

HIGHLIGHTS FROM
**THE 2017 SOCIETY OF
GYNECOLOGIC SURGEONS
SCIENTIFIC MEETING**

PART 1

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Society of Gynecologic Surgeons meeting presenters offer the ObGyn community surgical, practical, and life lessons

SGS meeting faculty offer features on mentor-mentee relationships, urologic injury management during gynecologic surgery, and accomplishments from the FPRN

Robert E. Gutman, MD

Welcome to Part 1 of 2 special sections of OBG MANAGEMENT, which highlights recent events from the Society of Gynecologic Surgeons (SGS) 2017 annual scientific meeting in San Antonio, Texas. The meeting's theme, "Mentorship in Surgery, Education, and Research," is extremely important for all medical professionals. We all can recall several people who were instrumental in our own personal development and career pathway, and many of us currently serve as mentors.

This month, SGS meeting keynote speaker Janet Bickel, MA, a leadership and career development coach and an expert on the topic of mentorship, shares insightful tips and recommendations for both mentors and mentees. Next month, part 2 of this special section will feature an article by Dr. Denise Elser on how to become actively involved in ObGyn mentorship. Dr. Elser's leadership role with the SGS and the American College of Obstetricians and Gynecologists mentorship programs helped make the SGS meeting's first-time "Mentorship Mingle" event a success. These authors offer valuable suggestions that reinforce current techniques, help you refine mentorship skills, and aid in overcoming obstacles to becoming a mentor.

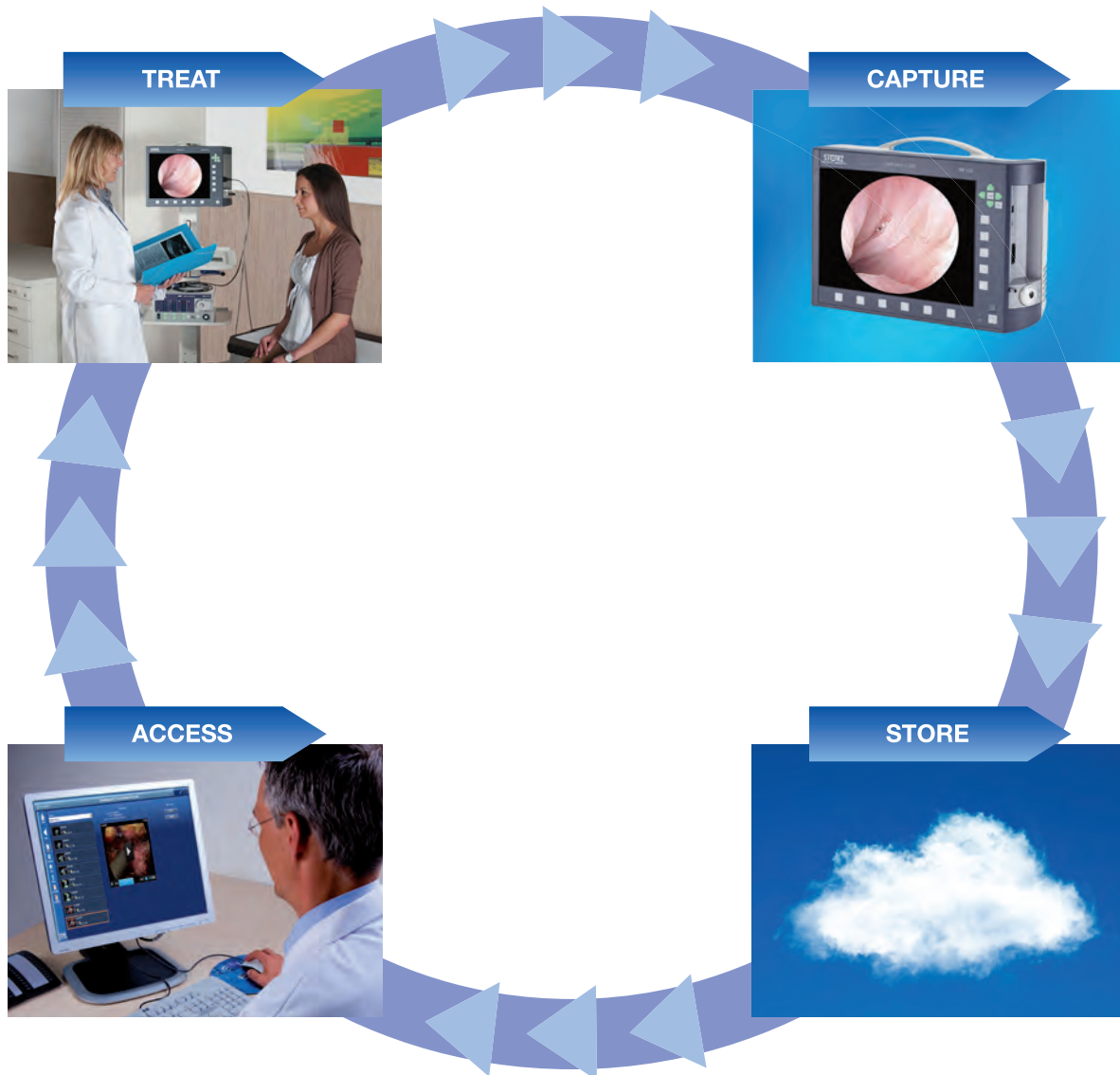
The meeting began with 4 diverse post-graduate workshops: a cadaver course, 3D pelvic

anatomy, iTeach for Gyn residents/fellows, and enhanced recovery after surgery. Drs. Elizabeth Mueller and Andrew Sokol ran the hands-on cadaver course, teaching laparoscopic suturing and management of bladder and ureteral injuries. In her article in this section, Dr. Mueller, the FPMRS division director at Loyola University, uses a case-based approach to summarize her expert opinion regarding minimally invasive techniques to detect and manage bladder and ureteral injuries at the time of gynecologic surgery.

Dr. Dee Fenner moderated an excellent debate about whether the specialty of obstetrics and gynecology should separate the "O" from the "G." The expertise and leadership of Drs. Kimberly Kenton and Geoffrey Cundiff in the field of ObGyn and female pelvic medicine and reconstructive surgery were evident as they provided compelling arguments for each side. Their thoughtful, balanced approach is relevant to all ObGyn providers and reinforces the potential benefit of increased tracking to achieve competency-based medical education in the specialty and subspecialty training of future ObGyns. They offer their perspectives in articles that will be featured next month.

Lastly, Drs. Kristin Jacobs and Lior Lowenstein highlight the 10-year anniversary of the Fellows Pelvic Research Network (FPRN). This network is the direct result of years of research mentorship by junior and senior advisory board members supported by SGS. ■

The author reports no financial relationships relevant to this article.



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HOW TO REPAIR UROLOGIC INJURY AT THE TIME OF GYNECOLOGIC SURGERY

Urologic injury is a known complication of all gynecologic procedures. By identifying the injury intraoperatively, we can reduce postoperative complications and long-term sequelae.

Elizabeth R. Mueller, MD, MSME

Gynecologic surgeons have pioneered the use of minimally invasive surgical approaches to treat diseases in women. Since Dr. Harry Reich of Kingston, Pennsylvania, introduced laparoscopic hysterectomy in 1988, procedural refinements and technologic advancements have led to widespread use of this technique.¹ In the United States, use of laparoscopic

approaches to hysterectomy increased from 0.3% in 1990 to 11.8% in 2003, with a resultant decline in both abdominal and vaginal approaches to hysterectomy.² Patients who undergo laparoscopic hysterectomy have shorter hospitalizations, fewer infections, less blood loss, and return to work more quickly than women who undergo an abdominal approach. Laparoscopic approaches are, however, associated with higher risks of bladder and ureteral injury.

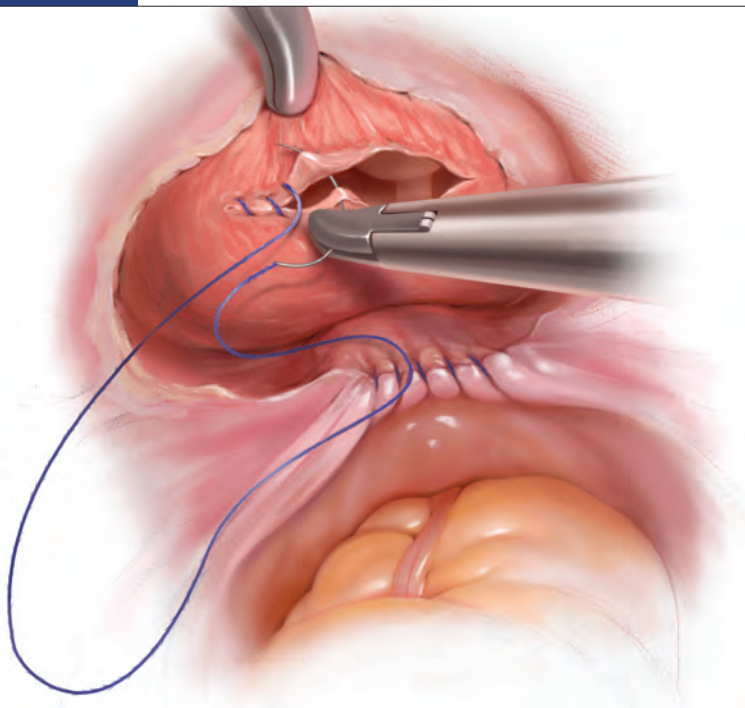
In this article, I briefly review the literature, describe 2 cases involving lower urinary tract injury during laparoscopic surgery, and discuss treatment options when injury is detected.

CASE 1 Cystotomy observed in the bladder wall after laparoscopic hysterectomy for prolapse

A 62-year-old woman with stage III pelvic organ prolapse consented to a laparoscopic hysterectomy, sacrocolpopexy, and a prophylactic midurethral sling. She had no history of abdominal surgery. The total laparoscopic hysterectomy proceeded without incident. The bladder flap was dissected down an additional 3 to 4 cm to accommodate the presence of the anterior mesh arm during sacrocolpopexy. The total vaginal hysterectomy was completed, the uterus was removed through the vaginal cuff, and the cuff was closed.

The surgeon performed a cystoscopy and observed that both ureters effluxed clear urine. However, he noted a 1.25-cm cystotomy in the midline posterior bladder wall about 2 cm behind the bladder trigone.

What approach would you take for repair? Consider these questions:



Double-layered closure of a cystotomy using absorbable barbed suture, with care taken to incorporate the lateral edges of the incision.

The author reports that she is an investigator for and is on the advisory board of Astellas Medical and Scientific Affairs.

ILLUSTRATION: KIMBERLY MARTENS FOR OBG MANAGEMENT

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- When and how should the bladder cystotomy be closed?
 - Should you complete the sacrocolpopexy?
 - For how long should a Foley catheter be placed?
 - Would you proceed with a midurethral sling?

Cystotomy: A known complication of gynecologic surgery

All these questions are legitimate and, of course, there are no randomized trials that can guide our clinical care. I will therefore discuss surgical principles, acknowledging that the following discussion is based on expert opinion. Ultimately, the treating surgeon's choices are based on his or her experience and clinical judgment at the time of the procedure.

Signs of a cystotomy during surgery may include an air-filled Foley drainage bag or blood-tinged urine in the Foley bag.

Cystotomies are a known complication of gynecologic procedures that involve mobilizing the bladder flap off the uterus, cervix, and vagina. Adelman performed a systematic review of English language studies over a 10-year period that enrolled more than 100 women.³ The highest rates of injuries were to the bladder, ranging from 0.05% to 0.66%. Total laparoscopic hysterectomy had the highest injury rate, and supracervical hysterectomy the lowest. The majority of cystotomies (80.6%) were recognized intraoperatively, whereas 7.5% were recognized postoperatively. The conversion rate to laparotomy to repair bladder injuries was 11%.

Signs of a cystotomy during surgery may include an air-filled Foley catheter drainage bag that is usually identified by the anesthesia team as the result of the abdominal insufflation passing through the cystotomy to the bag, which is at atmospheric pressure. Other signs are blood-tinged urine in the Foley bag and difficulty visualizing the bladder walls when cystoscopy is performed. Blood clots in the bladder should be irrigated gently and removed. A clot at the base of the bladder may occlude the bladder defect and prevent fluid loss from the bladder.

Closing a bladder cystotomy

Once a cystotomy is identified by cystoscopy, the treating surgeon can visualize it intra-abdominally by elevating the posterior bladder wall and looking for the fluid leak, aided by the light from the cystoscope. Visualization of the bladder edge is facilitated when the bladder is full. For this reason, placing a 3-way Foley catheter (at least 22F) that is connected to a 5-L fluid source and clamping the output channel can aid in laparoscopic closure of the cystotomy.

Closure of the cystotomy can be performed using an absorbable barbed suture on both layers, eliminating knot tying. The first layer is closed with care taken to incorporate the lateral edges of the incision, where a small piece of bladder mucosa may be inadvertently puckered outside of the suture line. Angling the sutures at 45° at the lateral edges can prevent this complication. Take care to ensure that each bite is through bladder mucosa.

Typically, a larger bite of mucosa and a smaller bite of the bladder muscularis are sufficient for the first layer. Once the first layer is closed, the bladder should be sufficiently emptied to allow for placement of the second row of sutures tension-free. The purpose of the second layer is to imbricate the first layer completely. Therefore, the starting and ending edges of the second layer must be lateral to the first layer. The second suture line should include the bladder serosa and the bladder muscularis. The sutures do not penetrate the bladder lumen. Once 2 layers are closed, inspect the suture line with the bladder full. A repeat cystoscopy is not necessary unless there is a concern for a bladder clot. Gentle irrigation of a clot will dislodge it.

Completing the sacrocolpopexy

Whether or not to proceed with the sacrocolpopexy is a decision the operating surgeon makes. Our team usually proceeds with mesh placement. Because it is essential that the cystotomy suture line be tension-free, prior to starting the cystotomy repair we place a Lucite stent in the vagina to aid dissection and mobilize the bladder, making certain that the cystotomy is 2 to 3 cm proximal to the distal edge of the dissection. This is important because tensioning of the sacrocolpopexy mesh could inadvertently place tension on the cystotomy repair. A third layer of closure may be indicated if an omental or peritoneal flap cannot be placed

between the bladder closure and the anterior vaginal wall mesh.

How long to leave in the Foley catheter

A Foley catheter is typically left in place for 1 to 2 weeks. Keeping the bladder nondistended minimizes the likelihood that the posterior bladder wall will drape over the mesh. We typically do not perform a cystogram on removal of the Foley catheter, although other authors have advocated this.

Midurethral sling placement, or not

Surgeon preference dictates whether or not to proceed with a midurethral sling. In our case scenario, the sling is being placed to prevent potential stress incontinence. My practice is not to place a sling whenever there is a cystotomy at the posterior bladder wall or bladder dome. Once the catheter is removed, the bladder wall may be subjected to increased pressure due to increased urethral resistance if a sling has been placed. In some cases, higher than normal bladder pressures or frank obstruction may increase the risk that the cystotomy repair will break down. Given the low morbidity associated with performing the sling procedure at a later date, I would defer sling placement until 2 to 3 months following the cystotomy repair.

CASE 1 Resolved: Cystotomy repaired after laparoscopic hysterectomy

The patient did well after cystotomy repair. The Foley catheter was removed 10 days after surgery, and the patient passed her voiding trial. She had a midurethral sling placed 6 weeks after her original surgery for stress incontinence symptoms.

CASE 2 Ureter injured during laparoscopic hysterectomy for fibroids

A 61-year-old woman underwent a laparoscopic hysterectomy (850-g uterus) and bilateral salpingo-oophorectomy for symptomatic uterine fibroids. At the end of the procedure, a cystoscopy revealed that the left ureter was not effluxing urine. Pelvic inspection revealed that the ureter was dilated and incorporated in the pedicle that contains the ovarian artery.

Consider these questions when planning the repair:

- What should be your next steps?
- Should the ureter be reimplemented?

- What postoperative care will be required for a woman who presents with a ureterovaginal fistula?

Most ureteral injuries are found postoperatively

Ureteral injuries are described in the gynecologic literature but often without the level of detail that would allow for careful analysis. In a review of the English language world literature reporting ureteral injury during laparoscopic surgery, Ostrzenski and colleagues reported that only 8.6% of ureteral injuries were found intraoperatively, whereas 70% were found postoperatively.⁴ More than 50% of the injuries were not described by location or instruments used at the time of the injury. Of the cases that were described, transection was most common, and the majority of the injuries occurred at the pelvic brim. Electrocautery was involved in 24% of cases, but this allows little perspective given that 48% of the time, the instrument used was not identified. A laparotomy was used to repair the ureteral injury in 61% of cases.

Steps in repairing the ureter

The first step in the surgical repair is to dissect out the ureter. If the pedicle was made from a thermal source, judicious use of small laparoscopic vascular clips helps to manage bleeding, and further thermal injuries are kept to a minimum until the anatomy is clearly identified. Dissection of the ureter below the pelvic brim on the left side is challenging because of the attachment of the descending and sigmoid colon to the left pelvic sidewall. Make a superficial incision in the posterior peritoneum medial to the ureter to protect the lateral blood supply.

Of ureteral injury cases described in the literature, transection was the most common, and the majority occurred at the pelvic brim.

In a pure laparoscopic case, passing a retrograde ureteral catheter over a guidewire may help locate the site of obstruction. This typically is done without the use of fluoroscopic guidance due to limitations on the operative table. During robot-assisted surgery, newer da Vinci Surgical

Agents used to improve detection of the ureteral jets during cystoscopy

- Dextrose 10% solution as cystoscopy fluid. The fluid viscosity difference makes ureteral jets easier to detect.
- Indigotindisulfonate sodium (Indigo Carmine) 0.8% solution, 5 mL ampule given IV 10 minutes prior to cystoscopy. Has a half-life of 5 minutes and is currently unavailable in the United States.
- Indocyanine green (ICG; IC-Green) 25 mg/10 mL (off-label use) given IV 2–3 minutes prior to cystoscopy.¹
- Phenazopyridine (Pyridium) 200 mg orally with a sip of water in preoperative holding area.

Reference

1. Doyle PJ, Lipetskaia L, Duecy E, Buchsbaum G, Wood RW. Sodium fluorescein use during intraoperative cystoscopy. *Obstet Gynecol.* 2015;125(3):548–550.
-

System robots have a near-infrared (NIR) fluorescence imaging system that can be turned on with a simple foot pedal. Indocyanine green, or ICG (25 mg sterile IC-Green [Akorn, Inc] in 10 mL of distilled water), is injected retrograde through the ureter using a cone-tipped catheter. The ICG binds reversibly to proteins on the urothelial lining.⁵ With the NIR fluorescence imaging system, the ureter outline can be seen clearly as a bright green image; this helps identify the site of obstruction or ureteral transection.

If the ureter is partially transected, place a ureteral stent over a guidewire and place interrupted sutures through both ends of the defect and then cover with omentum. Take care to understand if the partial transection was made by cautery. If that is the case, transect the ureter completely and dissect free the 2 ends. Remove and then spatulate a portion of the ureter on each end, and take care to place the suture knots on the outside of the ureter.

Mucosa-to-mucosa coaptation of both ends of the ureter is critical to healing without a stenosis or fistula. Interrupted absorbable sutures should be placed on the lateral side of the ureter first, and then a stent over a wire is placed across the anastomosis. This is best done from the bladder with assistance from the laparoscopic surgeon. Once the first layer is completed, several interrupted sutures

on the serosa of the ureteral ends will relieve some of the tension on the primary anastomosis.

A Foley catheter is left in place to ensure that any fluid entering the bladder from either kidney does not reflux up the stent on the affected side. While some experts advocate the use of a drain, it is not always necessary. If a drain is placed, it should be placed away from the anastomosis. The catheter is left in place for 2 weeks and removed in the office. The stent is removed in the operating room, and a retrograde pyelogram is taken to ensure that the ureter is patent and has healed without a stricture or anastomotic leak. A Lasix renal scan or ultrasound should be performed 6 weeks after stent removal to evaluate the kidneys and ureter.

Reimplanting the ureter into the bladder

The operating surgeon decides to proceed with a ureteral reimplant based on the degree of ureteral injury and the blood supply to the ureter. If the case is converted to a laparotomy, it is my practice to proceed with a ureteral reimplant, which typically has a higher success rate due to the excellent blood supply from the bladder.

Postoperative care for a woman with a ureterovaginal fistula

Patients with a delayed or unrecognized ureteral injury present with various symptoms, including vaginal drainage, fevers, flank pain, rising creatinine level, a fluid wave on physical examination, or peritonitis. The office examination includes a physical exam, laboratory testing, and a tampon dye test. Recommended imaging studies include renal ultrasound with radiography comment on ureteral jets and computed tomography urogram if creatinine levels are normal.

A trip to the operating room can aid in diagnosis and treatment. If a ureterovaginal fistula is found, we attempt to place a ureteral stent in retrograde fashion. If the stent cannot be placed due to technical difficulties, the radiology department often can place a stent antegrade through percutaneous nephrostomy access. If a stent can be internalized, a Foley catheter should be placed for 2 weeks to decrease the amount of urine that will pass across the fistula site by the refluxing ureteral stent.

Typically, if the patient presents with a ureterovaginal fistula, the vaginal drainage will

CONTINUED ON PAGE SS14

Hard work and talent are not enough: Mentoring and finding mentors across career stages

The recommendations presented here can boost your skills as both a mentor and a mentee

Janet Bickel, MA



Speed of change and complexities of competition mean both more opportunities to grow and more ways for careers to derail. Many skills not covered during medical school or postgraduate training have become crucial, such that hard work and talent are not enough to ensure career success or satisfaction.

Young professionals therefore largely rely on more experienced people in the specialty for help in acquiring and honing skills (including negotiation, project management, delegation, and interpretation of organizational politics) and in identifying a career direction that fits their strengths, values, and preferences. This knowledge traditionally is passed person to person through mentoring. The term has many connotations, but here *mentoring* might best be thought of as a scaffold for sharing expertise in the service of lifelong learning—expertise otherwise attainable only by direct experience. Mentoring is the most tangible bridge to continuing excellence in the practice of obstetrics and gynecology, especially in academic settings.

In this article, I present several recommendations for becoming a better mentor and identifying and mining the experience of mentors and learning partners. Health care providers and scientists committed to lifelong learning will find themselves in both camps for most of their professional lives.

Recommendations for mentors

These observations are intended to help mentors maximize their impact in the limited time they have for mentoring. What often distinguishes influential from less influential mentors is the ability to see beyond their experience. Rather than

Key takeaways

- Mentoring is the most tangible bridge to continuing excellence in the practice of obstetrics and gynecology, especially in academic settings.
- Rather than overrelying on their version of “reality,” skilled mentors offer learner-centered mentoring, recognizing that there are many ways to build a career.
- Individuals having difficulty identifying good mentors or role models at their institution should cast a broader net and become more active in their professional societies.

The author reports no financial relationships relevant to this article.

overrelying on their version of “reality,” skilled mentors offer learner-centered mentoring, recognizing there are many ways to build a career.

Other core practices include preparing for the first meeting, discussing expectations for the relationship, creating safety, and actively bridging differences.

Prepare for the first meeting

In advance, mentors should consider sending mentees a set of questions. Reflecting on the answers for just a few minutes helps mentors orient themselves to their mentees’ unique needs. Example questions include:

- Which of your accomplishments are you proud of?
- What are your greatest strengths and shortcomings in realizing your professional potential?
- Where do you see yourself in 5 to 10 years? What are the biggest questions you have about realizing your long-term goals?
- What skill and knowledge areas do you want to focus on during our time together?

Discuss expectations for the relationship

Mentors should invite mentees to articulate what they want out of their relationship. For mentees who struggle with the question, mentors can suggest these foci:

- career options assessment, including analysis of relevant trends
- competency building in project management, professional networking, management of tensions between personal life and work, and development of organizational savvy
- strategies for succeeding in new or upcoming roles and responsibilities
- participation in scholarly projects, such as identifying collaborators and determining author order on papers.

Create safety

At first, younger professionals may be unsure of themselves, or may avoid asking sensitive questions.¹ Mentors can help them open up by creating a safe exploratory space—by assuring and ensuring confidentiality and inviting any and all types of questions. Toward that end, it might be appropriate for mentors to disclose a difficulty or

uncertainty they themselves experienced, so mentees could relate.

Actively bridge differences

Forming relationships is easiest for people who have much in common. Bridging differences such as gender and ethnicity requires more work, including demonstrating a sensitivity to often unconscious assumptions. Most cultures allow women and some minorities a narrower range of assertive behavior. For example, a man who engages in such behavior is often said to be confident, analytic, good at details, open, and passionate, whereas a woman doing the same thing is described as conceited, cold, picky, unsure, and controlling. Mentors constricted by any stereotype cannot accurately assess potential or effectively nurture superior performance.²

In order to foster mentees’ work toward their personal goals and strengthen their sense of self-responsibility for development, mentors should try to discern what combination of support and challenge would be most beneficial. Does a mentee need more of a challenge, or less? Does he need more support, or less? The many questions that can be used to prompt dialogue along these lines include:

- What is your definition of success here?
- Tell me more about your understanding of this dilemma, and your options.
- How will you develop the necessary expertise?
- What is your plan for ensuring that you ____? And what is your plan B?
- How will you evaluate your progress?
- Let us agree on the desired outcome, and then we will discuss methods.
- Where are you being too hard, or too easy, on yourself?

At the end of an interaction, mentors should ask mentees to describe, in their own words, the takeaways of the discussion and any agreements reached. In addition, mentors and mentees should decide when to meet again. Two good closing questions are:

- What should I have asked you about, or encouraged you to do, that I did not?
- Is there another way our time together could have been more beneficial for you?

A productive relationship should be satisfying for both mentors and mentees. If after a few interactions the relationship seems a poor fit,

mentors should discuss their observations with mentees, invite the mentees' observations and, if appropriate, refer them to other mentors or advisors. Mentees who take the mentoring relationship for granted and underestimate the time and patience involved should be encouraged to become mentors themselves.

No matter their seniority level, dedicated professionals can improve their mentoring practices and outcomes. The ability to provide more learner-centered mentoring, which depends on an openness to differences, begins with an altruistic spirit of nurturing the next generation. Great mentors not only shape upcoming practitioners and leaders in their field but also expand their own legacy of positive influence in their own careers, likely becoming happier in the process. Vaillant's highly regarded longitudinal studies of adult development found a phase of career consolidation followed by a generativity phase, in which individuals guide the next generation unselfishly yet enjoy new levels of work- and nonwork-related meaning for themselves.³ Mastering the tasks of the generative phase triples the likelihood that professionals will experience "vital elderhood"—joy and health in their 70s and beyond.

Recommendations for mentees

Even highly motivated young professionals sometimes fail to seek and secure mentoring. The work culture may be noncollegial or unwelcoming, good role models may be in short supply, and previous negative experience with authority figures may be self-limiting. Another barrier is the idea of needing the "perfect mentor." Setting too many specific requirements for a mentor can close off opportunities. For example, a woman who assumes she will feel comfortable talking only with another woman will eliminate many potentially helpful male mentors.

Explore available programs

Whereas some professionals are born with "mentor receptors"—they easily attract excellent mentors and put their help to good use—most must work at it. Fortunately, more residencies and medical centers now offer their trainees and faculty the assistance of mentoring programs. Individuals having difficulty identifying good

Recommended leadership resources

These resources can benefit professionals who augment the assistance of mentors.

Negotiating

- Reardon KK. *The skilled negotiator: mastering the language of engagement*. San Francisco, CA: Jossey-Bass; 2004.
- Shell GR. *Bargaining for advantage: negotiation strategies for reasonable people*. New York, NY: Viking; 1999.
- Babcock L, Laschever S. *Ask for it: how women can use the power of negotiation to get what they really want*. New York, NY: Bantam Dell; 2008.

Time management

- Allen D. *Ready for anything: 52 productivity principles for work and life*. New York, NY: Viking; 2003.

Work-life integration

- Whyte D. *Three marriages: reimagining work, self and relationship*. New York, NY: Riverhead Books; 2009.

Career mobility

- Goldsmith M, Reiter M. *Mojo: how to get it, how to keep it, how to get it back if you lose it*. New York, NY: Hyperion; 2009.
- Ibarra H. *Working identity: unconventional strategies for reinventing your career*. Boston, MA: Harvard Business School Press; 2003.

Acquiring and learning from feedback

- Stone D, Heen S. *Thanks for the feedback: the science and art of receiving feedback well (even when it is off base, unfair, poorly delivered, and frankly, you're not in the mood)*. New York, NY: Viking; 2014.
- Goldsmith M, Reiter M. *What got you here won't get you there*. New York, NY: MJF Books; 2014.

Managing "up"

- Dankoski ME, Bickel J, Gusic ME. Discussing the undiscussable with the powerful: why and how faculty must learn to counteract organizational silence. *Acad Med*. 2014;89(12):1610–1613.
- www.janetbickel.com

Relational communication

- Schein EH. *Humble inquiry: the gentle art of asking instead of telling*. San Francisco, CA: Berrett-Koehler; 2013.
- Stone D, Patton B, Heen S. *Difficult conversations: how to discuss what matters most*. New York, NY: Viking; 1999.

mentors or role models at their institution should cast a broader net and become more active in their professional societies.

Approach your selected mentors

Mentees approaching a prospective good career resource should think of the process as a joint exploration. They might open the conversation or request by saying, “You have [certain] qualities/skills, which I aspire/want to improve. May I buy you a cup of coffee and pick your brain about how you came to be so great at [lecturing]?” Similarly, in advance of a professional meeting, mentees might send a prospect an email reading, “I heard your talk last year, and it stuck with me, and I would appreciate a chance to meet briefly to learn of any progress you have made,” or, “Your paper on [genetics] intersects with my interests. May I buy you a cup of coffee and...” If the meeting goes well, mentees can ask for another interaction. If the meeting goes really well, they can ask if the prospect will consider being a mentor or advisor. If the answer is no, mentees should not take it personally but should ask for a referral to another contact or possible advisor.

In a hiking analogy, as the best guides tend to be overbooked, savvy hikers should seek to connect with multiple experts and then seek to learn as much as possible from hikers they meet on the trail.⁴ Likewise, by continuing to expand their circle of colleagues and learning partners throughout their career, mentees can avoid becoming overreliant on any one person. Until mentees commit to a specific path, they should expose themselves to a variety of styles and options—the better to discern what stimulates their own development.

Get the most out of being a mentee

After identifying a mentor, mentees should keep in mind the characteristics of a “highly effective mentee.” For instance, one who:

- assumes and demonstrates responsibility for own career development
- collaborates with mentor to set goals for work together
- makes good use of mentor’s areas of expertise
- prepares for meetings (includes acting on items agreed on during previous interaction)
- respects mentor’s time
- expresses thanks
- understands what the mentee brings to the relationship—for example, appreciation, energy, or expertise in area of interest to mentor.

Stay competitive in your field

As attributed to the legendary poet Han-shan, “there is no path that goes all the way.” So, too, professionals’ developmental needs change over time, from early- to mid-career, and their constraints and possibilities are usually reevaluated at some point.⁵ Midcareer professionals may need to look outside the traditional mentor relationship for people who can serve as sounding boards, helping them take a fresh look at what they think is important, such as, How can they remain competitive? What might “rejuvenation” consist of? Should they consider a new path? Some professionals seek out a coach, someone they consider an outsourced supplier of individualized attention and a co-creator of a framework for growth. Coaching can be specifically focused on exploring alternative career options, navigating a transition, maximizing success in a new role, or building a high-functioning team.

Just as hard work and talent are not enough to ensure career satisfaction, good intentions and wishful thinking are not enough to ensure the development of satisfying mentoring relationships. The recommendations presented here can boost professionals’ skills as both mentors and mentees. ■

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4. Bickel J. Career development as a long-distance hike. *J Gen Int Med.* 2009;24(1):118–121.
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The FPRN: Prioritizing the trainee in gynecologic surgery

The Fellows' Pelvic Research Network (FPRN)[®] has built a solid network of collaborative research and professional relationships over the last decade. Our sights forward remain entrenched in our founding commitment to education and research exposure.

Kristin M. Jacobs, MD, and Lior Lowenstein, MD, MS, MHA

Happy 10-year anniversary, Fellows' Pelvic Research Network (FPRN)[®]! It is hard to believe that a decade has passed already since this groundbreaking organization was initiated. Considering the productivity of past and current participants, however, it is also remarkable that it has been only 10 years since the beginning. In this article, we highlight the history of this great organization as well as where it is today. Importantly, we would like to recognize and thank the founders of the FPRN and the current junior and senior advisory board members for their ongoing support.

Groundbreaking idea born in 2007

In 2007, Lior Lowenstein, MD, a fellow in Female Pelvic Medicine and Reconstructive Surgery (FPMRS) at Loyola University, suggested starting a research group that would promote fellowship-initiated projects on a bigger stage. He recognized that research was a pivotal part of fellowship training yet was a highly variable experience among programs nationwide. Envisioning a fellow-led group similar in structure to the National Institutes of Health Pelvic Floor Disorders Network (PFDN), Dr. Lowenstein believed it was important for fellows to participate in their very own multicenter research network. This groundbreaking idea quickly gained support from the Society of Gynecologic Surgeons (SGS), as it founded the fellow-led research initiative to embody its mission

statement to promote cutting-edge education and research in gynecologic surgery. Thus, the FPRN was born. At the helm stood some of the most influential members of the FPMRS community: Drs. Joe Schaffer, Steve Young, Linda Brubaker, Lior Lowenstein, Becky Rogers, Kim Kenton, Rajiv Gala, and Janet Hardy.

The first FPRN meeting was held at the April 2007 SGS annual meeting, with 18 fellows in attendance and 9 projects proposed, 2 of which were ultimately selected for implementation. The FPRN rapidly gained traction among FPMRS fellows, and within the first 5 years more than 10 articles had been published by FPRN members. By 2014, the FPRN became trademarked. In the same year, SGS joined forces with the American Urogynecologic Society (AUGS) and created the first specialty-specific group from the FPRN parent with focus on FPMRS fellows. And in 2015, the FPRN was happy to establish the Fellowship in Minimally Invasive Gynecologic Surgery (FMIGS) group. SGS provides funding to both groups, whereas the FPMRS group receives additional support from AUGS and the FMIGS group receives additional support from AAGL.

Network meeting attendance and published studies continue to grow

The FPRN groups meet twice annually: The FPMRS group meets at AUGS and SGS, and the FMIGS group meets at AAGL and SGS. The AUGS meeting in 2016 had 120 attendees, including fellows and junior and senior advisory board members. Our meetings review ongoing/current

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projects, introduce new proposals for critique and vote, and feature discussions with prominent members of the FPMRS and FMIGS communities.

Through these meetings we are able to uphold the original aims of the FPRN as outlined by Dr. Lowenstein and the founders¹:

- create an environment for fellows to participate in collaborative research and conduct multicenter studies as primary investigators
- enhance fellows' knowledge and skills in study design implementation of multicenter studies, data management, and statistical analysis
- provide an environment for fellows to develop professional relationships that will be sustained after graduation.

Fellows have made great use of the national FPRN network to examine numerous issues that significantly impact our practice. A retrospective study by Molden and colleagues, for example, identified risk factors for midurethral sling revision: pre-existing obstructive voiding symptoms, retropubic sling type, and concurrent surgery.² This work was awarded the 2010 SGS presidential prize for outstanding research in gynecologic surgery. Other studies have focused on resident training, such as the report by Jeppson and associates on robotic technology's impact on hysterectomy route and what it means for resident education.³ Investigations even have looked into the use of social media by pelvic floor disorder patients. In a multicenter survey, Mazloomdoost and colleagues demonstrated that women presenting to a urogynecology clinic report high use of the Internet; such information can facilitate how we distribute information and communicate with our patients.⁴

To date, the FPRN has published more than 30 papers. In addition, 10 studies are currently

ongoing, including our first double-blind, randomized, placebo-controlled trial, which is investigating nitrofurantoin prophylaxis in women undergoing catheterization for acute postoperative urinary retention after surgery for urinary incontinence and/or pelvic organ prolapse, with Dr. Erin Lavelle of Magee-Womens Hospital, Pittsburgh, serving as principal investigator.

Looking forward in gynecologic surgery

As the FPRN would not have been created without the founding members, it would not be thriving today without the continued support and dedication of our mentors. Currently, we have 28 senior advisory board members and 133 junior advisory board members. Our steering committee members include Dr. David "Ike" Rahn (FPMRS and FMIGS groups), Drs. Tom Gregory and Rob Gutman (FPMRS group), and Drs. Rosanne M. Kho and Allison Wyman (FMIGS group). Furthermore, the FPRN owes its continued success and growth to the deep commitment and persistent hard work of the SGS administration, Nancy Frankel, PhD, and Lennie Siegel. Last, but certainly not least, thank you to the AUGS, SGS, and AAGL staff who keep this growing organization on track.

It is an exciting time to be in gynecologic surgery. This field not only highly values evidence-based medicine but also is wholly dedicated to training and providing mentorship to young investigators by prioritizing the trainees' experience. Thank you to all who have made this possible. We are proud to be a part of the FPRN family and to work together to pioneer the discoveries that will enable us to provide better care to women for generations to come. ■

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stop within 24 to 48 hours of placement of a stent and a Foley catheter. Success rates for ureterovaginal fistula resolution with stent placement have been reported to be as high as 80%.⁶

Cystoscopy and agents that allow for easy discernment of ureteral efflux aid in identifying urinary tract injuries intraoperatively.

CASE 2 Resolved: Ureter repaired

The pedicle entrapping the ureter was located, and the ureter was dissected free from the pedicle. The ureteral wall was noted to have thermal marks. The decision was made to perform a laparoscopic uretero-ureterostomy. The ureter was transected and 1 cm of ureter proximal and distal to the injury was removed. The ureter was spatulated on both ends and closed in

an interrupted fashion. Once half of the sutures were in place, the stent was placed into the ureter through the transurethral cystoscope. In the recovery room, a plain film confirmed the proper location of the stent. The stent was removed 6 weeks after surgery in the clinic setting. A Lasix renal scan performed 12 weeks after surgery confirmed a well-healed ureter with no evidence of stricture or obstruction.

Look for injuries, and repair them, intraoperatively

Urinary tract injury is a known complication of all gynecologic procedures. Identifying the injury intraoperatively reduces postoperative complications and long-term sequelae. The use of cystoscopy and agents that allow for easy discernment of ureteral efflux aid in identifying urinary tract injuries intraoperatively. ■

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COMING IN PART 2

■ Should the Ob be separated from the Gyn?

Pro/con from Geoffrey W. Cundiff, MD, and Kimberly Kenton, MD

■ Mentorship in ObGyn and Gyn surgery

Denise Elser, MD

HIGHLIGHTS FROM THE 2017 SOCIETY OF GYNECOLOGIC SURGEONS SCIENTIFIC MEETING

PART 2

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Obstetrics and gynecology: A marriage of inconvenience?

For better or for worse, obstetrics and gynecology are united as a single specialty. Exploring the clinical implications of a separation allows for a thoughtful consideration of how the practice could evolve to best meet the needs of patients and providers.

Geoffrey W. Cundiff, MD



Calls to separate obstetrics and gynecology into 2 specialties are not new and may emanate from the relatively recent marriage of these specialties. It was not until 1903 that the American Medical Association held the first combined Section Meeting on Obstetrics and Diseases of Women. Many medical schools had separate departments for gynecology and obstetrics. Even the American College of Obstetricians and Gynecologists (ACOG) was not formed until 1951. While the combined specialty is relatively young, the appeals for separation have grown louder of late. Contemplating the factors behind the increased appeals is a pragmatic place to start a thoughtful consideration of the proposed separation.

Factors compelling separation

Perhaps the most convincing factor is the increasing segregation of providers into focused

practices. This includes the emergence of office-based practice, due in part to the rebranding of a surgical specialty, obstetrics and gynecology, as primary care during the 1990s.¹ Transforming obstetrics and gynecology into primary care coincided with increased primary maternity care by obstetricians, a trend accelerated by the paucity of family physicians and midwives to meet the primary maternity needs of the population.² Primary maternity care is time-consuming, leaving little time to pursue a surgical practice. The latest evolution of the primary care obstetrician is the laborist, who provides maternity care as a full-time shift worker.³ The laborist's dedication to a maternity ward fits nicely into modern concepts of team-based maternity care, and studies suggest better maternity outcomes with this model.^{4,5} This highlights another important driver of separation: modern health care's focus on enhancing the quality of care.

The literature provides ample evidence that higher clinical volume translates to better outcomes for both gynecology and obstetrics.^{6,7} This is a compelling argument for focusing clinical care and has been a major driver of the subspecialization of gynecologic surgery. The introduction of new technologies and minimally invasive surgical approaches has drastically enlarged the surgical repertoire within gynecology. Developing and maintaining competence across the entire field may be unrealistic and increasingly is pursued through subspecialty training following residency.

As training programs, practice patterns, and the focus on quality outcomes increasingly push providers away from the provision of general obstetrics and gynecology, it is not surprising that members of the specialty identify less with a combined specialty. However, before filing for a

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divorce, it is important to consider the implications of such a decision, which include repercussions for clinical care, medical education, and women's health care in general.

Implications of separation

Clinical care

Obstetrics is a surgical specialty, and eliminating gynecologic competencies from obstetricians' skill sets would negatively influence obstetric care. The loss of surgical skills would have the most serious consequences for difficult perineal repairs and cesarean deliveries, including cesarean hysterectomy. This is worrisome given the increased prevalence of placenta previa, placenta accreta, and postpartum hemorrhage.

At the same time, many gynecologic conditions are tied to or result from childbirth, and eliminating obstetric competencies from gynecologists' skill sets would also negatively influence gynecologic care. For example, infertility specialists would lose the obstetric context of infertility interventions and urogynecologists would lose the knowledge of how pregnancy and labor influence pelvic floor function and injury. Given the benefits of combined training, it is difficult to conceptualize the benefits that would be realized from training in the vestigial field. Urogynecologists are perhaps best equipped to recognize this value through contrasting themselves with urologists pursuing female pelvic medicine and reconstructive surgery (FPMRS). Urologists pursuing FPMRS come to fellowship training with excellent surgical skills but a significantly more limited understanding of female pelvic floor function.

Medical education

Obstetrics and gynecology are presently considered core subjects in medical education, enabling all medical students to be intimately introduced to the specialty. This serves as a principal driver in many graduates' decisions to pursue postgraduate training in the field.⁸ Losing that prominent position in medical education would significantly decrease the pool of candidates drawn to the specialty. The ability to pursue many different paths after training in the spectrum of obstetrics and gynecology is another attractive feature that would be lost should the specialty be dismantled.

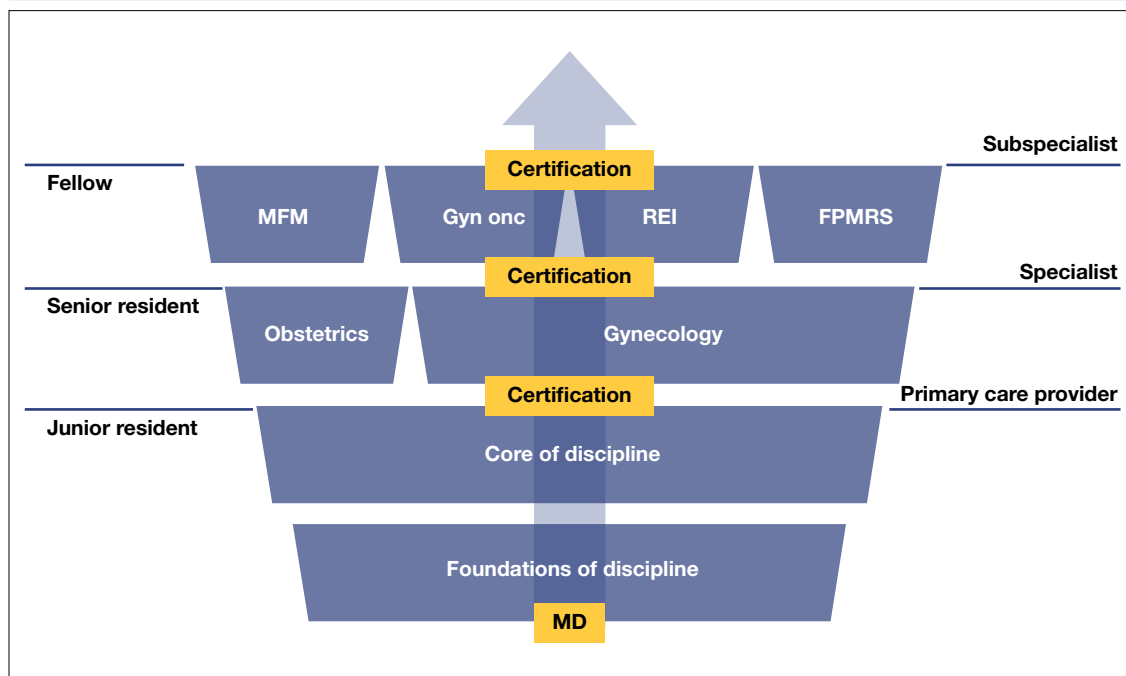
Additionally, postgraduate education must be tied to population needs or trainees will not have positions to fill. While the development of a postgraduate program in obstetrics could succeed due to the demand for primary care maternity care, a program in general gynecology would be less viable. ACOG projects a shortfall of 9,000 to 14,000 obstetricians in the next 20 years, and more than 20 states already have "red alerts" due to insufficient maternity providers to meet patients' needs.⁵ The same workforce gap does not exist in gynecology, with the exception of surgical subspecialties like gynecologic oncology and female pelvic medicine and reconstructive surgery.

This mismatch between the needs of a gynecologic residency and subsequent subspecialty training goes further than population demand. Increasingly, general gynecology is office based, while subspecialists provide for gynecologic surgical needs. This creates a disparity between postgraduate gynecology training, which needs a curriculum strong in nonsurgical care, and postgraduate training in surgical subspecialties. Can a gynecology residency prepare physicians to pursue subspecialty surgical training?

We need gynecologists to perform surgery—we just do not need as many of them given that general gynecology surgical volumes are dropping.⁹ Moreover, a significant proportion of basic surgical volume for current residents comes from cesarean deliveries. Eliminating this from the curriculum would significantly decrease the surgical volume of gynecologic residents. For a residency program focused on gynecology, the only means to address this would be by decreasing the number of resident spots, which would result in an insufficient number of candidates to meet the increasing volumes in subspecialty gynecologic surgical training.

Women's health care

Women's health care is a broad term, but such an all-encompassing concept is necessary to fully recognize the impact separating obstetrics and gynecology would have. In addition to the previously described deterioration in the quality and capacity of women's health care providers, the segregation of obstetrics from gynecology would also diminish the position of women's health in competing for health care resources. Much like undergraduate

FIGURE Competency-based medical education paradigm

Abbreviations: FPMRS, female pelvic medicine and reconstructive surgery; Gyn onc, gynecologic oncology; MFM, maternal-fetal medicine; REI, reproductive endocrinology and infertility.

education, where separating the O from the G surrenders clout in determining medical school curricula, it would also diminish political power in other important jurisdictions, including hospitals, health authorities, government regulation, and insurance and government reimbursements.

Several Canadian jurisdictions have applied this model, resulting in the department of obstetrics and gynecology being rendered the division of gynecology within the department of surgery, and the division of obstetrics within the department of maternity. As a result, obstetrics and gynecology leaders no longer sit on hospital or health authority committees that determine resource allocation or planning priorities. In effect, the separation erased women's health care from the agenda entirely. It also silenced ObGyns, who have historically been the most vocal and effective advocates for women's health.

Alternative models

If the consequences of separating obstetrics and gynecology seem prohibitive, then it is incumbent upon us to propose an alternative that addresses

the public's demand for quality care and providers' tendency to focus their practices. The solution is "streaming."

Streaming is not a new idea. Calls for a shorter core curriculum and earlier entry into subspecialties date back to 1985.¹⁰ In the early 1990s, as ACOG began rebranding obstetrics and gynecology as primary care, the Institute of Medicine recommended that the American Board of Obstetrics and Gynecology consider a shorter training period in core competencies, and the board expressed support for early tracking for future subspecialties.¹⁰ By 1995, the idea of a shorter training program in core obstetrics and gynecology with subsequent optional subspecialty training was a national discussion.¹¹ The logic of streaming was widely recognized but rarely has been implemented. Happily, the environment has changed recently with the embrace of competency-based medical education (CBME).

This paradigm shift is founded on the concept of preparing physicians for practice based on developing graduate skills or competencies that are founded on societal (patient) needs.¹² It recognizes the inherent differences in learners and provides a

TABLE ACGME Milestones with expected level of competence in the existing residency curriculum and the proposed streaming model¹⁵

Milestone	Existing milestone acquisition for residency training	Milestone acquisition in proposed streaming						
		Core (years 1-3)	Obstetrician	Maternal-fetal specialist	Gynecologist	Urogynecologist	Gynecologic oncologist	Reproductive endocrinologist
Patient care								
Antepartum care and complications of pregnancy	4		4					
Care of patients in the intrapartum period	4	4						
Care of patients in the postpartum period	4	4						
Obstetric technical skills	4		4					
Immediate care of the newborn	4	4						
Gynecology technical skills: laparotomy	4				4			
Gynecology technical skills: vaginal surgery	4				4			
Gynecology technical skills: endoscopy	4				4			
Family planning	4	4						
Ambulatory gynecology	4	4						
Care of patient with nonreproductive medical disorder	4	4						
Maternal-fetal medicine milestones				4				
Female pelvic medicine and reconstructive surgery milestones						4		
Gynecologic oncology milestones							4	
Reproductive endocrinology and infertility milestones								4
Medical knowledge								
Perioperative care	4	4						
Abdominal/pelvic pain (acute and chronic)	4	4						
Abnormal uterine bleeding (acute and chronic)	4	4						
Pelvic mass	4	4						
Pelvic floor disorders (urinary incontinence, pelvic organ prolapse, anal incontinence)	4	4						
First trimester bleeding	4	4						
Health care maintenance and disease prevention	4	4						
Maternal-fetal medicine milestones			4					
Female pelvic medicine and reconstructive surgery milestones						4		
Gynecologic oncology milestones							4	
Reproductive endocrinology and infertility milestones								4

Abbreviation: ACGME, Accreditation Council for Graduate Medical Education.

TABLE (CONTINUED) ACGME Milestones with expected level of competence in the existing residency curriculum and the proposed streaming model¹⁵

Milestone	Existing milestone acquisition for residency training	Milestone acquisition in proposed streaming						
		Core (years 1-3)	Obstetrician	Maternal-fetal specialist	Gynecologist	Urogynecologist	Gynecologic oncologist	Reproductive endocrinologist
Systems-based practice								
Patient safety and systems approach to medical errors	4	4						
Cost-effective care and patient advocacy	4	4						
Computer systems			4			4	4	4
Practice-based learning and improvement								
Self-directed learning/critical appraisal of medical literature	4	4						
Quality improvement process	4	4						
Education of team members			4			4	4	4
Scholarship			4			4	4	4
Professionalism								
Compassion, integrity, and respect for others	4	4						
Accountability and responsiveness to the needs of patients, society, and profession	4	4						
Respect for patient privacy, autonomy, patient-physician relationship	4	4						
Interpersonal and communication skills								
Communication with patients and families	4	4						
Communication with physicians and teamwork	4	4						
Informed consent	4	4						

Abbreviation: ACGME, Accreditation Council for Graduate Medical Education.

learner-centered approach, with greater flexibility and accountability through de-emphasizing time-based training. Moreover, it supports the move toward focused individual practices.

As a concept, CBME has received worldwide endorsement, although it has yet to be widely implemented. The US Accreditation Council for Graduate Medical Education (ACGME) recognized the value of CBME as far back as 1978.¹³ In Canada, the Royal College of Physicians and Surgeons of Canada (RCPSC) developed CanMEDS in 1996, a framework for CBME that is not only for residency education but also for the maintenance of certification of licensed specialists.¹⁴ The ACGME Milestones are also designed for a CBME curriculum and offer a framework for streaming.¹⁵

The ACGME Milestones were designed to assess key dimensions of competency in specific categories (see the **TABLE** in the online version of this article). Resident physicians' performance in each category is assessed based on 5 levels of competency, with Level 4 being the expected (but not required) competency for graduating residents. Many graduating residents do not achieve Level 4 competencies, particularly in gynecologic technical skills. There also is significant redundancy between the milestones for residency and fellowships in the categories of systems-based practice, practice-based learning and improvement, professionalism, and interpersonal and communications skills.

Because CBME is structured to assess sequential competencies, it lends itself to defining different levels of training (**FIGURE**). Initially, a core set of competencies that would prepare a resident to provide primary care, including primary maternity and ambulatory gynecology, is offered. For learners seeking more specialized skills in either obstetrics or gynecology, training could continue to achieve Level 4 competency in either one or both areas, depending on their practice plans. These specialty skills would also prepare residents for further subspecialty learning—maternal-fetal medicine after obstetrics and gynecologic surgical subspecialties following gynecology. While the Cleveland Clinic has begun a partial streaming class, wide adoption will require a national commitment to CBME by the ACGME residency review committee.

In summary, we cannot ignore the forces affecting our specialty. Our training and certification system no longer reflects the nature of evolving practice within obstetrics and gynecology. However, separating the constituent parts is an oversimplified solution that serves neither us nor the women we care for. We must be bold and evolve how we teach and certify physicians. This demands a system that accommodates the spectrum of practice, from primary care to specialty care to subspecialty care. Streaming is the solution and CBME is the mechanism to achieve it. ■

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The need for change in gynecologic surgery: Separating gynecology from obstetrics

Within the context of modern medicine and health care, is obstetrics and gynecology still maximizing health care for women? An expert explores the evolving challenges facing the field and alternative models for training that may help clinicians keep pace.

Kimberly Kenton, MD, MS



While obstetrics and gynecology has a long history of synergy and advocacy for women's health care, data are compelling that the field must evolve to continue to advocate for women's health. As a surgical field, we must acknowledge that declining major gynecologic surgical volume among both trainees and practicing surgeons impacts our patients' outcomes.

The debate over how to optimize health care for women dates back to the late 1800s when Howard Atwood Kelly identified many of the issues regarding gynecologic surgery and surgical training that our current discussions still focus on.

The author reports that she receives grant or research support from Boston Scientific and the National Institutes of Health, and that she serves as an expert witness for the Butler Snow Law Firm/Ethicon.

Dr. Kelly, along with William Halsted, William Osler, and William Welch, was a founding chairman at Johns Hopkins Medical School. Dr. Kelly believed that the barrier between gynecology and surgery was artificial, and he negotiated to divide the department of obstetrics and gynecology into 2 separate departments. In 1899, Dr. Kelly became the first chairman of the department of gynecology, and J. Whitridge Williams became the first chairman of the department of obstetrics.¹ Dr. Kelly touted goals for gynecologic surgical education similar to ours today. He advocated for wide surgical training and experience and that each year residents should be given increasing responsibility in the care of patients and procedures in the operating room (OR). His words echo those of the Accreditation Council of Graduate Medical

PHOTO: SHUTTERSTOCK

Education (ACGME), which sets minimum standards for surgical training and requires that “graded and progressive responsibility” be the core tenet of surgical training.

How we got here

The American Board of Obstetrics and Gynecology (ABOG) was established as one of the 4 founder boards of the American Board of Medical Specialties (ABMS) in 1930. In contrast to the traditional division of medicine and surgery, in 1951 ABOG and the American College of Obstetricians and Gynecologists’ (ACOG) vision was based on the comprehensive care of women rather than a discrete skill set. This unification of gynecologic surgery and obstetrics, with women’s health care at the center, has unquestionably led to huge advancements in legislation and standard setting for women’s health.

Our current challenge, however, is to decide how well the system—designed nearly 100 years ago—is working within the context of modern medicine and health care and, more importantly, if the system is still maximizing health care for women. Perhaps, if we are to achieve our primary mission and goal of optimizing health care for US women, we need to be nimble enough to adapt to changing needs and times.

While the aims of surgical training today are similar to those Dr. Kelly promoted in the late 1800s, we must acknowledge new challenges to the practice of obstetrics and gynecology in the current system. We are faced not only with decreasing surgical volume but also with increasing complexity of surgical procedures, subspecialization of care, emphasis on and accountability for quality and safety, decentralization of care (surgery is no longer done at a single academic site), and duty hour limitations. All these factors impact both resident surgical training and practice patterns of board-certified ObGyns.

Shifts in gynecologic surgery and training

Some argue that skill mastery requires 10,000 hours, or 20 hours per week for a decade, of deliberate practice.² This is far more time than most gynecologic residents or practicing surgeons

spend in the OR each week. However, a recent study of ABOG-accredited fellowship directors from female pelvic medicine and reconstructive surgery (FPMRS), gynecologic oncology, maternal-fetal medicine (MFM), and reproductive endocrinology and infertility (REI) showed that fellowship directors were concerned about their incoming fellows’ preparedness.³

Residents are required to perform 360 deliveries (200 vaginal, 145 cesarean, and 15 operative) compared with only 70 hysterectomies (35 abdominal, 20 laparoscopic, and 15 vaginal).

Responses from gynecologic surgery fellowship directors (FPMRS and gynecologic oncology) showed that less than 20% of surgical fellows could independently perform a vaginal hysterectomy, just 27% were able to repair a cystotomy, and barely half could perform an abdominal hysterectomy, adequately retract and pack the bowel, recognize surgical complications, or take general gynecologic call independently. By contrast, the majority of MFM program directors thought that their incoming fellows could perform basic obstetric procedures. Approximately three-quarters thought that fellows could independently perform a vacuum extraction, repair a 3rd-degree laceration, take obstetrics call, and recognize obstetric complications.³

Program directors’ perceptions parallel the minimum case volumes for each resident set by the ACGME for common gynecologic and obstetric procedures. These minimum requirements are largely based on the resident-reported number of each procedure performed during residency. They reflect workload rather than competency or proficiency. Residents are required to perform fivefold more deliveries than hysterectomies. Specifically, residents are required to perform 360 deliveries (200 vaginal, 145 cesarean, and 15 operative) compared with only 70 hysterectomies (35 abdominal, 20 laparoscopic, and 15 vaginal). It is therefore not surprising that graduates seem more proficient at obstetric than gynecologic surgical procedures. Arguably, we are training residents to meet women’s obstetric needs but not their gynecologic surgical needs. According to the National Residency Match

Program data from 2017, there were 1,288 obstetrics and gynecology residency positions, which is a 12% increase from 2006 (134 spots) and a 31% increase from 1980 (307 spots).

Yet numerous studies demonstrate a decline in hysterectomy volumes in the United States, which translates to fewer procedures per surgeon or resident.⁴ According to the New York State Department of Health Database from 2001 to 2006, the mean number of hysterectomies per ObGyn per year was 6.8; the median was only 3.⁵ Similarly, estimates of the mean number of hysterectomies done per graduating resident have decreased markedly over the last 40 years, with approximately 175 to 180 per resident in the 1980s, 120 in 1990, and 90 in 2015. Further complicating decreasing hysterectomy volumes is the advent of laparoscopic and robotic routes of access. In 1980, residents had to master 2 routes of hysterectomy (vaginal and abdominal), but they now need to develop competency in 4 routes of access (vaginal, abdominal, laparoscopic, and robotic).

While the number of residency slots has increased by 31% over the last 35 to 40 years, residents are performing approximately 48% fewer hysterectomies.

Procedures and proficiency: How many is too few?

The pressing question is: How many surgical procedures or hysterectomies does one need to perform to develop and maintain proficiency? Mounting data across surgical specialties show a strong association between surgeon volumes and operative morbidity and mortality. A recent systematic review explored the impact of gynecologic surgeon volumes on patient outcomes.⁶ Investigators defined low-volume surgeons as those who perform ≤ 10 of a particular procedure per year; they discovered that gynecologists performing ≤ 1 procedure a month had higher rates of adverse outcomes. Low-volume surgeons had increased rates of total, intraoperative, and post-operative complications. High-volume surgeons were more likely to perform hysterectomies by the vaginal or minimally invasive routes and at lower costs.^{5,7}

Decreased surgical experience may impact obstetrics outcomes as well. A study investigating unlabored primary cesarean deliveries at a single academic center from 2003 to 2010 found that total cesarean delivery time increased by 16 minutes over the study period, although time to deliver the baby out was unchanged. In other words, only the surgical portion of the case increased significantly. The cesarean delivery case volume per resident was unchanged during the study period, with a mean of 213 in 2003 and 227 in 2010. The mean number of abdominal hysterectomies per resident, however, decreased by 54% (from 114 to 52).⁸

Where do we go from here?

Fortunately, our major specialty organizations remain committed to ensuring the best quality of care for women. They recognize the need to re-evaluate optimal training schema and scope of practice for ObGyns and are launching important new initiatives to determine what the field must do to adapt to the changing health care and training environments to continue providing exceptional obstetric and gynecologic care.

Undeniable changes are occurring in health care, and they may adversely impact gynecologic care for women. While the number of residency slots has increased by 31% over the last 35 to 40 years, residents are performing approximately 48% fewer hysterectomies. This likely reflects ongoing demands to provide low-risk obstetric care, which carries over to independent practice.

Other health care models. We need to consider other models, including how other health systems administer obstetric care. In the United Kingdom, all pregnant women are cared for by midwives. There, as in many other European countries, midwives act as primary providers for healthy, low-risk obstetric patients, and ObGyns are reserved for women and fetuses at high risk or those undergoing medical procedures.

Residency pathways. Alternatively, many advocate for differentiating residents into tracks that allow them to focus on obstetrics, gynecology, or subspecialty training. Some large US health care systems have already adopted this model. Acknowledging that outcomes are better when high-volume physicians provide care, ObGyns are

required to focus their scope of practice to ensure that hysterectomies are not being done by surgeons who perform only 3 to 6 per year.

As health care changes, the field of obstetrics and gynecology must evolve to keep pace and to ensure that we do not lose sight of our mission.

Our mission remains constant: to provide the highest quality of obstetric and gynecologic care for women. Does our current model of training prepare our residents to meet that mission? If not, then we must change our training model to meet these standards. ■

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Top reasons why you should be a mentor to your ObGyn colleagues

Serving as a mentor to a new ObGyn benefits the young physician, the institution, and you

Denise M. Elser, MD

As ObGyns or gynecologic surgeons, most of us can identify a role model who profoundly influenced our education, career, and success. That mentor may have been an excellent surgeon, a compassionate caregiver, or a brilliant researcher. Some of us may have sought out a program or joined a department because we wanted to work under or alongside a specific seasoned veteran with a great reputation from whom we hoped to learn or seek advice. Yet, the fact is that finding a mentor in medicine is largely a matter of luck. Most of us formed informal mentoring relationships with a colleague whose path we just happened to cross at our hospital, in our department, or at a conference.

What exactly is a mentor?

A *mentor* can refer to anyone who is a trusted guiding influence in another (usually younger) person's life.¹

A mentor is different from a coach. A coach's job is task driven—usually short term—and is judged on performance. A mentor's job, on the other hand, is relationship driven, relatively long term, and development driven. While the initiation of the mentor-mentee relationship may be based on accomplishing a specific goal or task, it may extend into areas such as work-life balance, self-confidence, and self-perception.²

Do I have what it takes to be a mentor?

The short answer is, of course you do. If you are a successful ObGyn or gynecologic surgeon, you have many desirable skills and experiences that



you have honed along your career pathway and that have led you to your current position. Younger, less-experienced physicians or students can benefit from your wisdom and guidance.

A few common themes are found in the literature on mentoring³⁻⁵:

- **Listen.** To understand your mentee's situation, concerns, skills, barriers, and so on, you need to listen to the individual's story. Imagine being a therapist. At times, sit back, nod, say "uh-huh," and just listen.
- **Be compassionate.** To provide valuable guidance, you need to empathize with your mentee's situation and challenges.
- **Have patience.** Like a parent-child relationship, the relationship with a mentee may be frustrating if he or she does not follow the path you would have followed, does not heed your advice, or does not act as quickly as you would like. Let your mentee make mistakes; mistakes are a necessary part of learning.
- **Care about the relationship.** While coaching may involve caring about the result, mentoring involves much more. You need to care about your mentee as a person and not just as a project. When describing his or her goals and life situation, for example, your mentee may talk about his or her family life, love life, and even financial concerns.

The author reports no financial relationships relevant to this article.

PHOTO: SHUTTERSTOCK

Mentorship can be an antidote to burnout

The benefits for a protégé working with a mentor may seem obvious, but mentors also benefit from such relationships. If an organization involves high-stress jobs (for example, employees experience work overload and a lack of social support and feel incapable of completing tasks—a bit like practicing medicine), a formal mentorship program results in less emotional cognitive fatigue, greater confidence and efficacy, lower absentee rates, and less tendency to leave the organization—improvements that lead to a better work environment for all involved.

Mentors, however, realize benefits beyond helping a younger colleague or the department or practice they share. Serving as a mentor builds confidence, self-esteem, and a sense of accomplishment. Further, mentors are perceived by their peers and their supervisors to be more credible and competent. Being a mentor requires self-reflection. You will likely find that you have come farther than you realized. Give yourself a pat on the back. Finally, mentors are more visible in the organization in a positive way. They are more connected, interact with other leaders, and are believed to add value to the department.

- **Maintain confidentiality.** As a trusted confidante, you may hear intimate details you never expected. Protect your mentee's personal information as you would guard a patient's medical information.
- **Push to action.** Your goal is not only to provide wisdom and advice but also to motivate your mentee to take action. For example, although I know perfectly well how to exercise, spending an hour with my personal trainer at the health club helps me achieve a more vigorous workout than exercising solo.
- **Be a role model.** As the saying goes, actions speak louder than words. Keep growing. Question your own goals and the path you are taking to achieve them. What have you not achieved that you would like to? What are the barriers to your goals, and what can you do to get around or through them? How have your goals changed over the years?

Strongly consider becoming a mentee. Who would you choose as a mentor? If you have not partnered up with a mentor, why not?

What's in it for me?

Being a mentor has many potential benefits.

Personal benefits

Mentoring encourages lifelong learning. We may learn something from our mentee, such as computer or social media skills. The emotional attachment we develop with a mentee can stave off loneliness at a time when many of us are becoming empty nesters. Psychologist Erik Erikson identified 8 stages of life from infancy to adulthood. When we reach our 40s through our mid-60s, we are faced with “generativity versus stagnation.” Mentoring another person can help us remain productive at work. It helps us to give back to the community, recognize that we are part of the big picture, and thus helps us avoid stagnation. Helping a younger colleague provides us with a chance to pay back what we received from someone who helped us early in our career. Perhaps you will see mentoring as an opportunity to “pay it forward.”^{3,6}

Organization benefits

Mentoring helps organizations. Formal mentoring programs help develop a talent pool and may save on recruitment costs. Offering mentoring as part of an organization helps recruitment efforts. If you practice academic medicine or work in a large organization, the institution may reward these endeavors, as mentoring employees can provide an edge in recruiting, shorten learning curves, increase job satisfaction and loyalty, and improve productivity and quality.^{6,7}

Mentoring for ObGyns

In about 2010, 2 physicians in District VI of the American College of Obstetricians and Gynecologists (ACOG)—Dr. Thomas Arnold and Dr. Tamara Helfer—were champions of mentoring. Recognizing that organizations such as the American College of Surgeons and the Association of Healthcare Executives offered formal mentoring programs, they researched the topic and developed a pilot program for the District. Based on the success of the pilot, in 2016 ACOG decided to adopt the mentorship endeavor at a national level.

Every ACOG Fellow and Junior Fellow is welcome and encouraged to join the program. To join, log in to the ACOG website (<http://www.acog.org>)

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.org), go to <http://www.acog.org/About-ACOG/Careers/ACOG-Mentorship-Program/Join-Now> and hit the “join now” button. You can fill out the short survey, including whether you want to be paired as a mentee or a mentor, or both. Besides providing the matching service, the program sends monthly hints, highlights, and suggested video clips or readings for both mentors and mentees.

The Society of Gynecologic Surgeons (SGS) mentorship program is an affiliate of the ACOG formal mentorship program. This program uses MentorCity software to match mentors and mentees across the country. The questionnaire includes an open-ended question on what type of mentor a mentee is seeking, such as an SGS member, an ObGyn department chair, an SGS committee chair, or a National Institute of Health-funded researcher, or what topics a mentor is comfortable with, such as how to succeed in academic medicine, how to obtain a fellowship, running a private practice, or work-life-balance, to name just a few.

The “mentorship mingle” event was introduced at the 2017 SGS annual meeting in San Antonio. The 1-hour event featured 5 roundtables, each featuring 1 to 2 distinguished mentors and 7 to 8 younger physicians (fellows, residents, and attending physicians). Discussion topics assigned to the tables included the changing face of gynecologic surgery, cultivating an academic career, how to stay relevant, and incorporating research into private practice. The mentors rotated to a different table every 10 minutes, giving each attendee a chance to meet a senior and well-respected SGS member up close and personal. The event was sold out and an expanded version is planned for 2018.

Two examples of why ObGyns need mentors

Mentee #1. A young ObGyn who finished residency about 2 years ago joined a 2-person private practice in a small town. She soon discovered that because of her in-depth exposure to urogynecologic procedures in residency and the town’s lack of subspecialists, local physicians were referring women with urinary incontinence and pelvic organ prolapse to her. She was seeking a mentor with whom to discuss interesting or difficult cases as well as to brainstorm about workplace interactions.

Mentee #2. An ObGyn worked for about 10 years in an underserved area, paying back his National Health Service debt. After the debt was repaid, he faced a personal health challenge and thought it was important to relocate to live near family. He was seeking a “situational” mentor—someone with whom he could discuss his potential new private practice and who could provide advice on the contract negotiation.

Do I have time to be a good mentor?

Yes, you do. You can decide at the start of a mentoring relationship how much time you are willing to commit. Each mentoring pair has different needs, expectations, and agreements—a weekly cup of coffee or a quarterly phone call may work for some. You establish how much time and effort you are willing to put into the relationship.

You have learned an incredible amount throughout your career and have conquered many challenges to get where you are today. By sharing your knowledge and wisdom, you will help a young physician. And you will be glad that you did. ■

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