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Dear Dr. Scheinman,

It was a pleasure talking with you last week and I appreciate your getting back to me on these matters given your busy schedule. I want to thank you for the opportunity to present the following ideas and suggestions that I believe will enhance the overall quality of the Ob/Gyn residency program at Upstate as well as the associated third year medical student rotation in the same specialty.

The basis for this presentation is from more than 11 years of practicing Ob/Gyn in this community, my knowledge of the specialty, my own personal residency training, my understanding of what it takes to successfully impart functional knowledge and my interactions with both the Ob/Gyn residency program as well as numerous medical students while on rotation through the department. It stands to reason that the mission of the University would be to put forth the highest quality education for both medical students and resident physicians alike. Nonetheless, numerous deficiencies have been directly observed within this residency along with several medical students personally having expressed their utmost dissatisfaction with the Ob/Gyn rotation. I simply want to help make things better for all involved.

I am an alumnus of this school and hold dear my experiences here. After graduation, I went on to complete my residency in metro-Detroit where there were seven different programs. What this climate created was a level of excellence that was required of the various programs in order to remain solvent. Those who were unable to maintain it fell by the wayside – which was the fate of two such programs in my four years there. Fortunately, our program was amongst the strongest with such quality in the training that it truly did not become apparent until I was years removed from graduation. At the time I left, the program boasted not having had a single graduate fail the written boards for over seven years and a level of camaraderie between residents and attendings thought to be the norm. Moreover, we enjoyed the presence of numerous medical students on rotation throughout the year from Wayne State University, many of which were inspired by their experience to enter the specialty. Therefore, it pains me to know how unpopular this department has been for the students of my alma mater and to see repeated failures of the residents pertaining to their written boards. And for those med school graduates entering Ob/Gyn, few even consider Syracuse as an option. Again, I am not trying to be chastising. I simply want to help. My specific points are made in the following document. Thank you again.

Sincerely,

James R. Caputo, M.D.

The following is a detailed description of what I have personally observed from the Ob/ Gyn residency training program here at Upstate pertaining to medical education. Every statement is meant to bring about improvement towards the objective of producing highly capable and knowledgeable physicians. There certainly exists, however, several ways outside of these specifics to achieve that end. Admittedly, I lack a complete understanding of how the residency is structured for each rotation and for each year, since I am not that intimately involved. What is submitted below is only what I have seen and can only extrapolate there to be other areas that may indeed need addressing. The predicate for all comments is that learning in residency is primarily done through doing. If you are not involved, you are not learning. This was one of the primary messages imparted to us in Michigan.

Intern Year - Gyn Rotation

The Problem: For more than a decade, I have observed a large number of residents reach their forth year of training with a marginal set of surgical skills. In some cases, senior level residents cannot confidently perform some of the most basic procedures of the specialty. This not only leaves them ill prepared for practice outside of residency, it exposes patients to undue risk as well as creating a second class of practitioners who potentially undermine the overall impression of competency within the specialty, especially amongst peers in other disciplines. The reason I believe that this has been an issue with Upstate is how the residents experience their Gynecologic surgical training. We often forget how much we do not know coming into residency. For example, I remember not truly knowing what a normal ovary looked like as an intern until I did several basic cases which then provided this knowledge. The point is that with anything complex such as becoming a pelvic surgeon, you obviously must first start out simple and graduate upwards. I have not seen this as being the case at Upstate. Too many times, interns and second year residents are assigned to high level cases whereby they are not properly prepared to participate. One cannot expect an intern to assist in a laparoscopically assisted vaginal hysterectomy when they cannot perform the most basic of maneuvers in the case. This, unfortunately, happens all too commonly with the resident often showing their frustration.

The Solution: I base much of what I offer here on my own experiences – both in Detroit and Rochester (where I was in practice for 15 months before coming to Syracuse). I would assign every intern on their Gyn rotation to the outpatient surgery center as their sole place of coverage. The impact this would have is several fold. Firstly, as a new intern, there is nothing more comforting than to feel as though you have some autonomy or even a place within the hierarchy of the program with your new role as a practicing physician. With the designation as the outpatient surgery resident, most, if not all, cases would be covered by a resident, (which is also very important to learning as well as attending physician interaction), the intern would essentially be the "chief" of that part of the service and the entire staff of this OR setting would come to know and rely on this constant.

It would be an understatement to say that Crouse's outpatient OR would often not have a clue as to who was on service or whether a resident would even be available for any of the cases there. In the ten years working out of that OR, I performed over 1300 cases – some of which were highly complex, very interesting and moreover, a great learning experience. Unfortunately, if I had a resident for 300 of them, that might be an overestimate. This is simply unbelievable for someone who came from a program where every case **had** to be covered by a resident. How else are they to learn? By the end of their intern year, they would have personally performed hundreds of the most basic (yet necessary) surgical procedures that would serve as a substantial foundation for what was to come in the latter years of training. Currently, they are not getting this experience and frankly, it shows.

Third year rotation on MFM (high risk obstetrics)

The Problem: Currently, residents are assigned to do their MFM rotation in their third year of training at Upstate. This may not seem like a big issue to most until you understand the various roles residents play as they advance through their years. In the first year, they get a considerable amount of exposure to Obstetrics such that by the end of the year, they are pretty well versed in the basics as well as some higher risk applications. Yet, by the time they get to third year, they have had even more of this Obstetrical experience but now they must function as a senior resident. Senior residents are essentially those in the third and fourth years of training. Senior, because they must take on a supervisory role over their more junior counterparts, especially when on-call duties are at hand. The problem here is that while they are expected to function as a senior resident, many of them do not get the requisite training and exposure to the high risk portion of Obstetrics until the year is almost over. It is illogical to expect someone to serve with a level of expected knowledge before they have learned it. Yet, this is the case and simply should be changed.

The Solution: It is customary at every other program I have had exposure to have the residents complete their MFM rotation while in their second year of residency. They have had more than enough Ob and are more than capable to advance to this level of training with the volume of Obstetrics received in their intern year and rest of their second year. Thus, by the time they enter their third year, they can legitimately function as that senior resident without any underlying deficiency of knowledge. Surely, this acumen might also play a significant role in reducing any medical-legal risk already inherent in the specialty.

Role of Residents on Labor and Delivery

The Problem: Currently, the role of the residents while on assignment in Labor and Delivery has been one of the biggest deficiencies I have seen over the past eleven years. In both of my previous hospital experiences, (residency and first year out in Rochester), the role of the L and D residents has been the same. In both cases, the residents are encouraged to "take ownership" of the unit. What this means is that the output or product of this unit is solely a reflection of how solid and competent the residents are that "run" it. What I have witnessed is that the residents are seldom around, often do not know the fullness of patient information and up-to-date status that should be required of them, rarely engage the individual patients, often blow off deliveries, lack a fundamental knowledge of the labor process and exhibit on many occasions a bedside manner that lacks the empathy and understanding that should be synonymous with the specialty. Moreover, being that the residents basically serve as glorified technicians rather than Obstetricians with a thinking brain and fund of knowledge necessary to fully understand what is going on with many clinical circumstances, the liability this creates is staggering with numerous bad outcomes having already been witnessed as (what I believe to be) a result. I have seen care rendered and bad outcomes that could never have existed within the framework of my program in Detroit.

The Solution: This is not a simple fix. What it is going to take is a faculty member to literally demonstrate the right way of running and overseeing that unit by example. If this were to be done, not only would the residents clearly understand the difference, it would translate into a safer, more effective and academically superior institution. There are certain standards that cannot be compromised in the Labor and Delivery setting. Yet, unless this particular issue is even recognized, it cannot be addressed. Additionally, it should be mandatory that every single delivery be covered by a resident, when possible. This has been the policy everywhere else I have been and champions the whole point of learning by doing (and seeing). It cannot be calculated how much I have personally learned by just being there.

Written History and Physical on Surgical Cases:

The Problem: This might on the surface seem like a trivial matter, however, the ramifications of the residents not being required to write a basic history and physical in the chart for the cases in which they scrub are profound. Too many times I would have a case already started in the OR before the resident strolls in expecting to now first assist. They would not have bothered to even meet the patient or look at the chart to see why she was there. For this to be the relative norm at this program is a shame and indeed hard to believe. In my experience, if I had come into the OR under such circumstances, I would have been asked to leave the room without having any participation in the case. How else is a doctor in training going to learn how to piece together the clinical work-up, the diagnosis and the treatment that is so integral to their own understanding of the disease process? And aside from the obvious, it is just sound medicine and practice for a University residency program.

The Solution: Again, from my own experience and from what I have always seen as the standard, (even in medical school), in order for a resident to be given the privilege to scrub on a private attending case, they had to first meet the patient and then write a short H and P in the chart. While there may be this duplicity with documentation, what this does is gets the resident engaging the patient, taking a pointed history (since she is already waiting to go to surgery) and moreover, piecing together the steps necessary to arrive at the primary diagnosis and treatment. It also then allows the resident to better engage the attending so that they can continue to learn from the case were any questions to arise from their own write-up. This would not be set forth so as to challenge the attending or to make them feel defensive about how they manage their cases. It does however enable the resident to discern various cases as being soundly worked-up as opposed to those that might not be. This is just as important to their understanding.

Lack of any significant Gyn Pathology education

The Problem: Perhaps the most important avenue in learning about the various disease states within any specialty is to understand it on a pathophysiologic level. Without this knowledge, the resident and eventual attending physician maintains a very superficial understanding of how and why the patient is experiencing the problem. They end up relying too much on brush stroke therapies without truly comprehending the actual disease state on a histological level. While it is apparently the case that the residents at Upstate do have a formal pathology "conference" on a fairly regular basis, (once or twice a month) it is simply too cursory an exposure to gain any workable or persistent knowledge. This lack of pathophysiologic understanding is very apparent amongst the residents at Upstate. It was also apparent for all residents at my program as well until they went through their formal rotation in Pathology.

The Solution: Collaborate with the Pathology Department to formally create at least a month long rotation within their specialty during the third year. During this month, the resident would be trained to function as a junior Gyn Pathologist. They would learn how to process the gross specimens as they came in from the OR. They would learn which representative sections are submitted, why they are submitted and how they are processed for microscopic exam. Each day would be a combination of preparing the gross specimens for the day followed by reviewing the micro from the previous day. The level and depth of knowledge gained by being proficient here is immeasurable. This was the single most important rotation of my residency. For instance, just to know how and why a cervical cone biopsy was processed and what the varying degrees of dysplasia looked like under the microscope had a profound affect on my understanding of cervical disease. This is merely one example of the dozens of disease states that were proficiently learned on this level.

Gyn Oncology Rotation

The Problem: The residency is fortunate to have four competent Gyn Oncologists in this community from who they can learn. The problem here is not as momentous as some others but bears mentioning since this too can be improved upon. Currently, residents rotate through this subspecialty in their third year. Given the utmost intensity of this level of Gynecologic medicine and surgery, it is again illogical to expect a third year resident to fully benefit from this rotation. It is clear that the knowledge base of all Ob/Gyn residents is unbalanced as they progress through their four years. They get so much Ob so early that their comprehension here far outweighs that of Gynecology. The latter is a slower process of understanding that requires time and experience in order to fully grasp this arm of the specialty. I personally remember it taking much longer to feel comfortable with my knowledge base in Gyn compared to that of Ob. The pathology rotation (as stated above) was instrumental in leveling this playing field – so to speak. And with both Gynecologic didactic and surgical proficiency being not only critical to the rotation in Gyn Onc, it is simply not most beneficial to the residents, patients or attending physician for a third year resident to assume this responsibility. While they have been doing it this way for years it does not make it fundamentally correct.

The Solution: Simply switch this rotation to the fourth year of residency. But further, given the fact that it would take place during the chief year, the rotation should be for a single block of time equal to one fifth of the academic year since there are five residents. By moving it to fourth year as well as this latter point, the resident would be properly prepared for the most difficult and intense rotation of their entire residency. Their surgical skills will be much more advanced as well as their cognitive ability to grasp the complexity of Gynecologic Oncology. And with a single block of time, this continuity of care would only add to their learning since such follow-up is just not experienced once a patient is discharged from the numerous other Gyn cases they are part of. I have never seen a Gyn Oncology rotation outside of the Chief year.

Supervision in the resident continuity clinic

The Problem: I personally do not have any idea as to who staffs the resident outpatient clinic and how it is structured as far as case by case presentation. However, I bring this up since this aspect of the residents' training has got to be connected to perhaps one of the most troubling observations I have made to date. In the more than eleven years in this community, I had never had the chance to attend the weekly grand rounds or the subsequent resident case presentations that followed due to a busy surgical schedule on that same day of Friday. For the past year, though, I have been a regular at both. There have been some excellent grand rounds and the case presentations (known as Stats) are also a great format for learning – so long as the correct information and depth of explanation is imparted. What I have witnessed in both the resident fund of knowledge and ability to properly present a case is disconcerting. The thing is that they really don't understand to what degree they are lacking here since this is all they know. There is no formal structure as to how they present a patient, which is basic to any medical case presentation. Their level of understanding of the pathophysiologic basis of disease is critically lacking. There is no encouragement to formulate a differential diagnosis for any of the cases presented which, again, is fundamental to accurately caring for any patient by being able to properly discern one disease entity from another – which could drastically alter the treatment course of action. Further, because of these deficiencies, they are not always capable of recognizing when a case that has been presented is in itself deficient in management. This is why these conferences are held in the first place so that both good and not so good care can be identified and learned from.

The Solution: The only way I can see this changing on a residency scale is to address the problem on a one to one basis in their continuity clinics. With each patient seen, they would be expected to not only present the case properly but to formulate a differential diagnosis in order to show their breadth of knowledge and their ability to properly arrive at a true diagnosis. This would be so beneficial for them since they would then be applying this depth of understanding to their own patients which fosters deeper learning and the ability to retain it. The difference would be immediately seen with how they then approach those cases during the weekly stats hour. It would enable the residents to engage more since they are more learned overall. Lack of understanding contributes to resident silence. This is human nature. But when someone is knowledgeable in something, it empowers them to further speak up and have a say. It goes without saying how much this would impact their overall ability as a physician.

Lack of a Resident High Risk Obstetrics Clinic

The Problem: I became aware of the fact that the residents do not have a formal high risk Ob clinic for their own patients when they are designated as such. I thought this was a requirement of any residency since it provides the most direct avenue for residents to learn how to manage these patients. While many general Ob/Gyn physicians choose not to enter the realm of High Risk Ob, it still is a mandatory aspect of training since many will. Without such a set up for the residents to directly manage and learn from these cases, many simply cannot gain the necessary knowledge in order to incorporate higher risk cases into their own practices. They may have a desire but lack the ability due to lack of experience. And with the medical legal climate as it is, they simply abandon this aspect of their practice despite their fundamental right to otherwise do so. Perhaps one of the most definitive examples of this can be illustrated by numerous residents in the past telling me that they had no clue on how to manage a twin pregnancy. They never were able to fully manage such a pregnancy from conception to delivery. Whenever such a case came up within the residency, they were shipped out to the Perinatal Center and thus lost from any resident oversight. A large part of what an Obstetrician is supposed to know has been cut out of their training by no fault of their own and without them actually realizing the impact on their future practice.

The Solution: The solution is simple. As part of the Chief year assignments, one of the blocks would be for a clinic chief. This resident would oversee all aspects of the resident clinic for a fifth of the year. They would be the junior attending for all High Risk Ob cases as well as all Gyn surgical cases that emanate from within the resident continuity clinic. Were any patient to be designated as high risk, they would then be referred to a separate weekly clinic session devoted solely to these patients. We are fortunate to have a well-rounded and competent Perinatology Group in town that would then staff this weekly clinic and oversee the high risk management of these cases by the Chief and other junior residents on service. Their rotation on MFM in their second year would merely serve as a foundation for the management of these cases in their chief year. Managing their own patients is the only way they could fully obtain the working knowledge for handling these cases after graduation. Watching is one thing. Doing is another.

In summary, this is just a list of the most critical areas of concern that I have observed within the department. There are, of course, many ways in which to broaden the understanding and knowledge of the residents prior to graduation. It is hoped that the trueness of what was presented here can be seen as a definitive means to improve the program as a whole. I would like nothing more than to see this residency reach its full potential as one of the best in the land. The substrate for realizing this goal is already here. It just needs to be nurtured. Thank you for your attention and consideration. –James R. Caputo, M.D.