CBD is designed to:

- Guide the fellow's learning through structured feedback
- Help improve clinical decision making, clinical knowledge, and patient management
- Provide the fellow with an opportunity to discuss his/her approach to the case and identify strategies to improve his/her practice
- Be a teaching opportunity enabling the evaluator to share his/her professional knowledge and experience

Overview

A CBD encounter involves a comprehensive review of clinical cases between a fellow and an evaluator. The fellow is given feedback from an evaluator across a range of areas relating to clinical knowledge, clinical decision-making, and patient management. Each CBD encounter takes approximately 20–30 minutes.

Fellow responsibilities

- Arrange a CBD encounter with an evaluator
- Provide the evaluator with a copy of the CBD rating form

Evaluator responsibilities

- Choose the case(s) for discussion
- Use the CBD form to rate the fellow
- Provide constructive feedback and discuss improvement strategies
- Provide an overall judgment on the fellow's clinical decision-making skills

2. Direct Observation of Procedural Skills (DOPS). Appendix 2, Form 4:

The direct observation of procedural skills, commonly referred to as DOPS, is a workplace-based assessment (WBA) tool. The DOPS is a structured checklist for assessing competence in performing diagnostic and interventional procedures. It facilitates feedback in order to develop behaviors and performance related to operative, decision-making, communication, and teamwork skills. The assessment is formative, aimed at guiding further development of practice.

3. Mini-Clinical Evaluation Exercise (Mini-CEX). Appendix 2, Form 5:

Definition:

The mini-CEX is a 10- to 20-minute direct observation assessment or "snapshot" of a fellow-patient interaction. To be more useful, the evaluator should provide timely and specific feedback to the fellow after each assessment of a fellow-patient encounter.

Purpose:

A mini-CEX is designed to:

- Guide the fellow's learning through structured feedback
- Help improve communication, history taking, physical examination, and professional practice
- Provide the fellow with an opportunity to be observed during interactions with patients and identify strategies to improve their practice
- Be a teaching opportunity enabling the evaluator to share his/her professional knowledge and experience

Overview:

A mini-CEX encounter involves a fellow being observed in his/her workplace consulting with a patient. The fellow is given feedback across a range of areas relating to professional qualities and clinical competence from an evaluator immediately after observation.

Fellow responsibilities:

- Arrange a mini-CEX encounter with an evaluator
- Provide the evaluator with a copy of the mini-CEX rating form

Evaluator responsibilities:

- Choose an appropriate consultation for the encounter
- Use the mini-CEX rating form to rate the fellow
- Provide constructive feedback and discuss important strategies. If a fellow receives a rating that is unsatisfactory, the assessor must complete the 'Suggestions for Development' section. The form cannot be submitted if this section is left blank.

6.1.2. Summative Evaluation

6.1.2.1- Certification of Training-Completion

In order to be eligible to sit for final fellowship examinations, each trainee is required to obtain "Certification of Training-Completion". Based on the training bylaws and executive policy (please refer to www.scfhs.org) trainees will be granted "Certification of Training- Completion" once the following criteria is fulfilled in the Final In-Training Report (FITER):

a. Successful completion of all training rotations.
b. Completion of training requirements as outlined by scientific committee of specialty (e.g. logbook, research, others).
c. Clearance from SCFHS training affairs that ensure compliance with tuitions payment and completion of universal topics.
d. "Certification of Training-Completion" will be issued and approved by the UGPSC according to SCFHS

6.1.2.2- Final U-RPS Fellowship Examination

Upon completion of the training program each fellow will be expected to take a certification examination in Urogynecology conducted by the Saudi Commission for Health Specialties. Successful candidates will be awarded

the "**Certificate of Subspecialty Fellowship in Urogynecology and Pelvic Reconstructive Surgery**."

Final specialty examination is the summative assessment component that grant trainees the specialty's certification. It has two elements:

a) Final written exam: in order to be eligible for this exam, trainees are required to have "Certification of Training-Completion".

b) Final clinical exam: Trainees will be required to pass the final written exam in order to be eligible to set for the final clinical/practical exam.

Final Exams General rules:

The following are exam rules and regulations which is an excerpt from the SCFHS general exam rules and regulations (refer to SCFHS website):

a. The Saudi U-PRS written examination will be held once each year on a date published on the SCFHS website (normally towards the end of the calendar year).
b. The examination will be aligned with those competencies using a test blueprint that will have specific proportions of items testing at two levels of understanding, referred to here as K1 (recall and comprehension) and K2, usually delivered as questions with scenarios (interpretation, analysis, decision making, reasoning, and problem-solving).
c. Examination dates will be provided by the UGPSC in accordance with the fixed annual schedule submitted by the assessment department.
d. The clinical examinations (OSCE and SOE) will be held each year, four to eight weeks after the final written examination. If the percentage of failures in this examination is 50 percent or more, the exam will be repeated after six months.
e. The examination will be conducted over two days: the first day for the written examination and the second for the OSCE/SOE examination.
f. All score reports shall be issued by the SCFHS after approval of the Specialty Exam Committee within two weeks of the examination.
g. There shall be no re-sit exams.
h. A candidate may remain eligible for the Saudi U-RPS final exam for a period not longer than three years after the completion of the training, provided he/she can prove they have been clinically active.
i. A candidate who fails to pass the final written examination, including the exceptional attempt, has to repeat the final year of training, after which he/she is allowed to sit the final written examination twice after approval by the scientific council.
j. After exhausting all the above attempts (maximum six attempts), the candidate will not be permitted to sit the final written examination.
k. Challenges regarding content and/or process raised by examinees during the examination must be submitted in writing to the specialty exam committee within two weeks of the exam date.
l. All examinations will go through a systematic quality assurance process, including item selection, technical review, scientific review, classification, and item formatting.

Objectives (refer to Appendix 2: Form 7)

a. Determine the quantity and quality of specialty knowledge base ranked as competent, so that the individual can be used as a referral source for the specialty.
b. Using theoretical data, determine the candidate's ability to think logically, solve problems, apply basic medical science to clinical problems, and make judgments with valid comparisons.
c. Determine the fellow's ability to practice as a specialist and provide consultations in the general domain of his/her specialty for other health care professionals or other bodies that may seek assistance and advice.
d. Ensure that the candidate has the necessary clinical competencies relevant to his/her specialty, including but not limited to history taking, physical examination, documentation, procedural skills, communication skills, bioethics, diagnosis, management, investigation, and data interpretation.
e. Determine that a level of clinical excellence is demonstrated that shall be considered substantially above the ordinary.
f. All competencies contained within the specialty core curriculum are subject to be included in the examination.

Eligibility

a. Successful completion of the required period of fellowship training.
b. Obtaining a training completion certificate issued by the scientific committee based on a satisfactory FITER report (refer to Appendix 2: Form 8) and any other related requirements assigned by scientific board (e.g., research, publication, logbook, etc.)
    - A FITER is prepared by the program director for each fellow at the end of his/her final year.
    - This report might also involve clinical exams, oral exams, and other academic assignments.
    - Each fellow's logbook is part of this final report, and should be evaluated and scored by the local supervising committee.
    - At least one completed research paper is included in this final report, and should be submitted for evaluation.
    - The overall evaluation should be more than 70 percent, and the fellow is expected to have at least "met expectations" in 70 percent of the submitted evaluations. If this is not met, the assessment committee might decide to repeat some rotations or evaluations or not allow the fellow to sit the promotion examination or repeat the training year, whichever is appropriate.
c. Registering for the examination at least one month before the exam date.

Components of the final U-PRS Examination

a. Written examination

- A Saudi Scientific Committee U-PRS examination shall consist of one paper with 100–120 short-based answer (SBA)/multiple-choice questions. To assess the theoretical based knowledge required to function as a U-PRS consultant, the majority shall have clinical scenarios. Ten unscored items can be added for pretesting purposes.
- Two and a half hours shall be allowed to complete this exam.

b. Clinical Evaluations

This section can be divided into two parts: Objective Structured Clinical Examination (OSCE) and the Structured Oral Examination (SOE), and can only be attempted after successfully passing the final written examination.

6.3.4.b.1 Objectives

- Determine the ability of the fellow to practice as a specialist and provide consultation in the U-PRS subspecialty to other healthcare professionals. It also evaluates the knowledge of underlying physiologic and pathologic mechanisms necessary for diagnosis and management of clinical entities.
- Assesses the ability to order and interpret relevant laboratory data to properly understand and manage clinical entities for monitoring the progress of patients.
- It also assesses the fellow's ability to make clinical judgments in different clinical scenarios and to enumerate, in detail, the steps for conducting surgical management for the specified scenarios.

Examination Format

- The combined OSCE/SOE shall consist of 8 to 12 stations; at least five OSCE stations and at least two SOEs, preferably to be conducted within the same circuit.
- OSCE stations are encouraged to be manned stations (with real or simulated patients) with one examiner per station.
- The SOE component shall be conducted by two examiners based on predetermined questions and unified model answers (refer to the SCFHS general exam rules and regulations).
- SOE case development shall follow SCFHS standards.
- OSCE station development shall comply with the SCFHS OSCE manual.
- The time allocation for each station is 10–20 minutes per encounter.
- UPRS final clinical examination shall consist of OSCEs, SOEs, or a combination of both.

Passing Score

Written Examination

The passing score for the written and OSCE/SOE exam is 70 percent. However, if the percentage of candidates passing the examination is less than 70 percent, it can be lowered by one mark at a time, aiming at achieving a 70 percent passing rate or a 65 percent passing score, whichever comes first. Under no circumstances can the passing score be reduced below 65 percent. Negative marking is not allowed.

Clinical Evaluations

a. The pass/fail cut off for each OSCE/SOE station is determined by the UGPSC prior to conducting the exam using a Minimum Performance Level (MPL) Scoring System (refer to SCFHS general exam rules and regulations).
b. Each station shall be assigned an MPL based on the expected performance of a minimally competent candidate. The UGPSC shall approve station MPLs prior to the exam.
c. At least one examiner marks each OSCE station and two examiners independently mark each part of the SOE.
d. To pass the examination, a candidate must attain a score > MPL in at least 70 percent of the number of stations and 60 percent in each component (OSCE and SOE).

MCQs/OSCE/SOE Blueprint

a. The specialty exam committee shall produce a MCQs/OSCE/SOE blueprint at least one month prior to the scheduled exam date.
b. The MCQs/OSCE/SOE blueprint must guarantee the exam content covers the required knowledge, skills, and behaviors for safe and effective patient care.
c. The MCQs/OSCE/SOE blueprint should conform to the test specifications defined by SCFHS with regard to sampling domains and dimensions of care.

d. MCQs/OSCE/SOE includes but is not limited to areas of knowledge, skills, competencies, and professional characteristics of the competent and professional practitioner.
e. Exam domains shall map with the specialty's curriculum, including but not limited to history taking, physical examination, documentation, procedural skills, communication, ethical issues, investigation and data interpretation, and diagnosis and management, as described on the SCHFS website (http://www.scfhs.org.sa).

Score reports

a. All score reports shall go through a post-hoc item analysis before being issued and approved by the SCFHS assistant secretariat for postgraduate studies and UGPSC within two weeks of the examination.
b. The U-PRS fellowship examination committee is encouraged to provide the candidate with feedback for each section of the exam according to the test blueprint.

Exemptions

At present the SCFHS has no reciprocal arrangement with respect to this examination or qualification by any other college or board, in any specialty.

General Rules for Candidates

Registration and conduct of the examinations

a. Each candidate must bring his/her ID to the examination hall and present it at the registration desk.
b. Candidates arriving at the registration desk more than 30 minutes after the published starting time of the examination will not be allowed to sit the examination, and will be considered absent for purposes of calculating retakes or deferment unless an acceptable written justification is submitted and approved by the UGPSC.
c. The candidate must be seated in his/her assigned seat but may be moved at the discretion of a supervisor without any stated reason, who must then submit a report to the assessment department at SCFHS.
d. No candidate may leave the examination hall before 30 minutes have elapsed and must always be accompanied by a supervisor if he/she wishes to return.
e. Candidates attending an examination within their city of training should be free of clinical duty the day of the examination and not on-call the night before.
f. Candidates attending an examination outside their city of training should be free of clinical duty the day before the examination and not on-call the night before.

Withdrawal or Absence from the Examinations

Withdrawal from an examination

a. Notice of withdrawal of any candidate who cannot be present for an examination must be sent in writing with an explanation of the reason as soon as he/she is aware of being unable to attend, and no later 48 hours prior to the examination date. This should be sent to the SCFHS Examination Department.
b. If the withdrawal is made, due to an unpredictable event (such as illness or injury, which should be supported by documentary evidence such as a medical certificate), an alternative examination appointment will be offered upon approval by the SEC.
c. If exams are cancelled due to bad weather, security measures, or any other unavoidable event, alternative appointments will be offered at the SCFHS's discretion.
d. Approved withdrawn candidates are not considered in the examination result statistics.

Absent candidates, late withdrawals (less than 48 hours' notice), and those arriving at the registration desk more than 30 minutes after the published starting time of the examination:

a. Will not be allowed to sit the examination, and will be considered absent for purposes of calculating retakes or deferment unless an acceptable written justification is submitted and approved by the SEC; and
b. Accepted written justification for any of the above conditions mentioned in (2-a) shall not be considered an examination attempt.

The following refund policy applies to fee-based examinations:

a. The entire fee will be refunded for withdrawal from an examination received in writing by the Examination Department at least 30 days before the prescribed date of the exam.
b. Half the fee will be refunded if written notification is received between 14 and 29 days before the examination date.
c. The whole fee is forfeited if absence or written withdrawal is received less than 14 days before the examination date.

Prohibitions (misconduct)

Before the examination:

a. Seeking, providing, and/or obtaining unauthorized access to examination materials.
b. Providing false information or making false statements on or in connection with application forms, scheduling permits, or other exam-related documents.
c. Applying for an examination for which you are not eligible.
d. Communicating or attempting to communicate about specific test items, cases, answers, and/or exam results with an examiner, potential examiner, or formal or informal test developers at any time before, during, or after an examination.

During the examination:

a. Taking an examination for which, you are not eligible.
b. Taking an examination for someone or engaging someone to take an examination for you.
c. Giving, receiving, or obtaining unauthorized assistance during the examination or attempting to do so.
d. Making notes of any kind while in the secure areas of the test center, except on the writing materials provided at the test center for this purpose.
e. Failing to adhere to any exam policy, procedure, or rule, including instructions of the test center staff.
f. Verbal or physical harassment of test center staff or other examination staff, or other disruptive or unprofessional behavior during the registration, scheduling, or examination process.
g. Possessing any unauthorized materials, including photographic equipment, communication or recording devices, and cell phones, in the secure testing areas.
h. Any other electronic communication device, not herein mentioned, is prohibited in the examination hall irrespective if it is turned off, and no provision will be made to store it.
i. Communicating or attempting to communicate about specific test items, cases, and/or answers with another examinee, or formal or informal test preparation group at any time before, during, or after an examination.

After the examination:

a. Altering or misrepresenting examination scores.
b. Reproduction by any means, including, but not limited to, reconstruction through memorization, and/or dissemination of copyrighted examination materials by any means, including the Internet.

c. Communicating or attempting to communicate about specific test items, cases, and/or answers with another examinee, potential examinee, or formal or informal test preparation group at any time before, during, or after an examination.
d. Failure to cooperate fully in any investigation of a violation of the SCFHS rules.

Disciplinary Actions

a. Non-compliance with any of the above rules will be considered misconduct. At the discretion of the supervisor of the examination, various actions may be taken. This could vary from verbal warnings up to dismissal from the examination hall.
b. If the misconduct is severe enough (including but not limited to cheating notes or taking photos of questions) the supervisor has the right to nullify the candidates' submission and should submit a written report to the Specialty Examination Committee.
c. Failure to provide a valid ID will disqualify the candidate from registering at the examination hall and he/she will not be allowed to sit for the examination.
d. Impersonation or false identity shall be treated according to KSA government rules.
e. If the candidate does not immediately comply with a request to leave the examination hall, at the discretion of the proctor, security shall be called for a forced removal.
f. Any other conduct deemed to be cheating shall be reason for dismissal from the examination hall and the supervisor shall then write a report.
g. If irregular behavior or misconduct is found, the penalties include one or more of the following:
    - Cancellation of exam scores
    - Ban on future testing for periods ranging from six months to three years
    - Permanent annotation of the fellow's record/report
    - Possible legal action

6.9 Examination of the Component Blueprint

1. Short-Based Answers (SBA)/Multiple Choice	
Specialty Domain	**Number of Questions**
Basic general principle of U-PRS (anatomy, physiology, pathology, pharmacology)	10
Screening and diagnosis	10
Medical management	30
Surgical management	30
Epidemiology and biostatistics	7
Counseling	8
Ethical, legal, and risk management issues	10
Office procedures	8
Patient safety and quality	7
Total	**120**

2. Clinical Evaluations (OSCE/SOE)	
Specialty Domain	**Cases**
Urogynecology (urinary incontinence and pelvic floor dysfunction)	3
Medical management	3–4
Surgical management and office procedures	2–3
Epidemiology and biostatistics, counseling and ethical, legal, and risk management issues	2–3
Screening, diagnosis, basic with general principle of the core specialty, patient safety, and quality	2–3
Total	**12**

CHAPTER 7

7. ANNUAL EVALUATIONS

7.1 Faculty Evaluation (Refer to Appendix 2: Form 9)

The fellow/program must annually evaluate faculty performance as it relates to the educational program.

1. The evaluations should include a review of the faculty's availability, clinical teaching abilities, and commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.
2. It must also include annual written confidential evaluations by the fellows.

See Appendix 2: Form 10 for "Early Concern Note" for concerns about the performance and/or professional behavior of a physician colleague.

7.2 Program Evaluation and Improvement (Refer to Appendix 2: Form 11)

7.2.1 The program director must perform a complete program evaluation at the end of the year with the aim of:

1. Planning, developing, implementing, and evaluating the educational activities of the program.
2. Reviewing and making recommendations for the revision of competency-based curriculum goals and objectives.
3. Addressing areas of non-compliance with Saudi Scientific Committee standards.
4. Reviewing the program annually using evaluations of faculty, fellows, and others, as specified below.

7.2.2 The program must document formal, systematic evaluations of the curriculum at least annually and is responsible for rendering a written, annual program evaluation. The program must monitor and track each of the following areas:

- Fellow performance
- Faculty development
- Graduate performance, including performance of program graduates on the certification examination
- Program quality
- Progress on the previous year's action plan(s) should be reviewed and approved by the teaching faculty and documented in the meeting minutes

7.2.3 Fellows and faculty must have the opportunity to annually evaluate the program confidentially in writing.

7.2.4 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.

APPENDICES

Appendix 1: Rotations and Milestones

General Framework of the Required Rotations

Yearly planning for every trainee is highly recommended. Scheduling rotations will provide equal opportunity for all trainees and avoid conflict or dissatisfaction.

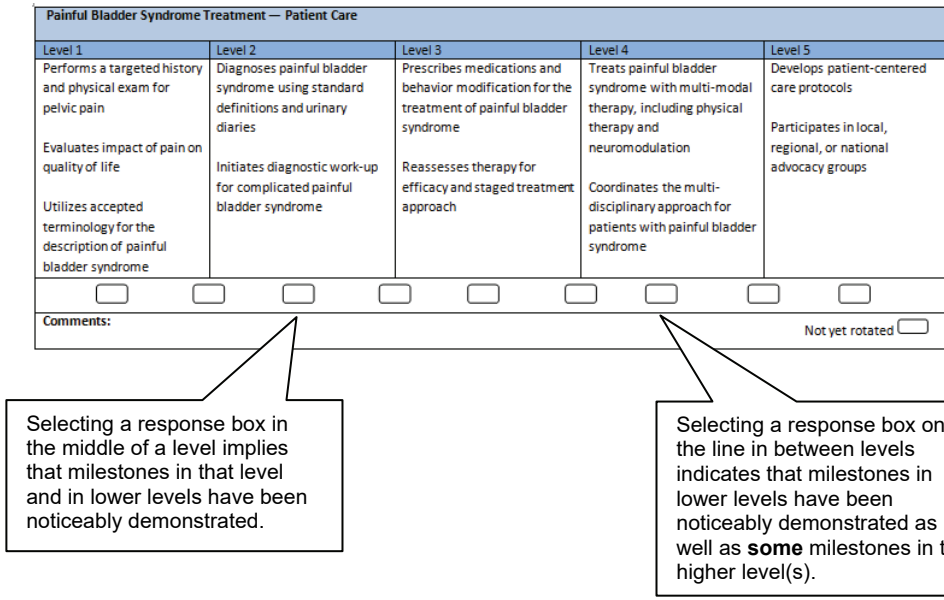
ROTATION	DURATION (block = 4 weeks)
Clinical Urogynecology blocks, including Physiotherapy	4 blocks
Urogynecology Procedure blocks	2 blocks
Colorectal/Plastic/Minimally Invasive	3 blocks
Research blocks	1 block
Urology blocks	2 blocks
Clinical Urogynecology blocks	3 blocks
Urogynecology Procedure blocks	3 blocks
Physiotherapy	1 block
Research block	3 blocks
Female Medical Imaging	1 block
Elective	1 block
Clinical Urogynecology blocks	4 blocks
Urogynecology Procedure blocks	4 blocks
Research block	1 blocks
Elective	3 blocks
Rotations can be taken in any approved center of the SCFHS, with a minimum requirement of a six-month rotation outside the home institution.	

Milestones

This section details the milestones designed for use in the semi-annual reviews of fellows' performance, and are reported to the UGPSC. These milestones are knowledge, skills, attitudes, and other attributes for each of the UGPSC competencies organized in a developmental framework from less to more advanced. They are descriptions and targets for fellow performance as a fellow moves from entry into fellowship through graduation.

Milestones are arranged into numbered levels. Tracking from Level 1 to Level 5 is equivalent to moving from novice to expert in the U-PRS subspecialty.
Level 1: The fellow demonstrates milestones expected of an incoming fellow.
Level 2: The fellow is advancing and demonstrates additional milestones, but is not yet performing at a mid-fellowship level.
Level 3: The fellow continues to advance and demonstrates additional milestones, consistently including the majority of milestones targeted for fellowship.
Level 4: The fellow has advanced so that he/she now significantly demonstrates the milestones targeted for fellowship.
Level 5: The fellow has advanced beyond performance targets set for fellowship and is demonstrating "aspirational" goals that might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional fellows will reach this level.

The diagram below indicates an example of how the table is to be filled out by evaluators:



Painful Bladder Syndrome Treatment — Patient Care				
Level 1	Level 2	Level 3	Level 4	Level 5
Performs a targeted history and physical exam for pelvic pain Evaluates impact of pain on quality of life Utilizes accepted terminology for the description of painful bladder syndrome	Diagnoses painful bladder syndrome using standard definitions and urinary diaries Initiates diagnostic work-up for complicated painful bladder syndrome	Prescribes medications and behavior modification for the treatment of painful bladder syndrome Reassesses therapy for efficacy and staged treatment approach	Treats painful bladder syndrome with multi-modal therapy, including physical therapy and neuromodulation Coordinates the multi-disciplinary approach for patients with painful bladder syndrome	Develops patient-centered care protocols Participates in local, regional, or national advocacy groups
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
Comments: Not yet rotated ☐				

General Pelvic Floor Evaluation—Medical Expert				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Is able to extract basic medical, surgical, obstetric, and gynecologic history. Can perform basic pelvic examinations.	Elicits a comprehensive history that incorporates a directed history identifying all pelvic floor disorders. Integrates the use of standardized quality of life, symptom severity, and sexual health measures in the evaluation of pelvic floor disorders. Performs focused pelvic floor physical examinations. Understands indications for diagnostic testing and imaging to evaluate pelvic floor disorders. Utilizes the appropriate terminology for the description of pelvic floor disorders.	Evaluates for co-existing environmental factors or diseases that may impact patient selection of or response to treatment. Interprets and reports a standardized quality of life, symptom severity, and sexual health measures. Performs and interprets diagnostic tests and imaging to evaluate pelvic floor disorders. Performs a detailed pelvic floor examination, including: neurological status; pelvic floor muscle and anal sphincter strength; pelvic floor support defects; urethral hypermobility; structural, anatomic, and congenital malformations; and signs of urinary and anal incontinence.	Extracts and interprets the histories of complex patients using appropriate terminology. Creates a differential diagnosis and establishes a care plan based on quality of life, symptom severity, ancillary testing, physical examination, and patient goals. Demonstrates frugal use of diagnostic testing and imaging modalities for evaluation of pelvic floor disorders.	Evaluates the cost utility of diagnostic testing. Develops new techniques for evaluating pelvic floor disorders.
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
Comments: ☐ **Not yet rotated**				

Urinary Incontinence and Overactive Bladder Treatment—Medical Expert				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Counsels patients on use of anti-incontinence devices, behavioral and physical therapy Can assess functional contributions to urinary incontinence Can assess patients for use of medications for treatment of urinary continence Assists in first-line surgical treatments Performs cystoscopy on uncomplicated patients	Fits and manages anti-incontinence devices Identifies appropriate functional interventions Initiates anti-incontinence medications Performs anti-incontinence procedures on uncomplicated patients Performs cystoscopy to evaluate for iatrogenic injury	Recognizes and manages anti-incontinence device complications Integrates non-surgical and surgical options into therapeutic plans for complex patients Integrates anti-incontinence and hormonal therapies Performs a variety of anti-incontinence procedures on complex patients Performs neuromodulation procedures Anticipates intra- and post-operative complications	Integrates combined therapies for complex patients Initiates behavioral and physical treatments and functional interventions Manages pharmacotherapy in complex patients Manages complications and failures following anti-incontinence procedures Recognizes and manages intra- and post-operative complications Performs placement of ureteral catheter Has the ability to initiate complex therapeutic interventions independently	Teaches and supervises combined therapies Teaches advanced surgical techniques to residents and junior fellows Incorporates cost awareness and risk-benefit principles into all clinical scenarios
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
Comments: ☐ **Not yet rotated**				

Anal Incontinence and Defecatory Dysfunction Treatment—Medical Expert				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Identifies and evaluates stool consistency, frequency, and type. Assesses impact of diet and current medications on bowel function.	Counsels patients on use of behavioral and physical therapy for anal incontinence. Assesses impact of diet and current medications and functional contributions to anal incontinence. Assesses patients for use of medications for the treatment of anal incontinence. Assists in surgical treatments for anal incontinence.	Integrates non-surgical and surgical options into therapeutic plans for complex patients. Identifies appropriate functional interventions. Initiates anti-incontinence medications. Performs neuromodulation procedures. Anticipates intra- and post-operative complications	Initiates and integrates combined therapies for complex patients Manages pharmacotherapy in complex patients Manages complications and failures following anti-incontinence procedures Recognizes and manages intra- and post-operative complications Performs sphincteroplasties on uncomplicated patients	Performs and manages repair and treatment of complex and/or recurrent obstetric sphincter injury following vaginal delivery Teaches and supervises a combination of therapies Teaches surgical techniques Incorporates cost awareness and risk-benefit principles into all clinical scenarios
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
Comments:			☐ **Not yet rotated**	

Pelvic Organ Prolapse Treatment—Medical Expert				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Counsels patients on use of pessaries, and behavioral and physical therapy Assesses functional contributions to pelvic organ prolapse Assesses patients for treatment of urogenital atrophy Assists in surgical treatments	Fits and manages pessaries Identifies appropriate functional interventions Initiates hormonal therapy for urogenital atrophy Performs primary prolapse procedures on uncomplicated patients	Recognizes and manages pessary complications Integrates non-surgical and surgical options into therapeutic plans for complex patients Assesses complications of hormonal therapy Performs a variety of prolapse procedures on complex patients Anticipates intra- and post-operative complications	Integrates combined therapies for complex patients Initiates behavioral and physical treatments and functional interventions Manages pharmacotherapy in complex patients Performs a variety of surgical approaches personalized to individual patients, including vaginal, open abdominal, and minimally invasive approaches, and the use of grafts Demonstrates the ability to perform complex therapeutic interventions independently Recognizes and manages intra- and post-operative complications	Teaches and supervises combined therapies Teaches advanced surgical techniques Incorporates cost awareness and risk-benefit principles into all clinical scenarios
☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

☐ **Not yet rotated**

Urogenital Fistulae and Urethral Diverticula Treatment—Medical Expert				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Elicits history relevant to fistulae and diverticula Performs physical examination relevant to fistulae and diverticula	Performs in-office evaluation of integrity of lower urinary tract Initiates conservative management of fistulae and diverticula Assists in surgical treatments	Performs and/or interprets appropriate ancillary testing to distinguish type and location of fistulae Evaluates patients for other etiologies of fistulae Evaluates timing and route of repair Performs fistula repair and diverticulectomies on uncomplicated patients Anticipates intra- and post-operative complications	Manages complications following fistula repair and diverticulectom Performs fistula repair and diverticulectomies on complex patients Recognizes and manages intra- and post-operative complications Recognizes the need for a multi-disciplinary approach for complex patients	Teaches surgical techniques Incorporates cost awareness and risk-benefit principles into all clinical scenarios Participates in programs for advocacy or treatment of genital urinary fistulae
☐	☐	☐	☐	☐	☐	☐	☐	☐
Comments:				☐ **Not yet rotated**

Painful Bladder Syndrome Treatment—Medical Experts				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Performs a targeted history and physical exam for pelvic pain Evaluates impact of pain on quality of life Utilizes accepted terminology for the description of painful bladder syndrome	Diagnoses painful bladder syndrome using standard definitions and urinary diaries Initiates diagnostic work-up for complicated painful bladder syndrome	Prescribes medications and behavior modification for the treatment of painful bladder syndrome Reassesses therapy for efficacy and a staged treatment approach	Treats painful bladder syndrome with multi-modal therapy, including physical therapy and neuromodulation Coordinates the multi-disciplinary approach for patients with painful bladder syndrome	Develops patient-centered care protocols Participates in local, regional, or national advocacy groups
☐	☐	☐	☐	☐	☐	☐	☐	☐
Comments:				☐ **Not yet rotated**

Urinary Tract Infection (UTI)—Medical Expert				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Evaluates impact of recurrent UTIs on quality of life Treats uncomplicated UTIs	Initiates diagnostic work-ups for complicated UTIs Treats complicated UTIs	Prescribes prophylactic treatment for UTIs	Coordinates treatment of multi-drug resistant organism infections	Develops patient-centered care protocols
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
Comments: ☐ **Not yet rotated**				

Pelvic Floor Anatomy and Physiology—Scholar				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Demonstrates knowledge of pelvic anatomy, including genital, urinary, colorectal, and musculoskeletal elements	Describes the vascular and nerve supply to each of the pelvic organs and structures, including the external genitalia, uterus, kidney, ureter, bladder, and recto-sigmoid colon Explains the normal anatomic supports of the vagina, rectum, bladder, urethra, and uterus, including the bony pelvis, pelvic floor nerves and musculature, and connective tissue Describes the normal function of the lower urinary tract during storage and micturition, and the mechanisms responsible for urinary continence Describes normal utero-vaginal physiology and function across the lifespan	Describes the inter-relationships and function of the pelvic organs and support mechanisms Describes the physiology of colorectal function, including neurologic and anatomic factors Understands the neurophysiology of normal and abnormal lower urinary tract and colorectal function	Understands and interprets the pathophysiology of pelvic floor disorders Demonstrates proficiency in teaching residents and junior fellows anatomy, physiology, and pathophysiology of pelvic floor disorders	Discusses current controversies involving the anatomy and pathophysiology of pelvic floor disorders Designs and executes innovative teaching and assessment tools for the understanding of pelvic anatomy and pathophysiology
☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

☐ **Not yet rotated**

Urinary Incontinence and Overactive Bladder Treatment—Scholar				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Describes behavioral treatments for urinary incontinence Knows the drugs and class of drugs used to treat urinary incontinence Knows the indications, contraindications, and safe and effective doses of relevant drugs Demonstrates knowledge of anti-incontinence surgical procedures	Describes how bladder training and time voiding are used to treat urinary incontinence Describes lower urinary tract receptors and mediators (detrusor, bladder neck, urethra), and potential sites for pharmacologic manipulation to treat various types of urinary incontinence Understands risks and benefits of common anti-incontinence surgery	Knows indications, contraindications, effectiveness, and compliance with behavioral interventions Describes effectiveness, side effects (including prevalence), rates of long-term continuation, and compliance with pharmacologic therapy Understands risks and benefits of complex anti-incontinence surgery Discusses alternatives, advantages, disadvantages, and evidence for anti-incontinence procedures at the time of vaginal and abdominal prolapse surgery	Evaluates quality of studies establishing comparative effectiveness, complication rates, and costs of behavioral therapy Evaluates quality of studies establishing comparative effectiveness, complication rates, and costs of pharmacologic therapy Describes the indications and complications of anti-incontinence procedures Evaluates quality of studies establishing comparative effectiveness, complication rates, and costs of surgical therapy	Teaches and supervises complex anti-incontinence procedures Conducts comparative effectiveness studies Performs systematic review of pharmacologic therapies
☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

☐ **Not yet rotated**

Anal Incontinence and Defecatory Dysfunction Treatment—Scholar				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Describes behavioral treatments for anal incontinence Knows prescription and non-prescription pharmaceuticals to treat constipation and diarrhea Demonstrates knowledge of surgical procedures for anal sphincter laceration following vaginal delivery	Describes how management of stool type and frequency impacts therapeutic options Knows the drugs and class of drugs used to treat anal incontinence, including the indications, contraindications, and safe and effective doses Demonstrates knowledge of common anti-incontinence surgical treatments Understands risks and benefits of common anti-incontinence surgical treatments	Knows indications and contraindications, effectiveness, and compliance with behavioral interventions Describes effectiveness, side effects, rates of long-term continuation, and compliance with pharmacologic therapies Understands risks and benefits of complex continence surgery Understands the role of a multi-disciplinary approach to patient care	Describes how patient characteristics and history impact treatment choices and outcomes Evaluates complication rates and costs of pharmacologic therapies Describes the indications for intra- and post-operative complications of, and controversies surrounding complex anti-incontinence procedures	Teaches non-surgical management of anal incontinence and defecatory dysfunction Performs systematic review of pharmacologic therapies Conducts comparative effectiveness studies
☐	☐	☐	☐	☐	☐	☐	☐	☐
Comments:				☐ **Not yet rotated**

Pelvic Organ Prolapse Treatment—Scholar				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Describes behavioral treatments for pelvic organ prolapse Discusses therapies in management of urogenital atrophy Demonstrates knowledge of primary surgical procedures	Compares non-surgical and surgical treatment options for symptomatic anterior, apical, and posterior prolapse Knows factors that impact successful pessary fitting for prolapse, including: stage, genital hiatus, type of pessary, presence of uterus, and sexual activity Discusses the role of pelvic floor physical therapy in management of prolapse Understands risks and benefits of common prolapse surgery	Understands how to fit and manage pessaries Knows indications and contraindications for, effectiveness of, and compliance with pessary use Describes effectiveness, side effects, rates of long-term continuation, and compliance with hormone replacement therapy Understands risks and benefits of complex prolapse surgery Discusses evidence-based advantages and disadvantages for approaches to prolapse surgery, including vaginal vs. abdominal, minimally invasive vs. open, grafts vs. no graft	Describes the management of pessary complications Describes the indications, intra- and post-operative complications of, and controversies surrounding complex prolapse procedures Evaluates the quality of studies establishing comparative effectiveness, complication rates, and costs of surgical therapy	Conducts comparative effectiveness studies Performs systematic review of prolapse therapies
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
Comments: ☐ **Not yet rotated**				

Urogenital Fistulae and Urethral Diverticula Treatment—Scholar				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Describes risk factors for genitourinary fistulae and urethral diverticula	Describes tests to diagnose genitourinary fistulae and diverticula Demonstrates knowledge of surgical procedures used to treat genitourinary fistulae and diverticula	Describes evidence-based alternatives, risks, benefits, complications, and success rates for surgical management Understands the role of the multi-disciplinary approach to patient care	Describes how the timing of surgical repair and post-operative management influence outcomes Describes the indications and intra- and post-operative complications of procedures	Understands epidemiology of fistulae Conducts research into mechanisms of fistula development and repair
☐	☐	☐	☐	☐ ☐ ☐ ☐

Comments:

☐ **Not yet rotated**

Painful Bladder Syndrome Treatment—Scholar				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Describes differential diagnosis for pelvic pain	Understands the signs, symptoms, and diagnostic evaluation of painful bladder syndrome	Describes evidence-based alternatives, risks, benefits, complications, and success rates for pharmacologic and non-pharmacologic management Understands the role of behavioral therapy, physical therapy, pharmacologic therapy, and neuromodulation in the management of painful bladder syndrome	Understands the role of the multi-disciplinary approach to patient care for complex urinary tract infection and painful bladder syndrome	Conducts research in painful bladder syndrome Leads a multi-disciplinary approach to patient care for painful bladder syndrome
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				☐ **Not yet rotated**

Urinary Tract Infection—Scholar				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Demonstrates knowledge of the pathophysiology and role of host factors for lower and upper UTIs Describes diagnostic methods and diagnostic criteria for the various types of UTIs Describes techniques, accuracy, sensitivity, specificity, and interpretation of diagnostic urine tests for primary and recurrent UTIs	Describes the indications for cystourethroscopy and upper tract imaging for both UTIs and painful bladder syndrome Describes treatment options for an uncomplicated UTI	Describes alternatives, risks, benefits, complications, success rates, and levels of evidence for pharmacologic and non-pharmacologic management Describes treatment options for complicated UTIs	Describes prophylactic treatment of UTIs Demonstrates knowledge of the treatment and management of infection with multi-drug resistant organisms Understands the role of the multi-disciplinary approach to patient care for complex UTI and painful bladder syndrome	Conducts research in the area of UTIs
☐	☐	☐	☐	☐ ☐ ☐ ☐

Comments:

☐ **Not yet rotated**

Neuro-Urology—Scholar				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Describes the pathophysiology of neurologic conditions that affect the bladder and lower urinary tract Describes the pathophysiology of the risks associated with neurogenic lower urinary tract dysfunction	Demonstrates knowledge of a complete neuro-urologic history elucidating relevant neurologic conditions and gross motor and sensory deficits Understands assessment of: lower limb reflexes and sensory and motor function; perineal sensation and reflexes; and pelvic floor and anal sphincter muscle strength	Describes evaluation of bladder storage and voiding function using urodynamic testing and standard terminology Understands the risks of bladder dysfunction to upper urinary tract function Describes options for bladder emptying Describes the use of pharmacological management of the neurogenic bladder	Describes the management plan to protect the upper urinary tract from neurogenic bladder dysfunction Understands the pathophysiology and management of autonomic dysreflexia Describes the use of surgical management of the neurogenic bladder Understands the need for a multi-disciplinary approach for the patient with neurogenic bladder	Conducts research in neuro-urology
☐	☐	☐	☐	☐

Comments:

☐ **Not yet rotated**

Computer Systems—Medical Expert				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Retrieves basic patient information from the electronic medical record (EMR)	Retrieves complex patient information from the EMR	Generates orders, communicates with referring physicians, and documents communication with patients	Uses EMR to its full potential, and facilitates integration of computer-based communication with team	Recommends changes to computer systems/records to provide additional useful functionality

Comments:

Not achieved level 1 yet

Health Care Economics—Medical Expert				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Has a basic understanding of the advantages and disadvantages of different payment systems	Has a basic understanding of the economics of inpatient vs. outpatient care and the impact of quality improvement incentives Develops an understanding of cost utility	Has a basic practical understanding of the pre-certification process, benefit managers, and structured computer-based order entry systems	Has an advanced practical understanding of the pre-certification process, benefit managers, and structured computer-based order entry systems,	Has a basic understanding of current state and national health care policies and their implications

Comments:

Not achieved level 1 yet

Conducts and coordinates patient care effectively in various healthcare delivery settings and systems—Collaborator				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Knows unique roles of and services provided by local health care delivery systems, and how to access these resources for patient care Knows and appreciates the roles of a variety of healthcare providers, including consultants, therapists, nurses, home care workers, pharmacists, and social workers Advocates for quality patient care	Manages and coordinates care and care transitions across multiple delivery systems, including ambulatory, sub-acute, acute, rehabilitation, and skilled nursing Advocates for quality patient care and optimal patient care systems	Discusses non-pharmacologic and non-procedural patient resources (such as physical therapy, social work, alternative medicine providers, chaplains, etc.) with patients and families Demonstrates how to lead a health care team by utilizing the skills and coordinating the activities of inter-professional team members (physician extenders/mid-levels, nurses, medical students, allied health workers, etc.) Negotiates patient-centered care among multiple care providers	Is adept at systems thinking Capably leads the healthcare team, understanding his/her personal role as leader Contributes meaningfully to inter-professional teams	Creates a process for screening at-risk patients (e.g., long-term care) Incorporates cost awareness and risk-benefit principles into all clinical scenarios
☐	☐	☐	☐	☐ ☐ ☐ ☐

Comments:

☐ **Not achieved level 1 yet**

Scholarly Activity—Scholar				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Critically reviews and interprets publications with the ability to identify study aims, hypotheses, design, and biases Explains validity, bias, confounding, and effect modification; describes commonly used study designs (e.g., RCT, cohort, case-control, cross-sectional); distinguishes between association and causation; and knows criteria for causal inference Demonstrates knowledge of basic principles underlying the ethical conduct of research and the protection of human subjects	Identifies research mentor(s) Designs a hypothesis-driven or hypothesis-generating study, including: • Defining the knowledge gap in the literature • Developing specific aims • Defining exposures and outcomes using standardized measures • Determining the sample size • Determining appropriate statistical analysis • Identifying strengths and limitations of study design Applies the principles of ethics and good clinical practice to the protection of human subjects recruited to participate in research	Demonstrates expertise in statistical analyses and epidemiology Conducts research ensuring data quality and safety Complies with local, regional, and national research oversight regulations Analyzes data Explores local, regional, and national funding mechanisms Maintains data safety and patient monitoring to ensure continued protection of human subjects	Writes publishable scientific thesis, including: • Abstract • Introduction • Methods • Results • Discussion • Summary • References Presents study findings to peers for review and critique	Obtains extramural funding for research study Publishes thesis in peer-reviewed journal
☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

☐ **Not achieved level 1 yet**

Implements Quality Improvement Project—Scholar				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Identifies problems in healthcare delivery	Begins working on a quality improvement project, either as an individual or team member	Continues to develop a quality improvement project, employing methods to measure and analyze the data	Completes a quality improvement project Displays effective teamwork skills	Develops and leads complex quality improvement projects and is able to conduct a root-cause analysis
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				

Comments:

☐ **Not achieved level 1 yet**

Professional Ethics and Accountability—Professionalism				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Demonstrates integrity, respect, honesty, and compassion Honest and truthful in all circumstances; reliably ethical Understands HIPAA policies and appropriate use concepts Demonstrates timeliness in completion of assigned rotations, reports, state licensure, and duties	Accountable in completion of duties, records, and patient care Sensitive and responsive to diverse patient population and needs, regardless of gender, age, race, sexual orientation, religion, or disability Demonstrates knowledge of local, regional, and national regulations for billing and coding	Acknowledges errors with program director, faculty members, and/or patients Takes on responsibility related to learning, coordination of care, patient care, Continuous Quality Improvement (CQI), and compliance issues	Serves as a role model for honesty, integrity, professionalism, and compassionate patient care Demonstrates commitment to self-improvement Responds well to constructive criticism Prioritizes patient needs over self-interest Advocates for quality patient care Operates professionally and independently in various educational and patient care environments	Demonstrates leadership in the department and professional organizations
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
Comments:				
☐ **Not achieved level 1 yet**				

Health Care Teamwork—Communicator				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Communicates clearly and effectively, and works well with all members of the healthcare team	Communicates results of routinely performed procedures in a clear and concise fashion, verbally, in written procedure reports, and in electronic records	Discusses and advises referring healthcare providers about the appropriateness of procedures in routine clinical situations Communicates results of complex, less common procedures in a clear and concise fashion, verbally, in written procedure reports, and electronically	Discusses and advises referring healthcare providers about the appropriateness of procedures in complex, uncommon situations	Independently acts as a consultant during interdisciplinary conferences
☐	☐	☐	☐	☐ ☐ ☐ ☐

Comments:

☐ **Not achieved level 1 yet**

Effective Communication—Communicator				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Demonstrates adequate skills of listening without interrupting, ensuring that his/her message is understood, and allowing opportunity for questions Exhibits basic communication skills during medical interviews, counseling and education, and hospitalization updates where the patient's condition is non-acute or life-threatening Consistently checks that the patient understands all the information presented and invites questions Demonstrates sensitivity to patients' cultures	Exhibits basic communication skills in non-stressful situations and in some stressful, challenging situations Able to deliver bad news to the patient or family related to condition severity Demonstrates patient-centered skills while counseling and obtaining informed consent across a diverse set of situations involving serious illness Condition-specific information related to risks, benefits, and treatment options is mostly complete and accurate	Delivers bad news to the family about complications and death, and is capable of informing the family of a medical error that caused harm Provides patient-centered counseling in cases of acute and probable terminal illness	Acts as a role model by demonstrating effective communication to residents and junior fellows Capable of effective communication in the most challenging and emotionally charged situations, and effectively invites participation from all stakeholders	Demonstrates highly proficient counseling behaviors that are personalized and participatory, allowing predictive recommendations with high resolution of the anticipated benefits and possible risks and complications
☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

☐ **Not achieved level 1 yet**

Appendix 2: Assessment Forms

Form 1: On call Rating Form

Fellow name: _____ Level: _____

While on call, the fellow performed these tasks appropriately for his/her level of training:

Tasks	CanMEDS Role	Ready for independent call status	Not ready for independent call status	Insufficient Exposure	Initials and date
Assessment of patients and establishment of care plans	Medical Expert				
Management of referred cases and phone advice	Leader, Collaborator				
Performance of surgeries and instrumental deliveries	Medical Expert				
Communication (verbal and written) with staff, referring physicians and other professionals (nurses, clerical staff, social worker, etc.)	Collaborator				
Communications and interactions with patients and families	Communicator				
Supervision and teaching of medical students and residents	Scholar				

Self-assessment ability (aware of own limitations, seeks advice and assistance when appropriate)	Professional				

Issues that represent outstanding performance or need attention:

_____

_____

_____

Evaluator Name: Evaluator Signature:

Form 2: Presentation Rating Form

Fellow Name: _____ Level: _____

Date of Presentation: _____

Topic: _____

Please use the following scale to evaluate the presentation:

Very Weak	Weak	Acceptable	Good	Very Good	Not Applicable
1	2	3	4	5	N/A

Medical Expert	1	2	3	4	5	N/A
Demonstrated thorough knowledge of the topic						
Presented at the appropriate level and with adequate skills						
Well-prepared, knows content, and answers questions						
Comments (optional):						
Communicator	1	2	3	4	5	N/A
Provided objectives and an outline						
Presentation was clear and organized						
Used effected methods and presentation style						
Established good rapport with the audience						
Comments (optional):						
Collaborator	1	2	3	4	5	N/A
Invited comments from learners and led discussions						
Worked with supervisor/team effectively in preparing the session						
Comments (optional):						
Health advocate	1	2	3	4	5	N/A
Managed time effectively						
Addressed preventive aspects of care						
Comments (optional):						

Scholar	1	2	3	4	5	N/A
Posed appropriate learning questions:						
Accessed and interpreted the relevant literature						
Professional	1	2	3	4	5	N/A
Maintained patients' confidentiality if clinical material was used						
Identified and managed relevant conflicts of interest						
Supported conclusions with relevant convincing evidence						
Comments (optional):						

Overall Performance:

Did not meet expectations	Short of expectations	Met expectations	Exceeded expectations	Far exceeded expectations

Comments:

_____

_____

_____

Evaluator Name: Evaluator Signature:

Form 3: Case-Based Discussion (CBD)

Definition

Case-Based Discussion (CBD)
The purpose of a Case-Based Discussion (CBD) encounter is to evaluate the level of professional judgment exercised in clinical cases by the fellow. CBD is designed to:

- Guide the fellow's learning through structured feedback
- Help improve clinical decision making, clinical knowledge, and patient management
- Provide the fellow with an opportunity to discuss his/her approach to the case and identify strategies to improve his/her practice
- Be a teaching opportunity enabling the evaluator to share his/her professional knowledge and experience

Overview

A CBD encounter involves a comprehensive review of clinical cases between a fellow and an evaluator. The fellow is given feedback from an evaluator across a range of areas relating to clinical knowledge, clinical decision-making, and patient management. Each CBD encounter takes approximately 20–30 minutes.

Fellow responsibilities

- Arrange a CBD encounter with an evaluator
- Provide the evaluator with a copy of the CBD rating form

Evaluator responsibilities

- Choose the case(s) for discussion
- Use the CBD form to rate the fellow
- Provide constructive feedback and discuss improvement strategies
- Provide an overall judgment on the fellow's clinical decision-making skills

Case-Based Discussions (CBD) Rating Form

Fellow name: SCFHS Registration no: Residency level:

Date:

Brief summary of case:

New case Follow-up Case

Assessment setting:
Inpatient Ambulatory ICU CCU Emergency department

Other _____

Complexity:
Low Moderate High

Focus:
Data gathering Diagnosis Therapy Counseling

Other _____

Assessment

SCORE FOR STAGE OF TRAINING									
Questions	**Unsatisfactory**			**Satisfactory**			**Superior**		
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Medical Record Documentation									
Clinical Assessment									
Investigation and Referrals									
Treatment									
Follow-up and Future Planning									
Professionalism									

Clinical Judgment									
Leadership/Management Skills									
Overall performance									

Suggestions for Development:

Evaluator Name:

Evaluator Signature:

Form 4: Direct Observation of Procedural Skills (DOPS)

The direct observation of procedural skills, commonly referred to as DOPS, is a workplace-based assessment (WBA) tool. The DOPS is a structured checklist for assessing competence in performing diagnostic and interventional procedures. It facilitates feedback in order to develop behaviors and performance related to operative, decision-making, communication, and teamwork skills. The assessment is formative, aimed at guiding further development of practice.

Direct Observation of Procedural Skills (DOP) Rating Form

Fellow's Name: SCFHS Registration no:

Procedure observed:

Observed by: Date:

Signature of observer:

Description	Satisfactory	Unsatisfactory	Comment
Understood the indications for the procedure and clinical alternatives			
Explained plans and potential risks to the patient clearly and in an understandable manner			
Good understanding of the theoretical background, including anatomy, physiology, and imaging of the procedure			
Good advanced preparation for the procedure			
Communicated the procedural plan to relevant staff			
Explained procedure to the patient and obtained valid informed consent			
Aware of risks of cross-infection and demonstrated an effected aseptic technique during the procedure			
Procedure success or failure was understood in the current setting			
Coped well with unexpected problems			
Demonstrated awareness through constant monitoring/maintained focus			
Confidently demonstrated correct procedural sequence with minimal hesitation			
Skillfully handled patient and tissues gently			
Maintained accurate and legible records, including descriptions of problems or difficulties			
Issued clear post-procedural instructions to the patient and/or staff			
Sought to work to the highest professional standards at all times			

DOP Rating Form, continued

Assessment	
Practice was satisfactory	
Practice was unsatisfactory	
Examples of good practice: **Areas of practice requiring improvement:** **Further learning and experience should focus on the following:**	

Form 5: Mini-Clinical Evaluation Exercise (Mini-CEX)

Definition:

The mini-CEX is a 10- to 20-minute direct observation assessment or "snapshot" of a fellow-patient interaction. To be more useful, the evaluator should provide timely and specific feedback to the fellow after each assessment of a fellow-patient encounter.

Purpose:

A mini-CEX is designed to:

- Guide the fellow's learning through structured feedback
- Help improve communication, history taking, physical examination, and professional practice
- Provide the fellow with an opportunity to be observed during interactions with patients and identify strategies to improve their practice
- Be a teaching opportunity enabling the evaluator to share his/her professional knowledge and experience

Overview:

A mini-CEX encounter involves a fellow being observed in his/her workplace consulting with a patient. The fellow is given feedback across a range of areas relating to professional qualities and clinical competence from an evaluator immediately after observation.

Fellow responsibilities:

- Arrange a mini-CEX encounter with an evaluator
- Provide the evaluator with a copy of the mini-CEX rating form

Evaluator responsibilities:

- Choose an appropriate consultation for the encounter
- Use the mini-CEX rating form to rate the fellow
- Provide constructive feedback and discuss important strategies. If a fellow receives a rating that is unsatisfactory, the assessor must complete the 'Suggestions for Development' section. The form cannot be submitted if this section is left blank.

Mini-Clinical Evaluation Exercise (mini-CEX) Rating Form

Fellow name: SCFHS registration no: Residency Level:

Date:

Mini-CEX time: min

Observing: min

Providing feedback: min

Brief summary of case:

New case **Follow-up Case**

Assessment setting:

Inpatient Ambulatory ICU CCU Emergency department

Other _____

Complexity:

Low Moderate High

Focus:

Data gathering Diagnosis Therapy Counseling

Other _____

Assessment

SCORE FOR STAGE OF TRAINING									
Questions	**Unsatisfactory**			**Satisfactory**			**Superior**		
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
History taking									
Physical examination skills									
Communication skills									
Critical judgment									
Humanistic quality/ professionalism									
Organization and proficiency									
Overall clinical care									

Suggestions for Development:

Evaluator Name:

Evaluator Signature:

Mini-Clinical Evaluation Exercise (mini-CEX) Rating Form, continued

Questions	Description
History taking	Facilitates patient's narrative, uses appropriate questions to obtain accurate and adequate information effectively, and responds to verbal and nonverbal cues appropriately
Physical examination skills	Follows an efficient, logical sequence; examinations are appropriate for clinical problems; provides patients with explanations; is sensitive to patients' comfort and modesty
Communication skills	Explores patients' perspectives; uses jargon-free language; is open, honest, and empathetic; agrees on management plans and therapies with patients
Critical judgment	Forms appropriate diagnoses and suitable management plans; orders selectively and performs appropriate diagnostic studies; considers risks and benefits
Humanistic quality/professionalism	Shows respect, compassion, and empathy; establishes trust; attends to patient's comfort needs; respects confidentiality; behaves in an ethical manner; is aware of legal framework and his/her own limitations
Organization and proficiency	Prioritizes, is timely and concise, summarizes
Overall clinical care	Demonstrates global judgment based on the above topics

Form 6: Continuous Evaluation Report (CER)

Definition:

The CanMEDS-based competencies end of rotation evaluation form is a summative evaluation report prepared for each resident at the end of each year based on the end-of-rotation reports, which might also involve clinical, oral exams, and completing other academic or clinical assignment(s). These academic or clinical assignments should be documented by an electronic tracking system on an annual basis. Evaluations will be based on the accomplishment of the minimum requirements of the procedures and clinical skills as determined by the program.

CER Examination Bylaws:

Introduction

Annual CER is a component of promotion to the next year of a specialist-training program. Eligibility of promotion includes a satisfactory overall annual CER.

CER Format

a. At least three ITERs are submitted by the program director upon approval by the fellowship training committee for each trainee during the specific training year, based on a series of workplace-based assessments considered relevant by the specialty.
b. An annual CER is based the five components of assessment and evaluation.
c. If any other assessment format is used, the UGPSC must agree to its implementation.

CER Format

a. The promotion written and OSCE examinations shall be held once a year within four to six weeks after completion of nine months of training in that particular year.

Continuous Evaluation Report (CER)

Fellow Name: SCFHS no: Training Center:

Level of training: Rotation Dates:

Assessment components should include the following:

a) Knowledge:

1. Academic Activities: The cumulative average of weekly protected academic activity evaluations will be incorporated in the final yearly CER.
2. Annual Progress written exam - once a year

b) Skills:

3. OSCE (Objective Structured Clinical Examination) - once a year.
4. Log Book- once a year.

c) Performance and attitude:

5. ITERs (In-training Evaluation Report). The average of minimum of three ITERs per academic year will be incorporated in the final yearly CER.

percentage	< 50%	50-59.4%	60-69.4%	> 70%
Description	Clear fail	Borderline fail	Borderline pass	Clear pass
Academic Activity (average)				
Log Book				
OSCE				
Written Examination				
ITERs				

Final recommendation for promotion by UGPSC:

Unconditioned Promotion	Recommended Promotion

*Comments and justifications (only for Recommended Promotion), ref to 6.1.1.2 :

Form 7: Fellow Evaluation Standards

I. Clinical Knowledge

Fellows are expected to attain knowledge and competency in comprehensive management of the following:

II. Evaluation:

	Fellow 1	Fellow 2	Fellow 3
Ante/intra/post-partum anatomical and physiological evaluation of the perineum	✓		
Perineal tears evaluation	✓		
Anal sphincter evaluation		✓	
Ante/intra/post-partum evaluation and management of urinary incontinence	✓		
Ante/intra/post-partum evaluation and management of voiding dysfunction/urinary retention	✓		
Ante/intra/post-partum evaluation and management of anal incontinence		✓	
Ante/intra/post-partum evaluation and management of constipation	✓		
Evidence-based labor management to avoid perineal damage		✓	
Urinary tract infections	✓		
Vaginal infections	✓		
Urinary incontinence	✓		
Voiding dysfunctions		✓	
Anal Incontinence		✓	
Anal sphincter tone	✓		
Pelvic floor reflexes	✓		
Bladder diary	✓		
Pad test	✓		
Stress test	✓		
Q-Tip test	✓		
Pelvic floor muscle function	✓		

Neurological examination and evaluation of lower limbs reflexes	✓	
Classification and grading of pelvic organ prolapse: a-Baden-Walker14	✓	
b-POP-Q15/Simplified POP-Q16		
c-FASS17		
Bedside urodynamic tests:		✓
A) Free uroflowmetry (without electronic recording)		
B) One/two channel cystometry (without electronic recording)		✓
C) Measurement of post-void residual urine by catheter or ultrasound (if available)		✓
Three-swab vaginal test to diagnose the site of urogenital fistula		✓

III. Investigation

	Fellow 1	Fellow 2	Fellow 3
Urodynamic studies, uroflowmetry		✓	
Filling cystometry		✓	
Voiding cystometry		✓	
Valsalva leak point pressure		✓	
Urethral pressure profile		✓	
Urethro-cystoscopy	✓		
Ano-rectal physiology studies	✓		
Neurophysiological tests	✓		
Radiological investigations (cysto-urethrodefecography, pelvic floor ultrasound, MRI, etc.)		✓	

IV. Procedures and Surgical Principles

The fellow should acquire the necessary skills during his/her training period through skills assessment. The appropriate use of diagnostic and therapeutic procedures/surgeries is indicated by:

- Demonstrating thorough knowledge of a patient's condition/disease prior to treatment.
- Understanding the indications, risks, benefits, and limitations of a specific invasive prenatal procedures or surgery in urogynecology.
- Obtaining informed consent (as per hospital policies).
- Demonstrating the required knowledge of the surgical procedure.
- Correctly and precisely documenting information related to procedures performed and their outcomes.
- Demonstrating appropriate knowledge about recommended pre- and postsurgical prophylaxes that guarantee patient safety.
- Conducting appropriate postoperative follow-up with patients (i.e., communicating about the procedure findings, relating long-term sequelae, and arranging for adequate aftercare).
- Identifying and reporting any adverse event to the appropriate authority in a timely and professional manner.

V. Management

	Fellow 1	Fellow 2	Fellow 3
Identify management of urinary/vaginal infections	✓		
Identify and explain vaginal pessaries	✓		
Identify and explain drugs (antibiotics, antimuscarinics, estrogen replacement therapy, etc.)	✓		
Identify novel anti-incontinence pharmacological therapy drugs, for example, mirabegron, botulinum toxin, etc.	✓		
Identify pelvic floor rehabilitation (including electrostimulation)		✓	
Describe neuro-modulation	✓		
Identify defecatory dysfunctions and constipation		✓	
Diagnose chronic and acute urinary retention		✓	
Diagnose and manage sexual dysfunctions			✓
Define pelvic floor dysfunction (PFD) and discuss the incidence thereof	✓		
Explain the etiology and pathogenesis of PFD	✓		
Describe genital and extra-genital complications of obstructed labor	✓		
Diagnose PFD	✓		
Outline Female Genital Mutilation (FGM) classification	✓		
Understand how to evaluate fistula surgery outcome	✓		
Identify prognostic factors for surgical outcome	✓		
Describe approaches for the immediate management of female urogenital fistula (UGF), e.g., vesicovaginal fistula (VVF), etc.	✓		
Describe and carry out pre-operative care		✓	
Describe the surgical technique of UGF repair and perform a simple procedure		✓	
Provide basic post-operative care and identify any complications		✓	
Describe and provide pre-operative management of rectovaginal fistulae (RVFs)		✓	
Repair simple RVFs and third-and fourth-degree tears (anal sphincter trauma)		✓	
Describe surgical techniques for complicated RVFs			✓
Describe and provide post-operative care			✓
Management of complicated complex fistulae			✓
Identify different types of complicated/complex fistulae			✓

Describe surgical techniques for the repair of complicated/complex fistulae	✓
Repair complicated/complex fistulae	✓
Identify and manage patient's pre-operative co-morbidities and prevent intra-operative complications	✓
Prevent intra-operative complications, detect them if they occur, and determine appropriate management thereof	✓
Identify immediate post-operative complications and outline the management thereof	✓
Identify late post-operative complications and outline the management thereof	✓
Understand the principles of sedation, spinal anesthesia, and general anesthesia	✓

VI. Surgical treatment

	Fellow 1	Fellow 2	Fellow 3
Basic principles of surgical techniques	✓		
Obstetric perineal tears surgical reconstruction	✓		
Urinary incontinence, mid-urethral sling procedures—retropubic, pubo-vaginal, mid-urethral (TVT), and transobturator (TOT)	✓		
Urethral bulking agents—vesicovaginal fistula repair		✓	
Operative injuries of the bladder and the ureters		✓	
Urethral diverticulum repair and/or excision		✓	
Colpo-suspension (laparotomy or laparoscopy)		✓	
Le Fort procedure/colpocleisis			✓
Pubo-vaginal slings		✓	
Abdominal repair of primary and recurrent prolapse, including sacrocolpopexy, rectopexy, uterosacral ligament plication, sacrohysteropexy, Moscowitz and Halban procedure, colposuspension, and similar suprapubic suspension operations (open techniques)		✓	
Abdominal repair of primary and recurrent prolapse, including sacrocolpopexy, rectopexy, uterosacral ligament plication, sacrohysteropexy, Moscowitz and Halban procedure, colposuspension, and similar suprapubic suspension operations (through minimally invasive techniques)			✓
Anterior vaginal compartment reconstructive surgery (VCRS) without mesh		✓	
Anterior VCRS with mesh		✓	
Apical VCRS without mesh including sacrospinous colpopexy		✓	
Apical VCRS with mesh		✓	
Posterior VCRS without mesh		✓	
Posterior VCRS with mesh		✓	
Vaginal hysterectomy and Modified McCall culdoplasty for vaginal vault prolapse		✓	
Abdominal hysterectomy		✓	

Laparoscopic hysterectomy		✓	
Urinary diversion and colostomy			✓
Standard steps in fistula closure	✓		
Repair of urinary fistulae with extensive vaginal scarring		Supervision	✓
Repair of urethral fistulae		Supervision	✓
Urethral reconstruction		Supervision	✓
Repair of circumferential VVF		Supervision	✓
Repair a re-implantation of ureteric fistulae		Supervision	✓
Repair of third- and fourth-degree tears			✓
Repair of RVF and anal sphincter injury			✓
Repair of circumferential RVF			✓
Repair of vault fistula using the abdominal or vaginal route			✓
Repair of vesicocervical and vesicouterine fistulae			✓
A variety of plastic surgery procedures, including McIndoe procedures for creation of a neovagina as well as various rotational flaps for reconstructive surgery			✓
Sacral nerve stimulation and implantation/artificial anal sphincter (if available)		Supervision	✓

By the end of each year, the trainee is expected to be competent in performing those procedures/surgeries according to their level.

This curriculum has been adopted from different curricula and applied to ours based on applicability.

Form 8: Final In-Training Evaluation Report (FITER)/Comprehensive Competency Report (CCR)

(CCR) Definition

The FITER is completed by the resident training Program Director. FITER is prepared by program directors for each fellow at the end of his/her final year in fellowship, which might also involve clinical and oral exams and completing other academic assignment(s).
This is a summative evaluation prepared at the end of the fellowship program, which grants the fellow with a full range of competencies (knowledge, skills, and attitudes) required for a specialist, and readiness to sit the Saudi certification examination. The FITER is not a composite of the regular in-training evaluations; rather, it is a testimony of the evaluation of competencies at the end of a fellowship education program.

FITER Examination Bylaw

Obtaining a training completion certificate issued by the local supervisory committee based on a satisfactory FITER report and any other related requirements assigned by any mentioned scientific boards (e.g., research, publication, logbook, etc.) grants eligibility to sit the final U-PRS examination.

(FITER): Annual Fellow Assessment

UROGYNECOLOGY AND PELVIC RECONSTRUCTIVE SURGERY

FELLOW YEARLY ASSESSMENT

Fellow Name:

Fellow SCFHS Number:

Evaluation covering the last year as a fellow:

In the view of the UGPSC, the trainee mentioned above has acquired the competencies of the specialty/subspecialty as prescribed in the Objectives of Training and is competent to practice as a U-PRS specialist.

	Yes	No
Written exams		
Oral exams		
Clinical observations (e.g., CERs) from faculty		
OSCEs		
Feedback from healthcare professionals		
Completion of a scholarly project		
Other evaluations:		

Comments:

Name of Program Director/Assessor for CCR:

Date:

Signature:

This is to attest that I have read this document.

Name of Fellow:

SCFHS number:

Date:

Signature:

Fellow's comments:

Note: If, during the period from the date of signature of this document to the completion of training, the UGPSC judges that the candidate's demonstration of competence is inconsistent with the present evaluation, it may declare the document null and void and replace it with an updated FITER. Eligibility for the examination would be dependent on the updated FITER.

Final In-Training Evaluation Report (FITER)/Comprehensive Competency Report (CCR) Continued

FITER: (Medical Expert Competency)

Fellow Name:

Fellow SCFHS number:

	Meeting Expectations*					
Competencies	**Rarely**	**Inconsistently**	**Generally**	**Sometimes Exceeds**	**Consistently Exceeds**	**N/A**
Medical Expert						
• Possesses basic scientific and clinical knowledge relevant to specialty						
• Performs histories and physical examinations that are complete, accurate, and well-organized						
• Uses all pertinent information to arrive at complete and accurate clinical decisions						
• Recognizes and manages emergency conditions resulting in prompt and appropriate treatment. Remains calm, acts in a timely manner, and prioritizes correctly						

• Recognizes and appropriately manages patients with complex problems and multi-system diseases						
• Demonstrates proficiency in pre-operative and post-operative patient management, including indications for surgical intervention						
Please comment on the strengths and weaknesses of the candidate and provide a rationale for your ratings. Make direct reference to the objectives and give specific examples wherever possible.						

* Rarely ≤ 30%, Inconsistently > 30–60%, Generally > 60–80%, * Sometimes Exceeds > 80–90%, Consistently Exceeds > 90%

Final In-Training Evaluation Report (FITER)/Comprehensive Competency Report (CCR) Continued

FITER: (Procedures and Clinical Skills Competency)

Fellow Name:

Fellow SCFHS number:

	Meeting Expectations*					
Competencies	**Rarely**	**Inconsistently**	**Generally**	**Sometimes Exceeds**	**Consistently Exceeds**	**N/A**
Procedures and Clinical Skills						
Demonstrates the ability to perform diagnostic and therapeutic procedures/skills described in the U-PRS Specialty						
• Endoscopic Procedures						
• Open Surgical Procedures						
• Laparoscopic Procedures						
• Other Procedures						
• Clinical Skills						
Please comment on the strengths and weaknesses of the candidate and provide a rationale for your ratings. Make direct reference to the objectives and give specific examples wherever possible.						

* Rarely ≤ 30%, Inconsistently > 30–60%, Generally > 60–80%, * Sometimes Exceeds > 80–90%, Consistently Exceeds > 90%

Final In-Training Evaluation Report (FITER)/Comprehensive Competency Report (CCR) Continued

FITER: (Communicator Competency)

Fellow Name:

Fellow SCFHS number:

	Meeting Expectations*					
Competencies	**Rarely**	**Inconsistently**	**Generally**	**Sometimes Exceeds**	**Consistently Exceeds**	**N/A**
Communicator						
• Establishes a therapeutic relationship with patients and communicates well with the family. Provides clear and thorough explanations of diagnosis, investigation, and management in a professional manner. Demonstrates empathy and sensitivity to racial, gender, and cultural issues						
• Prepares documentation that is accurate and timely						
• Develops diagnostic and therapeutic plans that are understandable to patients and clear and concise for other healthcare personnel, including other consultants						

• Presents clinical summaries and scientific information in a clear and concise manner to a healthcare audience						
Please comment on the strengths and weaknesses of the candidate and provide a rationale for your ratings. Make direct reference to the objectives and give specific examples wherever possible.						

* Rarely ≤ 30%, Inconsistently > 30–60%, Generally > 60–80%, * Sometimes Exceeds > 80–90%, Consistently Exceeds > 90%

Final In-Training Evaluation Report (FITER)/Comprehensive Competency Report (CCR) Continued

FITER: (Collaborator Competency)

Fellow Name:

Fellow SCFHS number:

	Meeting Expectations*					
Competencies	**Rarely**	**Inconsistently**	**Generally**	**Sometimes Exceeds**	**Consistently Exceeds**	**N/A**
Collaborator						
• Interacts effectively with health professionals by recognizing and acknowledging their roles and expertise						
• Consults and delegates effectively						
• Establishes good relationships with peers and other health professionals						
• Effectively provides and receives information from other health professionals						
• Manages conflict situations well						
Please comment on the strengths and weaknesses of the candidate and provide a rationale for your ratings. Make direct reference to the objectives and give specific examples wherever possible.						

* Rarely ≤ 30%, Inconsistently > 30–60%, Generally > 60–80%, * Sometimes Exceeds > 80–90%, Consistently Exceeds > 90%

Final In-Training Evaluation Report (FITER)/Comprehensive Competency Report (CCR) Continued

FITER: (Leader Competency)

Fellow Name:

Fellow SCFHS number:

	Meeting Expectations*					
Competencies	**Rarely**	**Inconsistently**	**Generally**	**Sometimes Exceeds**	**Consistently Exceeds**	**N/A**
Leader						
• Understands and makes effective use of information technology, such as methods for searching medical databases						
• Makes cost-effective use of healthcare resources based on sound judgment						
• Prioritizes and uses personal and professional time effectively in order to achieve a balanced personal and professional life						
• Demonstrates an understanding of the principles of practice management						

• Demonstrates the ability to effectively utilize healthcare resources to maximize benefits to all patients, including managing waiting lists						

Please comment on the strengths and weaknesses of the candidate and provide a rationale for your ratings. Make direct reference to the objectives and give specific examples wherever possible.

* Rarely ≤ 30%, Inconsistently > 30–60%, Generally > 60–80%, * Sometimes Exceeds > 80–90%, Consistently Exceeds > 90%

Final In-Training Evaluation Report (FITER)/Comprehensive Competency Report (CCR) Continued

FITER: (Health Advocate Competency)

Fellow Name:

Fellow SCFHS number:

	Meeting Expectations*					
Competencies	**Rarely**	**Inconsistently**	**Generally**	**Sometimes Exceeds**	**Consistently Exceeds**	**N/A**
Health Advocate						
• Understands the specialist's role to intervene on behalf of patients with respect to the social, economic, and biological factors that may impact their health						
• Understands the specialist's role to intervene on behalf of the community with respect to the social, economic, and biological factors that may impact community health						
• Recognizes and responds appropriately in advocacy situations						
Please comment on the strengths and weaknesses of the candidate and provide a rationale for your ratings. Make direct reference to the objectives and give specific examples wherever possible.						

* Rarely ≤ 30%, Inconsistently > 30–60%, Generally > 60–80%, * Sometimes Exceeds > 80–90%, Consistently Exceeds > 90%

Final In-Training Evaluation Report (FITER)/Comprehensive Competency Report (CCR) Continued

FITER: (Scholar Competency)

Fellow Name:

Fellow SCFHS number:

	Meeting Expectations*					
Competencies	**Rarely**	**Inconsistently**	**Generally**	**Sometimes Exceeds**	**Consistently Exceeds**	**N/A**
Scholar						
• Demonstrates an understanding of, and a commitment to, the need for continuous learning. Develops and implements an ongoing and effective personal learning strategy						
• Critically appraises medical information by asking relevant questions and determining which information is reliable. Successfully integrates information from a variety of sources						

• Understands the principles of adult learning and helps others learn by providing guidance, teaching, and giving constructive feedback						
• Facilitates the learning of patients, other house staff/students, and other health professionals						
• Completes the electronic log book in a timely fashion						
Please comment on the strengths and weaknesses of the candidate and provide a rationale for your ratings. Make direct reference to the objectives and give specific examples wherever possible.						

* Rarely ≤ 30%, Inconsistently > 30–60%, Generally > 60–80%, * Sometimes Exceeds > 80–90%, Consistently Exceeds > 90%

Final In-Training Evaluation Report (FITER)/Comprehensive Competency Report (CCR) Continued

FITER: (Professional Competency)

Fellow Name:

Fellow SCFHS number:

	Meeting Expectations*					
Competencies	**Rarely**	**Inconsistently**	**Generally**	**Sometimes Exceeds**	**Consistently Exceeds**	**N/A**
Professional						
• Demonstrates integrity, honesty, compassion, and respect for diversity						
• Fulfills medical, legal, and professional obligations of the specialist						
• Meets deadlines and demonstrates punctuality						
• Monitors patients and provides follow-up						
• Understands the principles of ethics and applies these in clinical situations						
• Demonstrates an awareness of limitations, and seeks advice when necessary. Accepts advice graciously						

• Demonstrates respect towards other physicians and healthcare workers						
• Participates in professional organizations—local, provincial, and national						
Please comment on the strengths and weaknesses of the candidate and provide a rationale for your ratings. Make direct reference to the objectives and give specific examples wherever possible.						

* Rarely ≤ 30%, Inconsistently > 30–60%, Generally > 60–80%, * Sometimes Exceeds > 80–90%, Consistently Exceeds > 90%

FITER continued:

Mandatory Courses and Workshops:

Did the fellow finish all the mandatory courses and workshops? Yes No
If no please state the reason:

_____

_____

_____

Criteria for the required surgical skills:

Did the fellow finish all the required surgical skills? Yes No

If no please justify:

_____

_____

_____

_____

Based on the above ratings of each component skill, please provide an overall rating of and comments about the trainee's clinical performance.

_____

_____

_____

_____

_____ _____

Evaluator's Signature Date

_____ _____

Trainee's Signature Date

(FITER): Fellow Research Performance Evaluation

FORM TO EVALUATE RESEARCH PERFORMANCE

Physician's Name: _____ Date: _____

Level of Training: ☐ F1 ☐ F2 ☐ F3

Research Interest: ☐ Basic Research ☐ Health Services Research
☐ Clinical Research ☐ Educational Research
☐ Other

Type of Research: ☐ Original research ☐ Collaborative

Indicate period of research time this assessment covers: From: _____ To: _____

Briefly describe the goals and objectives of the research project(s) in which this physician is involved:

_____

_____

_____

_____

Components of Research Conduct (rating applicable)		Unsatisfactory	Marginal	Satisfactory	Good	Outstanding
Attributes	Spirit of inquiry					
	Honesty					
	Scientific integrity					
	Collaboration					
	Productivity					
	Responsiveness to criticism					
Contents	Research methodology					
	Study design and interpretation					
	Research ethics					
	Responsible use of informed consent					
	Principles of authorship/ research papers					
	Critical assessment of scientific literature					
	Interpretation of data/ biostatistics					

Indicate the strategies used to evaluate the physician's research activities: (√ applicable)

□ Observation and supervision
□ Research design
□ Grant writing
□ Participation in research conferences
□ Scientific presentations
□ Publications/peer reviewed journals
□ Other _____

General Comments: _____

_____

_____

_____

Have you reviewed this assessment with the physician? □ Yes □ No

Evaluator's Name _____

Evaluator's Title: _____

Form 9: Assessment of Faculty

UROGYNECOLOGY AND PELVIC RECONSTRUCTIVE SURGERY

ASSESSMENT OF FACULTY/TEACHING CONSULTANT

Attending Physician: Service/Rotation:

Evaluator: Month/Year:

For each of the following criteria, please rate (√) the attending physician whose rotation you have just completed.

(NO) Not Observed, (1) Marginal, (2) Satisfactory, (3) Very Good, (4) Excellent

Availability:	NO	1	2	3	4
Was usually prompt					
Adhered to rounds and consult schedu					
Kept interruptions to a minimum					
Spent enough time on rounds; was unhurried					

Comments:

_____

_____

_____

_____

_____

Teaching:	NO	1	2	3	4
Kept discussions focused on case or topic					
Asked questions in non-threatening way					
Used bedside teaching to demonstrate history-taking and physical skills					
Emphasized problem solving (thought processes leading to decisions)					
Integrated social/ethical aspects of medicine, cost containment, pain control, patient management, humane treatment of the patient					
Stimulated team members to read					

Researched and reviewed pertinent topics					
Accommodated teaching to actively incorporate all members of team					
Provided special help as needed to team members					

Comments:

_____

_____

_____

_____

_____

Professionalism and Humanistic Patient Care:	NO	1	2	3	4
Placed the patient's interests first					
Displayed a sensitive, caring, respectful attitude toward patients					
Established rapport with team members					
Showed respect for physicians in other specialties/subspecialties and healthcare professionals					
Served as a role model					
Was enthusiastic and stimulating					
Demonstrated gender sensitivity					
Recognized own limitations; was appropriately self-critical					

Comments:

_____

_____

_____

_____

_____

Fund of Knowledge/Continuing Scholarship:	NO	1	2	3	4
Demonstrated broad knowledge of medicine					
Was up-to-date					
Identified important elements in case analysis					
Used relevant medical/scientific literature in supporting clinical advice					
Discussed pertinent aspects of population and evidence-based medicine					

Recommendations:

_____

_____

_____

_____

_____

Would you recommend that this faculty member continue to serve as a faculty/teaching consultant for the training program?

□ Yes □ No

To further enhance professional development, would you recommend that this faculty member receive formal training in teaching and faculty education?

□ Yes □ No

Overall Comments:

_____

_____

_____

_____

_____

Form 10: Early Concern Note

UROGYNECOLOGY AND PELVIC RECONSTRUCTIVE SURGERY

EARLY CONCERN NOTE

Subject: Early Concern Note about Physician Performance
From: Program Director

Please complete and submit this card to me when you have any concerns about the performance and/or professional behavior of a physician colleague. This information will be used confidentially and constructively to help the physician.

Name of Physician: _____ Date: _____

My concerns about the performance and/or professional behavior of this physician are based on: (please √)

____ critical incident
____ gut reaction
____ series of "red" flags

I have discussed my concerns with the physician	____ Yes	____ No
I feel uncomfortable discussing my concerns with the physician	____ Yes	____ No
Please call me about these concerns	____ Yes	____ No

Comments:

_____

_____

_____

_____

_____

Name: _____ Phone: _____

Form 11: Program Assessment

UROGYNECOLOGY AND PELVIC RECONSTRUCTIVE SURGERY

FELLOW'S ANNUAL ASSESSMENT OF A SUBSPECIALTY TRAINING PROGRAM

	NA	1	2	3	4	5
I. TRAINING ENVIRONMENT:						
Quality and diversity of pathology seen						
Learning value of attending rounds						
Adequacy of attending supervision						
Quality of attending supervision						
Quality and timeliness of feedback from attending						
Opportunity to perform required procedures						
Opportunity to perform research						
Quality of research environment						
Interdisciplinary support a. Nursing						
b. Social work						
c. Dietary						
d. Pharmacy						
Availability of consultations a. Physiotherapy						
b. General OB						
c. Urogynecology						
d. Oncology						
e. Colorectal						
f. Female medical imaging						
Ancillary services a. Laboratory data retrieval						
b. Radiology data film retrieval						
c. Procedure report retrieval						
d. Intravenous and phlebotomy services						
e. Messenger/transport services						
f. Secretarial/clerical services						
Appropriateness of workload						
Overall quality of rotation						
Identify the core strengths and weaknesses of the program						

Core strengths:

_____

_____

_____

_____

_____

Areas needing improvement:

_____

_____

_____

_____

_____

II. TEACHING CONFERENCES: Please rate the quality of the teaching conferences listed below	**NA**	**1**	**2**	**3**	**4**	**5**
Professor's Rounds						
Chief of Service Rounds						
Grand Rounds						
Core Curriculum Lectures						
Morning Report						
Clinical Pathology Conference						
Morbidity and Mortality Conference						
Journal Club						
Subspecialty Conferences						
Research Seminars						
Radiology						
EthCOMM Seminars						

Comments:

_____

_____

III. TEACHING FACULTY:	NA	1	2	3	4	5
Availability						
Commitment to teaching						
Quality						
Promote scientific/discovery literacy						

Comments:

_____

_____

IV. ON-CALL FACILITIES:	NA	1	2	3	4	5
Room availability						
Privacy						
Safety						
Adequate housekeeping						

Comments:

_____

_____

V. OVERALL QUALITY OF TRAINING:	NA	1	2	3	4	5
Please rate the overall quality of your training program						

Comments:

_____

_____

GENERAL QUESTIONS

1. My colleagues behave in an appropriate manner.

□ Yes □ No

2. My colleagues are reliable.

□ Yes □ No

3. In time of conflict or trouble, I turn to my colleagues for support.

□ Yes □ No

4. I would have members of my class as partners in my practice.

□ Yes □ No

5. My attending physicians behave in an appropriate manner.

□ Yes □ No

6. My attending physicians are reliable.

□ Yes □ No

7. In times of conflict or trouble, I turn to my attending physicians for support.

□ Yes □ No

8. The educational atmosphere encourages excellence.

□ Yes □ No

9. The educational atmosphere recognizes excellence.

□ Yes □ No

10. I wish someone had motivated me more to expand and strengthen my knowledge base.

□ Yes □ No

Appendix 3: Logbook

The Logbook will be part of the portfolio. The purposes of the logbook are to:
1. Monitor each fellow's performance on a continual basis
2. Document and record the cases seen and managed by the fellows
3. Maintain a record of procedures and technical interventions performed
4. Enable fellows and supervisors to identify learning gaps
5. Provide a basis for feedback for the fellows

Requirements of the Logbook:
1. The items that will be kept in the case log will be reviewed periodically by the program director and the teaching staff.
2. The logbook must demonstrate that each fellow has an adequate number of U-PRS cases, as designated by the UGPSC.
3. The fellow should be able to fill in a minimum of 20–30 CME hours of courses annually
4. The fellow is required to include all office visits, hospital ambulatory care, and office procedures for each facility where they practice every 12 months in their logbook.

The following tables are examples of some of the items that each fellow's logbook should include; however, the logbooks should not be limited to this list.

PERSONAL DETAILS

Name:	
Address:	
Telephone:	

TRAINING DETAILS

Training site:	
Training year:	
Calendar year:	
Period of training covered by this Logbook:	/ /20 to / /20

1. Surgical Procedure

Laparoscopic Surgery/Abdominal Surgery/Vaginal Surgery

Date	MRN	Procedure	Indication	Assist	Supervised	Unsupervised	Teaching by fellow	Outcome complication comments

2. Ambulatory Clinic Sessions

Date	MRN	Procedure	Indication	Assist	Supervised	Unsupervised	Teaching by fellow	Outcome complication comments

3. Medical Imaging (procedures)

Date	Procedure	Procedure observed	Minutes required
3/10/2016	MRI pelvis ultrasound		20

4. Meeting presentation

Date	Venue	Topics

5. Research activity

Date	Hours	Research work

6. CME Hours Activity

Date	Hours	Name of course/workshop	Number of CMEs

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