OBGYN Pocket Guide; combining associative learning and narrative medicine for the purpose of improved retention in obstetrics and gynecology residency

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Background

- Transitioning from medical school as a fulltime learner with a content heavy curriculum to a fulltime resident which is primarily clinical, is a well-known challenging evolution in medicine.
- In medical school, materials are collated and delivered to learners in a highly structured format.
- During residency, interns are expected to transition from a passive to an independent learner and assimilate information on their own.
- Residents are inundated by educational resources and struggle with extrapolating and then incorporating clinically relevant points into practice.
- This results in interns scoring lower in their specialty specific yearly exams. These yearly exams are called CREOGS in Obstetrics and Gynecology.

Aim

- To create a pocket guide learning tool that combines two learning modalities:
  - Associative learning: the principal that ideas and experiences reinforce and mentally link to one another through imagery.
  - Narrative medicine: the principal that employs a resident's narrative skills to augment their clinical understanding and retention.
- To create a learning guide to help residents retain information.
- To create a powerful, deeper connection between content and clinical experience.

Methods

- Our associative learning pocket guide is a collection of commonly used facts referenced in the field of Obstetrics and Gynecology.
- Extrapolated learning points will be presented in a 5x7" spiral bound booklet. Each collection of facts are associated with either an original table, flow chart, or clipart format.
- On the backside of each content page will be two sections; one that outlines critical learning points related to the topic, and another that gives residents the opportunity to use narrative skills to associate their own clinical interactions with patients.
- CREOG scores, percent correct, and percentile rank for interns will be recorded in January 2021 and analyzed for improvement in comparison to the last 5 years of intern scores.

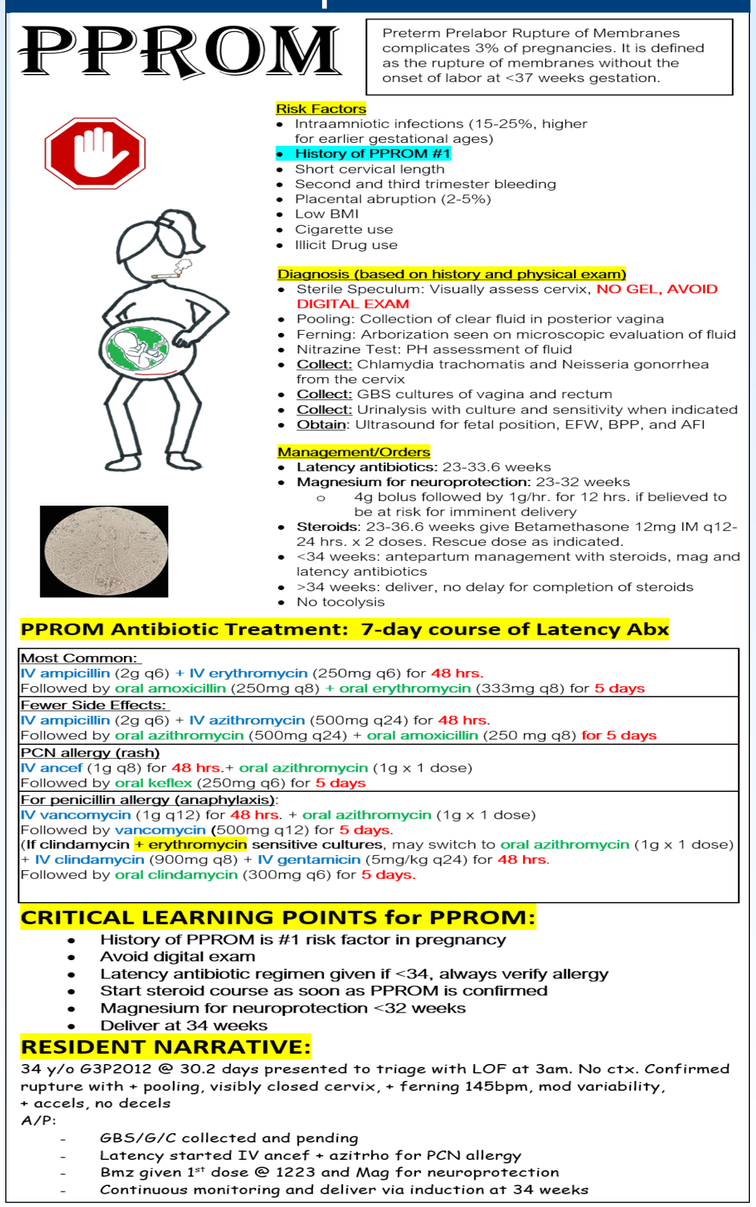
Results

- The projected results will be better retention of commonly referenced facts and better CREOG scores amongst interns using the pocket guide.

Conclusion

- This booklet will provide residents with a readily accessible learning tool that will allow them to associate fundamental content with patient experiences to improve understanding and retention of information.

Sample Guide



PPROM

Preterm Prelabor Rupture of Membranes complicates 3% of pregnancies. It is defined as the rupture of membranes without the onset of labor at <37 weeks gestation.

Risk Factors
- Intraamniotic infections (15-25%, higher for earlier gestational ages)
- History of PPROM #1
- Short cervical length
- Second and third trimester bleeding
- Placental abruption (2-5%)
- Low BMI
- Cigarette use
- Illicit Drug use

Diagnosis (based on history and physical exam)
- Sterile Speculum: Visually assess cervix, NO GEL, AVOID DIGITAL EXAM
- Pooling: Collection of clear fluid in posterior vagina
- Ferning: Arborization seen on microscopic evaluation of fluid
- Nitrazine Test: PH assessment of fluid
- Collect: Chlamydia trachomatis and Neisseria gonorrhea from the cervix
- Collect: GBS cultures of vagina and rectum
- Collect: Urinalysis with culture and sensitivity when indicated
- Obtain: Ultrasound for fetal position, EFW, BPP, and AFI

Management/Orders
- **Latency antibiotics:** 23-33.6 weeks
- **Magnesium for neuroprotection:** 23-32 weeks
  - 4g bolus followed by 1g/hr. for 12 hrs. if believed to be at risk for imminent delivery
- **Steroids:** 23-36.6 weeks give Betamethasone 12mg IM q12-24 hrs. x 2 doses. Rescue dose as indicated.
- <34 weeks: antepartum management with steroids, mag and latency antibiotics
- >34 weeks: deliver, no delay for completion of steroids
- No tocolysis

PPROM Antibiotic Treatment: 7-day course of Latency Abx

Most Common: IV ampicillin (2g q6) + IV erythromycin (250mg q6) for 48 hrs. Followed by oral amoxicillin (250mg q8) + oral erythromycin (333mg q8) for 5 days
Fewer Side Effects: IV ampicillin (2g q6) + IV azithromycin (500mg q24) for 48 hrs. Followed by oral azithromycin (500mg q24) + oral amoxicillin (250 mg q8) for 5 days
PCN allergy (rash) IV ancef (1g q8) for 48 hrs.+ oral azithromycin (1g x 1 dose) Followed by oral keflex (250mg q6) for 5 days
For penicillin allergy (anaphylaxis): IV vancomycin (1g q12) for 48 hrs. + oral azithromycin (1g x 1 dose) Followed by vancomycin (500mg q12) for 5 days. (If clindamycin + erythromycin sensitive cultures, may switch to oral azithromycin (1g x 1 dose) + IV clindamycin (900mg q8) + IV gentamicin (5mg/kg q24) for 48 hrs. Followed by oral clindamycin (300mg q6) for 5 days.

CRITICAL LEARNING POINTS for PPROM:
- History of PPROM is #1 risk factor in pregnancy
- Avoid digital exam
- Latency antibiotic regimen given if <34, always verify allergy
- Start steroid course as soon as PPROM is confirmed
- Magnesium for neuroprotection <32 weeks
- Deliver at 34 weeks

RESIDENT NARRATIVE:

34 y/o G3P2012 @ 30.2 days presented to triage with LOF at 3am. No ctx. Confirmed rupture with + pooling, visibly closed cervix, + ferning 145bpm, mod variability, + accels, no decels

A/P:
- GBS/G/C collected and pending
- Latency started IV ancef + azitrho for PCN allergy
- Bmz given 1st dose @ 1223 and Mag for neuroprotection
- Continuous monitoring and deliver via induction at 34 weeks

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