

2016 Bulletin
for the
Oral Examination
for
Basic Certification
in
Obstetrics and Gynecology

The American Board of
Obstetrics and Gynecology, Inc.



The American Board of
Obstetrics & Gynecology
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First in Women's Health

This bulletin, issued in 2015, represents the official statement of the requirements in effect for the basic oral examinations to be given in November and December, 2016, and January, 2017.

IMPORTANT INFORMATION
All Candidates
for the
2016 Oral Examination
for
Basic Certification in OB-Gyn

1. The eligibility of current fellows to apply for the oral examination has been expanded. If you are currently a fellow in an OB-Gyn related fellowship program please read this Bulletin carefully.
2. It is the candidate's responsibility to meet all deadlines for submission of applications, fees, case lists, and all other required materials. Deadlines are based on the receipt of the material at the ABOG office and will not be extended.
3. All Board-related correspondence should be sent using a service with tracking ability. (The USPS does not guarantee on-time delivery. Time-sensitive materials should be sent by another service.)
4. All new Diplomates must enter the Maintenance of Certification (MOC) process in 2017. MOC is a continuous process, and failure to complete the assignments each year by the deadline will result in loss of Board certification. The MOC process is described in the *MOC Bulletin*.
5. It is the responsibility of each candidate to update their personal email and mailing addresses in the profile section of their personal ABOG home page.
6. There is a limit to eligibility to sit for the oral certification examination. In addition, beginning in 2018 all candidates must achieve board certification in Basic Obstetrics and Gynecology within 8 years of the completion of their training. If certification is not achieved within 8 years, the physician is no longer eligible to apply for either the written or oral examination unless an additional 12 months of residency training is completed.
7. Candidates must have an unrestricted medical license to apply. In addition, they must report any and all negative actions taken against their license(s) at ANY time since obtaining the license(s), even if the action has been cleared or ended. Such actions include, but are not limited to suspension, revocation, reprimand, fine, probation, required course work, proctoring, etc.

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GENERAL INFORMATION FOR ALL CANDIDATES

I. CANDIDATE RESPONSIBILITY

The process of certification in Obstetrics and Gynecology by the American Board of Obstetrics and Gynecology (ABOG) is voluntary. ABOG does not assume responsibility to contact potential candidates. Rather, each candidate is responsible for initiating the process, completing all applications, submitting required materials by the deadlines, and paying the appropriate fees. Candidates must meet the eligibility requirements published in the *Bulletin* dated for the year in which they are to take the examination as these may change from year to year. The *Bulletin* is available on-line at www.abog.org. It is the candidate's responsibility to become familiar with all of the material contained in the *Bulletin*, including the information in the Appendices. In addition, each candidate is responsible for reading all of the policies included under the "Policies" tab on the ABOG home page.

After application, it is the candidate's responsibility to inform ABOG of any changes in email and other addresses by changing the information in their profiles on their ABOG personal home page.

II. DEFINITION OF AN OBSTETRICIAN-GYNECOLOGIST

Candidates for the oral examination must practice within the boundaries indicated in the *Definition of an Obstetrician-Gynecologist*. The *Definition* can be found on the ABOG website under "Policies."

III. CANDIDATE BOARD STATUS

All applicants for the Basic Oral Examination must have achieved "Active Candidate" status by passing the Basic Written Examination.

IV. DURATION OF CERTIFICATE VALIDITY

All certificates issued by ABOG in 1986 and thereafter are time-limited and remain in effect only if the Diplomate participates in and successfully completes the MOC process each year. Certificates issued after successful completion of the oral examination in November or December, 2016 and January, 2017 will expire December 31, 2017 unless the 2017 MOC assignments are completed successfully and on time.

A Diplomate who allows their certification to expire should contact the ABOG regarding the requirements for the re-entry process. The MOC phone number is 214-721-7510; the email address is MOC@abog.org. A Diplomate with a certificate that has been expired for six years or longer will be required to take the Basic Written and Oral Examinations in order to re-establish Diplomate status.

Details of the MOC process can be found in the MOC Bulletin which is available on-line at www.abog.org.

THE ORAL EXAMINATION

I. Introduction

The oral examination will evaluate the candidate's approach to and rationale for the clinical care of various patient management problems in obstetrics, gynecology and women's health. The candidate's case list and structured hypothetical questions (possibly including visual aids) will be used by the examiners.

Candidates will be expected to demonstrate a level of knowledge that allows them to serve as consultants to physicians in their community who are non-obstetrician-gynecologists, and to provide safe and effective care to women.

Candidates will be expected to demonstrate that they have acquired the capability to practice independently, to perform major gynecologic surgery, and spontaneous and operative obstetric deliveries safely, to manage complications, and to perform the essential diagnostic procedures required of a consultant in obstetrics, gynecology and women's health.

The candidate must bring one copy of their case list with them to the oral examination. That copy of the list must be identical to the list mailed to ABOG, and contain no additional information.

II. The Application Process for the 2016 Oral Examination: General Information

The 2016 oral examinations will be given in November 2016, December 2016, and January 2017.

A. Applications will be accepted on-line at www.abog.org beginning February 1, 2016. The application fee must be paid on-line by credit card at the time of application. No other form of payment will be accepted. All fees are quoted and payable in US dollars. The application fee for the oral examination will not be refunded nor credited against a future examination.

B. The completed Hospital Privileges Verification Form that automatically prints at the time of application must be faxed to the ABOG office on or before March 15, 2016, 5 pm CST. If the candidate is currently in an ACGME or ABOG accredited fellowship, this form may be completed by the fellowship director.

C. Late fees will apply for applications received after 5 pm CST, March 15, 2016. A full the list of deadlines and fees is shown below on page 6.

D. April 29, 2016 is the last day for receipt of an application to take the 2016 oral examination. Applications received after this date will not be accepted.

E. All inquiries, applications and correspondence must be in English.

F. Candidates will be notified by ABOG by July 15, 2016, to submit properly formatted case lists in triplicate and to pay the examination fee. The case list must be submitted by August 1, 2016, 5 pm CDT to avoid a late fee.

G. Case lists received between August 2, 2016 and August 15, 2016, 5 pm CDT will be assessed a late fee. No case lists will be accepted after August 15, 2016, 5 pm CDT.

III. Fees and Deadlines

The following table lists the deadlines and fees for the oral examination. Deadlines cannot be extended.

ORAL EXAMINATION DEADLINES

February 1, 2016	Applications available on-line
April 29, 2016, 5 pm CDT	No applications accepted after this date
July 15, 2016	Candidates will be notified to submit case lists, a photograph, and to pay the examination fee
August 1, 2016, 5 pm CDT	Last day for receipt of case lists, photograph and examination fee without additional late fee
August 2, to August 15, 2016, 5 pm CDT	Late fee applies
August 15, 2016, 5 pm CDT	No case lists or examination fees accepted after this date and time.

ORAL TEST FEES: APPLICATION FEES

February 1, 2016 to March 15, 2016, 5 pm CDT	\$840
March 16, 2016 to April 15, 2016, 5 pm CDT	\$840 + \$345 late fee = \$1185
April 16, 2016 to April 29, 2016, 5 pm CDT	\$840 + \$825 late fee = \$1665

ORAL TEST FEES: EXAMINATION FEES

July, 2016 to August 1, 2016, 5 pm CDT	\$975
August 2, 2016 to August 15, 2016, 5 pm CDT	\$975 + \$345 late fee = \$1320

After approval, if the candidate experiences an event that prevents sitting for the examination, the Board should be notified immediately. If the request is made prior to September 15, 2016, and if the review committee agrees that the request is due to circumstances beyond the control of the candidate, the examination portion of the fee may be refunded. However, the application fee and late fees are not refundable. The review committee will not consider any request that is based primarily on non-emergency matters.

IV. Eligibility to Sit for the 2016 Oral Examination

- A. The candidate must have received a passing grade** on the written examination **prior** to making application for the oral examination. Candidates may not apply for the oral examination pending the results of the written examination. No exceptions to this requirement will be made.
- B. Limitation of Eligibility.** Candidates who fail the oral examination 3 times or fail to pass the oral examination within 6 years of passing the written examination become ineligible to repeat the oral examination. To regain eligibility, the candidate must repeat and pass the written examination and fulfill all other requirements to become admissible to the oral examination

For fellows in an ABOG or ACGME-accredited fellowship in Maternal-Fetal-Medicine, Gynecologic Oncology, Reproductive Endocrinology and Infertility, or Female Pelvic Medicine and Reconstructive Surgery (FPMRS), an additional year of eligibility is added for every year of training. However, if the candidate leaves the fellowship program before completion, the six year limit applies.

Beginning in 2018, physicians must achieve basic certification within 8 years of the completion of their residency training. Specifically, they will not be eligible to apply for either the basic written or oral examination after eight years, and they may not advertise themselves to the public or to any credentialing organization including insurance payers as being “board eligible” unless and until they have completed a minimum of 12 additional months of residency training in an ACGME-accredited residency program.

- C. Good moral and ethical character.** The Board requires evidence of a candidate’s professional reputation, moral and ethical character, and in-hospital practice privileges from administrative officers of organizations and institutions to whom the candidate and their conduct of practice is known. If a candidate is involved in an investigation regarding practice activities by a health care organization, or for ethical or moral issues, the individual will not be scheduled for examination, and the application will be deferred. The Board usually will defer such a decision for a minimum of one year to gain further information.

A physician who has been convicted of a felony will not be allowed sit for the oral examination.

- D. The candidate must possess at least one unrestricted license to practice medicine in a US state or territory or a province of Canada to be eligible to apply for the oral examination.** In addition, each such license must not be restricted, suspended or revoked, nor may it be on probation. The term “restricted” includes any and all limitations or requirements placed on a physician’s license regardless of whether such limitation or requirement deals directly with patient care. An educational or institutional license does not meet this requirement unless the candidate is currently in an ABOG or ACGME-accredited fellowship training program.

If a candidate has ever had any action taken against any medical license in any territory, province or state of the United States or Canada, or any foreign country at any time, a written explanation must be provided with the application. Such actions include, but are not limited to, reprimands, conditions, restrictions, suspension, fines, required course work and revocation. These actions must be reported even if they have occurred in the past and are no longer active.

ABOG will investigate every candidate’s license(s) using various search techniques. A candidate that fails to inform ABOG or any action against their medical license in any state, territory or foreign nation shall be ineligible to sit for the Oral Examination for at least three years. The Board reserves the right to determine candidate eligibility to sit for the oral examination after reviewing all material.

Candidates who are currently enrolled in an ABOG-accredited fellowship program or an ACGME-accredited FPMRS fellowship program do not need to have an independent license to practice medicine. However, if such a license(s) is held, the license(s) must be unencumbered.

E. Actively engaged in unsupervised clinical practice:

Candidates for the 2016 oral examination must be in an unsupervised clinical practice of Obstetrics and Gynecology from July 1, 2015 through June 30, 2016. During that year of practice, no more than 8 weeks of leave is allowed for any reason (this includes medical leave, maternity leave, vacation, not starting practice by July 1, etc.).

An exemption to the 8 week of leave condition may be made if there is a medical, maternity or emergency reason for the extended leave. In such a case, the physician must be in practice between July 1, 2015 and July 31, 2016, with no more than 12 weeks of leave for any and all reasons. All such requests for an exemption must be submitted in writing to the ABOG office for approval. In addition, the submitted case list must include all cases between July 1, 2015 and July 31, 2016.

Example a: A physician does not enter practice until August 1 (4 weeks of leave) and is then involved in an MVA and is out of practice for 7 weeks. That physician is eligible to request an exemption, but must be in practice from August 1, 2015 through July 31, 2016 except for the 7 weeks of medical leave due to the MVA. The candidate's case list must be collected between August 1, 2015 and July 31, 2016.

Example b: A physician enters practice on July 1 and takes 12 weeks of maternity leave. That physician may request an exemption, but must be in practice from July 1, 2015 through July 31, 2016 except for the 12 weeks of maternity leave. The candidate's case list must be collected between July 1, 2015 and July 31, 2016.

The number of days that equals a "week" is the candidate's usual number of work days in an average calendar work week.

Physicians who are in a non-ABOG or ACGME accredited fellowship related to the field of Obstetrics and Gynecology may apply for the oral examination during their fellowship if they meet all of the additional requirements, including submission of an acceptable case list.

Time spent in a teaching or research appointment, or in a non-clinical fellowship or graduate education program that does not involve unrestricted privileges to practice as an obstetrician and gynecologist and does not include clinical practice will not fulfill the practice requirement.

F. Unrestricted Hospital Privileges

Candidates for the oral examination must hold unrestricted hospital privileges to practice as an obstetrician-gynecologist in each of the hospitals in which the candidate has been responsible for patient care between July 1, 2015, and June 30, 2016. These privileges must be in effect no later than September 1, 2015, and must remain in effect until the date of the oral examination. Privileges must be in place no later than September 1, 2015, even if an exemption to the 8 weeks of leave has been granted.

"Unrestricted hospital privileges" means that the physician has full clinical privileges to admit patients and to practice general obstetrics and gynecology. Required proctoring for new privileges is not considered a restriction for examination purposes. However, when quality of care, professionalism or peer review activities have led to a limitation of privileges or required proctoring, this is considered a restricted practice, and the physician is not eligible to sit for the oral examination. Any Focused Practice Evaluation (FPPE) must be reported with the application. That information will be reviewed by ABOG to determine if represents a significant restriction. If the candidate's privileges are under investigation, suspended or on probation (for cause), that candidate is not eligible to apply for the oral examination until and unless the investigation is completed, or the suspension or probation is lifted and full and unrestricted privileges are granted.

Candidates who are enrolled in a fellowship in an area of medicine related to Obstetrics and Gynecology are not required to hold hospital privileges. However, if a fellow has such privileges, they must be unrestricted and not under investigation for any reason.

G. Approval of application and review of licensure and privileges

If the application, licensure and privileges are acceptable after review by ABOG, the candidate will be notified by July 15, 2016. The candidate will then be asked to submit case lists (see below).

The case lists should not be mailed until the candidate is notified of approval from the Board.

ABOG reserves the right to make the final decision concerning the applicant's admission to the oral examination after considering all circumstances affecting the individual situation, including a review of the case lists.

H. Test Security and Attestation

At the time of application and again on the day of the oral examination, each candidate must sign the following terms of agreement. If a candidate refuses to sign the agreement they will not be allowed to sit for the Basic Oral Examination.

1. I understand and irrevocably agree that, if I am certified as a Diplomate of the ABOG, the ABOG is authorized to provide my name and business address for publication in the following: *Obstetrics & Gynecology, The American Journal of Obstetrics and Gynecology, The Directory of Medical Specialists, the American Board of Medical Specialties Directory of Certified Obstetricians and Gynecologists, and the Directory of American Medical Association.* In addition, my name and business address will be forwarded to the American College of Obstetricians and Gynecologists and the American Congress of Obstetricians and Gynecologists.
2. I agree that the ABOG is authorized to make my name and business address available on request to the public including, but not limited to, hospitals, insurers, agencies of government and lay persons.
3. I understand and irrevocably agree that the results of my examination may be made available to my Program Director and/or the American College of Graduate Medical Education (ACGME).
4. I agree that de-identified results of my examination may be used for research purposes by ABOG.
5. I understand that all ABOG test materials including, but not limited to the structured case histories and images utilized during the oral examination are copyrighted, and that it is illegal to disclose the content of the examination in whole or in part to any individual, organization or business. Furthermore, I understand that if I provide the information to such entities I may be prosecuted under the US Copyright laws.
6. I understand that if I divulge the content of the oral examination in whole or in part to any individual, organization or business my test result, if any, will be negated and I will not be allowed to re-apply for the examination for a minimum of three years. Furthermore, if I had been awarded Diplomate status, such status will also be withdrawn.
7. I understand that I may not record any portion of the oral examination by any means in whole or in part, and a violation will be treated as outlined in numbers 5 and 6 above.
8. I understand that I may not memorize or attempt to memorize any portion of the oral examination for the purpose of transmitting such material to any individual, organization or business.
9. I attest that since the date of my application for the ABOG oral examination, I have had no change in my hospital privileges including, but not limited to limitation, restriction or suspension, that I have had no substance abuse offenses, and that there has been no reprimand, suspension, revocation, restriction or other condition placed on my license to practice medicine in any state or country.

[At the time of the oral examination, the candidate will be required to sign a statement that there has been no change in their hospital privileges since the date of application.]

I. Practice in a country other than the United States or Canada

A candidate who practices outside of the United States, its territories or Canada, must submit, with the application, a letter(s) from a senior responsible officer in the hospital(s) where the candidate practices, verifying the candidate's responsibility for independent, unsupervised care of patients.

J. Use of Case Lists During the Oral Examination

The candidate's patient case lists will be used as a basis for questions which will be patient management oriented. Questions will be developed which test the ability of the candidate to:

1. develop a diagnosis, including the necessary clinical, laboratory and diagnostic procedures;
2. select and apply proper treatment under elective and emergency conditions;
3. prevent, recognize and manage complications; and
4. plan and direct follow-up and continuing care.

Carelessly prepared or incomplete case lists may contribute to failure to pass the oral examination.

The candidate must bring a copy of their patient case lists to the oral examination for personal reference.

K. Other requirements

The candidate must meet all of the requirements in the Bulletin for the year for which they are applying for the test. For example, those applying for the 2016 written or oral examinations must meet the requirements in the 2016 Bulletin.

V. Oral Examination Content

The topics upon which the oral examination is based are shown in Appendix C.

VI. Conduct of the Oral Examination

The candidates for examination will be informed of the time and place of the registration process when they receive information concerning their assigned examination date. Candidates who are late for registration will not be allowed to sit for the examination. After registration, the candidates will be taken to the ABOG testing center where an orientation will be provided. After the orientation, the candidates will report to the testing floor.

Each candidate will be assigned an examination room, and will remain in that room for the 3 hours of the examination. The candidate will be informed of the names of the 6 examiners—2 in Obstetrics, 2 in Gynecology, and 2 in Office Practice and Women's Health—who will conduct their examination. If the candidate believes that one or more examiner would be inappropriate to provide them with a fair test, an alternate examiner will be provided. Each pair of examiners will award a grade in their area, but the final grade will be decided by members of the ABOG Board of Directors after reviewing all of the information from the examination.

The test will consist of three, one-hour oral tests in each of the areas of Obstetrics, Gynecology, and Office Practice and Women's Health. Questions about communication, ethics and patient safety may be included in each of the 3 major areas. Each hour will be divided into 2 sections of approximately 30 minutes in length. One section will be devoted to questions derived from the candidate's case list, and the other section will consist of several "structured and/or simulated cases" that have been written by ABOG. The structured cases are used to elicit the candidate's responses to specific clinical situations. The examination will be conducted in English. A list of the topics that may be covered in the examination can be found in Appendix C.

At the end of the examination, the candidates will be returned to the registration area.

VII. Use of Case Lists During the Examination

During each hour of the examination approximately 30 minutes of questions will be developed from those cases submitted by the candidate. Some of the questions will specifically address how the candidate evaluated and managed their actual patient. The examiner will also use the actual case to explore the candidate's management of similar patients with different specifics. For example, if the candidate listed a 48 year-old woman with an adnexal mass, after discussing the actual management, the candidate might be asked if the management would have been different (and how) if the patient were 18 years old, or 78 years old.

VIII. Case List Preparation

A. General Information

The candidate must submit 3 separate, typewritten copies of case lists and summary sheets in Obstetrics and in Gynecology listing all patients dismissed from their care in all hospitals and surgical centers between July 1, 2015 and June 30, 2016. During these 12 months of case collection, no more than 8 weeks away from clinical practice is allowed unless the candidate has been granted an exemption to the 8 weeks limit (see above). If an exemption is granted, the list must include all hospitalized patients between July 1, 2015 and July 31, 2016.

A minimum of 20 patients in Obstetrics and 20 patients in Gynecology must be included (see below). In addition, a list of 40 office practice patients (no more or fewer) must be submitted. A practice that consists of ambulatory care exclusively will not be considered adequate to fulfill the requirements to sit for the oral examination. Cases falling into the "uncategorized" option may not be used to meet the minimum requirements.

Patient case lists that fail to provide the required information, have not been prepared in the required format, include an insufficient number of patients, are inadequately or incompletely prepared, are not appropriately de-identified, or fail to provide sufficient breadth and depth of clinical problems may disqualify the candidate from admission to the oral examination.

The completeness and accuracy of submitted case lists are subject to audit by the ABOG. All audits will be conducted in accordance with the provisions of the HIPAA Privacy Rule. Permission to conduct on-site audits will be required of each candidate prior to final approval to take the oral examination.

Patient case lists must be de-identified in accordance with the requirements of Section 164-514(b)(2)(i)&(ii) of the Final Privacy Rule Standards for Privacy of Individually Identifiable Health Information issued by the Department of Health and Human Services under the Health Insurance Portability and Accounting Act of 1996 (HIPAA). The de-identification requirements are listed below.

The candidate is personally responsible for the proper preparation, de-identified accuracy, and completeness of the case lists.

Falsification of information in the case lists may result in ineligibility to apply for the oral examination for a minimum of three years. The candidate must then meet all requirements in effect at the end of the deferred period. If the falsification is discovered after the candidate has successfully completed the oral examination, the results of the oral examination will be voided, and the candidate's certification will be revoked.

B. Format

The case lists must be accurately printed in landscape layout across unbound sheets of white paper 8.5 X 11 inches in size. Examples of the headings for the individual case lists can be found in Appendix A. The type font must be 10 point. Lists submitted with smaller or larger type will not be accepted. Headings must be included. Three copies of the complete list must be submitted, as well as three copies of the summary sheet(s).

Candidates must list sufficient information for each case to allow the Examiner to understand the care provided. Phrases such as “usual” and “standard” should not be used. All laboratory tests and imaging studies should be listed.

Standard nomenclature should be used. Only approved abbreviations are acceptable. A list of approved abbreviations can be found in Appendix B. The case lists must be submitted in the English language.

Case lists submitted to ABOG will not be returned to the candidate after the examination. The candidate must bring a copy of their case list with them to the oral examination. No notes should be made on that copy of the list.

The American Board of Obstetrics and Gynecology offers a case list collection and reporting software package for the oral examination. Information about the ABOG case list software can be found in the Publications section of the ABOG website (www.abog.org) or phone 214-871-1619.

C. Patients to be listed

Case lists must include all patients admitted to all hospitals and cared for at all surgical centers where the candidate holds admitting and/or surgical privileges between July 1, 2015, and June 30, 2016 (July 31, 2016 if an extension has been granted). The lists must include a minimum of 20 obstetrical and 20 gynecological admissions, but all patients must be listed. This includes all admitted as well as all short-stay and outpatient surgical patients, even if not officially admitted to a hospital. The case lists must demonstrate sufficient numbers, sufficient breadth and sufficient depth of clinical experience. Candidates should not list patients for whom they have only provided a consultation.

The office practice case list is strictly limited to 40 patients. These must be from the candidate's practice between July 1, 2015, and June 30, 2016 (or July 31, 2016 if granted an extension). In rare cases, a fellow may request to use Office Practice cases from the senior year of fellowship. Cases from the senior year of residency may not be used for the Office Practice case list.

Three unbound copies of each of the 3 case lists must be submitted: Obstetrical patients, gynecologic patients, and office practice patients. The patients listed must be only those for whom the candidate has had personal responsibility for professional management and care. In the case of partnership or group practice, the patients listed should be only those managed by the candidate. If some portion of the care was provided by a partner, that care should be indicated on the case list. If the candidate is back-up for a midwifery group, a midwife delivery may not be listed unless the physician actually performed the delivery.

Candidates may not reuse any case or case list from a previous examination.

If the candidate does not perform obstetrical procedures, or if the candidate does not perform gynecologic procedures, the minimum number and types of gynecological or obstetrical cases must be obtained from the additional sources listed below. Regardless of the candidate's current practice or training, the examination will cover all 3 areas. Candidates who limit their practice to outpatient care only will not be eligible to sit for the oral examination.

If, but only if, a minimum of 20 gynecological and 20 obstetrical patients cannot be collected from the candidate's practice during the 12-month period from July 1, 2015, through June 30, 2016, additional cases may be listed, depending on the candidate's current practice and training:

1. Candidates who have been in practice for one year or more

Candidates who have been in practice for one year or more and cannot meet the minimum number of cases between July 1, 2015 and June 30, 2016, have two choices: They can submit a complete 18-month case list beginning January 1, 2015, and ending June 30, 2016 or they may submit a 12-month case list and use cases from their senior year of residency to reach the minimums. If residency cases are used, it is only necessary to add a sufficient number of residency cases to meet the minimum numbers.

Candidates may not use senior resident cases to meet minimum numbers in both the Obstetrics and Gynecology case lists.

If an 18-month list is submitted, one summary sheet for the 18 month period must be submitted.

If a 12-month case list and residency cases are submitted, a separate summary sheet for each list as well as a summary sheet that includes totals for from both lists must be submitted. Residency cases earlier than July 1, 2010 may not be used.

If a candidate cannot meet the minimum number of cases in one area after using an 18 month case list and/or using residency cases, they should email the Director of Examinations. They must describe the reasons why they cannot meet the minimum requirements. The proper ABOG committee will then review the circumstances for the deficiency. The decision of the committee concerning the eligibility of the candidate will be final and cannot be appealed.

2. Candidates currently in fellowship training

Candidates who begin fellowship training in an OB-Gyn related clinical field in July or August 2015 may apply for the Oral Examination as described above, but may not use senior resident cases for more than one of the case lists (Obstetrics or Gynecology).

3. Candidates who have completed fellowship training

Candidates who have completed fellowship training should use cases from their practice. A 12 or 18 month case list may be submitted. If their fellowship training was in a field related to Ob-Gyn they may use cases from their fellowship training if they cannot meet the minimum number of required cases from their practice. Additionally, they may use cases from their senior year of residency training if needed, but may not use senior resident cases for more than one of the case lists (Obstetrics or Gynecology).

D. Specific Instructions for each section of the case list

The headings for case list categories are shown below. The specific instructions for each section follow:

1. Office Practice Case List

The candidate must list a total of 40 patients (no more or fewer) with conditions that fit into the listed Office Practice categories. Follow these rules when listing office practice patients:

- a. Do not list more than two patients in any one category;
- b. It is not necessary to include a patient in every category; and
- c. Do not include any patient that appears on the hospital lists.
- d. Do not include any patients that had procedures performed in any location except the office. Specifically, patients who had an outpatient procedure in a surgical center should be listed on the Gynecology case list.

Office Practice Categories

1. Preventive care and health maintenance
2. Lifestyle counseling (smoking cessation, obesity, diet, exercise, substance abuse)
3. Sexual dysfunction
4. Family planning (contraception including IUD placement, etc.)
5. Genetic counseling
6. Geriatric care
7. Disorders of menstruation (amenorrhea, dysmenorrhea, abnormal uterine bleeding, etc.)
8. Infertility evaluation and management
9. Immunizations
10. Endometriosis: diagnosis and office management
11. Perimenopausal and menopausal care
12. Pediatric and adolescent gynecology
13. PCOS
14. Evaluation and management of acute and chronic pelvic pain
15. Vaginal disease (infections, VAIN, etc.)
16. Vulvar disease (infections, dermatoses, VIN, etc.)
17. Breast disease, benign and malignant
18. Evaluation and office management of urinary and rectal incontinence
19. Urinary tract infections
20. Sexually transmitted infections
21. Uterine myomata
22. Office surgery (biopsy, hysteroscopy, sterilization, LEEP, etc.)
23. Abnormal cytology, colposcopy and CIN
24. Ultrasonography
25. Galactorrhea
26. Hirsutism
27. Benign pelvic masses
28. Sexual assault
29. Domestic violence
30. Office evaluation and management of pelvic floor defects
31. Endocrine diseases (e.g. diabetes mellitus, thyroid or adrenal disease)
32. Major medical diseases (respiratory, gastrointestinal, cardiovascular, hypertension, etc.)
33. Minor medical diseases (Headache, low back pain, irritable bowel, etc.)
34. Medical management of ectopic pregnancy
35. Psychiatric illnesses (depression, anorexia, bulimia, etc.)
36. Diagnosis and management of hypercholesterolemia and dyslipidemias
99. Uncategorized (cases in this category do not count toward the required 40 cases)

List each patient separately and include the problem (one of the categories listed above), diagnostic procedures, treatment, results and number of office visits during the 12-month period. Group patients together under each separate category.

2. Gynecology Case List

A list of all hospitalized and short-stay gynecological patients must be prepared in the required format and listed in order as follows:

- a. List all gynecologic patients managed during the same 12-month period (or 18-month period, if an extended time case list is submitted and/or patients chosen from the fellowship or senior year of residency).
- b. A minimum of 20 gynecologic patients is required, and a candidate cannot count more than two patients from any one of the gynecology categories listed below.

Example, A candidate has 5 patients who had a diagnostic laparoscopy. They all must be reported on the case list, but only 2 of the 5 will be counted as meeting the minimum requirement of 20 gynecological cases.

c. The preoperative diagnosis should appear for all major and minor surgical procedures. The size of ovarian cysts and neoplasms must be recorded. For non-surgical conditions, the admission diagnosis should be recorded. The treatment recorded should include all surgical procedures, as well as primary non-surgical therapy. "Surgical diagnosis" is the final pathology diagnosis. For hysterectomy specimens, the uterine weight in grams must be recorded. In cases without tissue for histologic diagnosis, the final clinical diagnosis should be listed.

d. "Days in hospital" is the arithmetic difference between the date of discharge and the date of admission. Specific dates of admission and discharge must not be provided. If a patient had an outpatient procedure and was not admitted, list the number of days in hospital as "0."

e. Group patients together under each separate category, then list any remaining patients that do not fit into any of the listed categories.

Gynecology Categories

1. Abdominal hysterectomy, any type (e.g. total, subtotal, laparoscopic, robotic)
2. Laparotomy
3. Vaginal hysterectomy (including laparoscopically assisted)
4. Diagnostic laparoscopy
5. Operative laparoscopy (other than tubal sterilization and hysterectomy)
6. Operative hysteroscopy
7. Uterine myomas
8. Repair of pelvic floor defects; prolapse
9. Endometriosis and adenomyosis: surgical management
10. Tubal sterilization
11. Invasive carcinoma
12. Urinary and fecal incontinence: operative management
13. Ectopic pregnancy: surgical management
14. Operative management of pelvic pain
15. Congenital abnormalities of the reproductive tract
16. Pelvic inflammatory disease
17. Adnexal problems (excluding ectopic pregnancy and PID)
18. Abnormal uterine bleeding
19. Surgical management of VIN, CIN and VAIN
20. Postoperative complications (hemorrhage, wound, urinary tract, GI, Pain, thrombotic, embolic, neurologic, fever, etc.)
21. Management of rectovaginal or urinary tract fistula
22. Preoperative evaluation of coexisting conditions (respiratory, cardiac, metabolic diseases)
23. Gestational trophoblastic disease
24. Incomplete, septic, complete and other abortion
25. Intraoperative complications (e.g. blood loss, hemorrhage, bowel injury, urinary tract injury)
26. D&C
27. Emergency care
99. Uncategorized (cases in this category do not count toward the required 20 cases)

3. Obstetrics Case List

A list of a minimum of 20 obstetrical patients must be prepared in the required format. List separately each patient with a complication or abnormality, as well as medical and surgical intervention during pregnancy, labor, delivery and the puerperium. In addition, a total of the number of normal, uncomplicated obstetrical patients managed during the same 12-month period (or 18-month period, if an extended time case list is submitted) should appear on the obstetrical summary sheet and at the beginning of the obstetrical list. These normal, uncomplicated obstetrical patients should not be listed individually.

The term "normal obstetrical patient" for this listing implies that the:

- a. pregnancy, labor, delivery and the puerperium were uncomplicated, and labor began spontaneously between the 39th and 41st week of gestation; patients delivering between 37wks and 38 wk 6 days should be individually listed in the "late preterm" category;
- b. membranes ruptured or were ruptured after labor began;
- c. presentation was vertex, position was occiput OA, LOA or ROA, and labor was less than 24 hours in duration;
- d. delivery was spontaneous or by outlet forceps or vacuum with or without episiotomy, from an anterior position;
- e. the infant had a five minute Apgar score of 6 or more and weighed between 2500 and 4500 gms and was healthy; and
- f. placental delivery was uncomplicated and blood loss was less than 500 mL.

All deliveries not fulfilling these criteria must be listed individually. Include the gestational age at admission.

A minimum of 20 obstetrical patients is required, and a candidate cannot count more than two patients in any of the categories listed below.

Example: A candidate has 5 obstetrical patients with diabetes mellitus. They all must be reported on the case list, but only 2 of the 5 will be counted as meeting the minimum requirement of 20 obstetrical cases.

Group patients together under each separate category listed below, then list the remaining patients who do not fit into a specific category.

If the candidate is back-up for a midwifery group, a midwife delivery may not be listed unless the physician actually performed the delivery.

The "days in hospital" includes all prenatal and postnatal days. The number of days listed is the arithmetic difference between the admission and discharge date.

Obstetrical Categories

1. Preconception evaluation, prenatal and genetic diagnoses
2. Ultrasonography
3. Premature labor
4. Premature rupture of fetal membranes at term
5. Preterm premature rupture of fetal membranes
6. Cerclage
7. Preterm delivery (before 37 weeks gestation)
8. Late preterm (37 weeks 0 days to 38 weeks 6 days gestation)
9. Post term pregnancy and delivery
10. Induction and augmentation of labor
11. Labor abnormalities (including dystocia)
12. Fetal heart rate abnormalities (e.g. variable or late deceleration, absent or poor variability, tachycardia, bradycardia)
13. Breech and other fetal malpresentations
14. Cord problems (e.g. prolapsed cord, cord entanglement)
15. Operative vaginal delivery (e.g. vacuum, forceps)
16. Obstetrical hemorrhage (e.g. antepartum, intrapartum, postpartum)
17. Obstetrical vaginal lacerations (e.g. 3rd and 4th degree lacerations cervical laceration)
18. Vaginal or perineal hematoma
19. Primary cesarean delivery

20. Repeat cesarean delivery
21. Vaginal birth after cesarean delivery
22. Cesarean hysterectomy
23. Complications of cesarean delivery (e.g. hemorrhage, wound infection, disruption or hematoma)
24. Complications of OB anesthesia (e.g. epidural hypotension, general anesthesia complications)
25. Intrapartum or intra-amniotic infection (e.g. amnionitis, chorioamnionitis)
26. Puerperal infection (e.g. post cesarean endometritis)
27. Second trimester spontaneous abortion
28. Third trimester fetal loss
29. Hypertensive disorders of pregnancy (chronic hypertension, preeclampsia, eclampsia)
30. Cardiovascular or pulmonary disease complicating pregnancy
31. Renal or neurological disease complicating pregnancy
32. Hematological or endocrine diseases complicating pregnancy
33. Autoimmune disorders of pregnancy
34. Infectious diseases (HIV, Group A streptococcus, etc.)
35. Psychiatric disease complicating pregnancy
36. Pregnancies complicated by human immunodeficiency virus infection (HIV)
37. Abnormal fetal growth
38. Pregnancies complicated by fetal anomalies
39. Placental abnormalities (e.g. low lying, previa, abruption)
40. Thromboembolic complications
41. Trauma in pregnancy (e. g. automobile accidents)
99. Uncategorized (cases in this category do not count toward the required 20 cases)

If, but only if, a candidate cannot list 20 obstetrical cases in the above categories, an 18-month case list and/or an appropriate number of cases from fellowship or senior residency case logs may be included. If senior resident cases are used, only list 20 cases.

E. Affidavits

Each list of gynecology and obstetrics patients from each hospital and surgical center must be verified on the appropriate affidavit form. The record librarian or similar hospital official must submit a statement attesting that (1) the patients listed were cared for by the candidate, and (2) that all of the hospitalized patients dismissed from the candidate's care have been separately listed or reported in the totals for the period indicated. For cases chosen from the fellowship or senior residency year, the affidavit must be obtained from the candidate's Program Director or the medical records librarian.

F. Summary Sheet

Candidates must submit summary sheets as follows:

1. Candidates in practice submitting either a 12 month or an 18 month case list only must include a summary sheet listing all of their patients during the collection time period.
2. Candidates in practice who submit cases from practice and cases from fellowship and/or residency must submit a summary sheet for each (practice, fellowship and/or residency) as well as a combined summary sheet showing the total of all cases from all sources.
3. Candidates using cases from fellowship only must include a summary sheet showing cases from fellowship.

G. Case List Verification and Audit

The list of patients provided by the candidate is subject to independent verification and audit by an agent or employee of ABOG. As a condition of candidacy, the candidate agrees to cooperate fully with any audit authorized by the Board, including, but not limited to:

1. providing full and unrestricted access to the candidate's office records of patients for whom the candidate had personal responsibility for professional management and care during the period for which the lists of patients are required;

2. authorizing access to such hospital or other institutional records as the ABOG deems necessary, in its absolute discretion, to verify the completeness and accuracy of the patient lists submitted by the candidate; and
3. using the candidate's best efforts to obtain, where necessary and possible, written patient consent to release to the Board information concerning the patient's condition and treatment.

Any audit undertaken by the Board pursuant to the authority granted by this Section shall be conducted in compliance with the HIPAA Privacy Rule.

H. De-Identification of Patient Case Lists

1. General

Secretary of the DHHS issued a Final Privacy Rule (HIPAA Privacy Rule) governing the terms and conditions by which health care providers can make available individually identifiable health information. The HIPAA Privacy Rule permits the release of patient information if the information does not permit the patient to be individually identified. Therefore, candidates must exclude from the case lists submitted to the Board such information as could permit the identification of an individual patient.

2. De-Identification of Patient Case Lists Requirements

The HIPAA Privacy Rule enumerates the categories of information that must be removed from patient case lists prior to submission to the Board.

Section 164.514(b) provides that health information is not individually identifiable if the following identifiers are removed:

- a. Names;
- b. Geographic subdivisions smaller than a state;
- c. Dates related to an individual (except year);
- d. All ages over 89. Patients aged 90 or older should be listed without an age, but in the appropriate category;
- e. All of the following numbers and addresses: telephone, fax, e-mail, social security, medical record, health plan, beneficiary, account, certificate, and license; and
- f. Any other unique identifying number, characteristic, or codes.

3. Warning Concerning Omissions

The de-identification of patient case lists does not allow the omission of any patients under the candidate's care which are otherwise required to be reported. The completeness of the candidate's case list is subject to audit. Any effort to use the HIPAA privacy rule to mislead the Board as to the breadth and depth of the candidate's practice, the numbers of patients or the outcome of treatment will subject the candidate to disqualification from examination and other discipline as appropriate.

IX. Final Approval and Notification of Admission to the Oral Examination

Candidates who have fulfilled all the requirements, and the Board has determined that they are eligible to sit for the examination will receive an email notifying them of the day, time and place to report for their examination. The email will also include a link that will allow them to make hotel reservations. Candidates will not receive the ABOG discounted hotel rate unless they make their reservations after they have received the hotel link. This information will be sent at least one month prior to the examination.

The candidate must make hotel reservations by calling the hotel. It is strongly recommended that all candidates stay at the hotel where the registration for the oral examination is held.

It is the candidate's responsibility to ensure that addresses, both email and physical, are current and correct.

Candidates may NOT request a specific month for their test unless there is a serious reason that is out of the control of the candidate such as military deployment or a pregnancy complication. Any request must be accompanied by documentation. Such requests must be received in the ABOG office no later than May 1, 2016. ABOG reserves the right to deny any such request. Once ABOG has assigned a test week, no change request can be honored.

X. New Diplomates

After passing the Oral Examination, each new Diplomate is required to apply for and enter the Maintenance of Certification (MOC) process. The MOC application is on-line at www.abog.org. There is no charge for the first year of MOC for new Basic ABOG Diplomates. Failure to enter the process and complete all assignments will result in loss of certification status as of December 31, 2016.

For more information about the MOC process, please read the *MOC Bulletin* which can be found at www.abog.org in the Downloads category.

XI. Non-Admissible Candidates, Re-Examination and Postponement

A candidate disapproved for the oral examination may reapply by submitting a new application, paying the appropriate fees, and meeting the requirements applicable at the time of the re-application.

XII. Oral Examination Appeal Process

If, at the completion of the oral examination, a candidate believes the examination has not been conducted in a fair and unprejudiced manner, a second examination may be requested. The request must be made within one hour of the completion of the oral examination. To do so, a candidate must telephone the Board office (214-871-1619).

If the request is granted:

- A. the results of the appealed examination, regardless whether pass or fail, will be discarded;
- B. the candidate must reapply for the oral examination the next year (i.e., cannot delay beyond the next year) and meet all of the requirements applicable at that time;
- C. if the candidate meets the requirements, a second examination will be scheduled at the next regularly scheduled annual oral examinations at no additional charge;
- D. the candidate must prepare a new case list for the repeat examination;
- E. the repeat examination will be conducted by a different team of examiners, who will not be informed that the examination is being conducted as a result of an appeal;
- F. neither the questions nor the candidate's answers on the first examination will be known to or taken into account by the second group of examiners; and
- G. the decision of the examiners conducting the second examination will be used by the Board to determine the results of the candidate's oral examination.

Appeals based on the composition of the oral examination team shall not be considered if the candidate was informed before the oral examination of the identity of each member of the team and did not object to the participation of any member in time for an acceptable substitute to be provided.

Appeals based on the content of the examination, the sufficiency or accuracy of the answers given, or the final grade will not be considered.

XIII. List of Certified Diplomates

Each year the Board office notifies the American College of Obstetricians and Gynecologists and the American Congress of Obstetricians and Gynecologists of the names and addresses of the Diplomates certified in that year. A list of the names is also sent to the American Board of Medical Specialties with the request that they be included in the next issue of the Directory of Certified Obstetrician-Gynecologists. Diplomate status may also be provided to other organizations, government agencies and the lay public. Candidates must sign a statement acknowledging this fact at the time of the oral examination.

After this effort to assure initial listings of the newly certified Diplomates, the Board assumes no responsibility for a Diplomate's listing in subsequent issues of any directory.

The results of the oral examination may also be forwarded to the candidate's residency program and/or the American College of Graduate Medical Education (ACGME). De-identified results of the oral examination may be used by ABOG for research purposes.

Appendix A: Case List Headings

Gynecological Case List Forms

LIST OF GYNECOLOGICAL PATIENTS*						<input type="checkbox"/> Post Residency Cases	<input type="checkbox"/> Senior Residency Cases	<input type="checkbox"/> Fellow ship Cases		
#	H O S P #	P A T #	A G E	G R A V	P A R A	DIAGNOSIS PREOPERATIVE OR ADMISSION	TREATMENT	SURGICAL PATHOLOGY DIAGNOSIS (Uterine Wt. in gms.)	COMPLICATIONS (Include blood transfusions)	Days In Hosp. (Not Dates)
I. Gynecological Categories (1-99)										
II. Total number of <u>ultrasound</u> and <u>Color Doppler Examinations</u> performed by you upon hospitalized gynecological patients _____										

Obstetrical Case List Forms

LIST OF OBSTETRICAL PATIENTS*							<input type="checkbox"/> Post Residency Cases	<input type="checkbox"/> Senior Residency Cases	<input type="checkbox"/> Fellow ship Cases					
#	H O S P #	P A T #	A G E	G R A V	P A R A	Gest Age	COMPLICATIONS		Operative Procedures And/or Treatment	Days In Hosp. (Not Dates)	NEWBORN			
							Antepartum	Delivery or Postpartum			Perinatal Death	Wgt	APGAR 1 & 5 Minutes	Days In Hosp. (Not Dates)
I. Number of Uncomplicated Spontaneous Deliveries _____														
II. Obstetrical Categories (1-99)														
III. Total number of <u>ultrasound</u> and <u>Color Doppler examinations</u> performed by you upon hospitalized obstetrical patients _____														
IV. Total number of:														
A. APGAR scores 5 or less _____														
B. Infants < 2500 gms _____														
C. Perinatal Deaths _____														

Office Practice Case List Forms

LIST OF OFFICE PRACTICE PATIENTS*								
#	A G E	G R A V	P A R A	PROBLEM	DIAGNOSTIC PROCEDURES	TREATMENT	RESULTS	No. of Visits
I. Office Practice Categories (1-99)								
II. Total Number of <u>Ultrasound</u> and <u>Color Doppler Examinations</u> in:								
A. Obstetrical patients _____								
B. Gynecological patients _____								
C. Other areas such as abdominal, thoracic, pediatric, etc. _____								

*Patients' names, initials, and hospital names must not be used. Patients who are over 89 years of age must not have their age listed.

refers to a sequential ordering which is assigned by the computer for ALL patients from all hospitals, i.e., 1-xxx.

Hospital # refers to the sequential ordering of hospitals being reported from, i.e., Hospital A = First hospital from which patients are being reported;
Hospital B = Second hospital from which patients are being reported;
Hospital C = Third hospital from which patients are being reported.

Patient # refers to a sequential ordering of patients reported from a given hospital, e.g., Hospital A, patients 1-x; Hospital B, patients 1-xx.

Appendix B: Acceptable Case List Abbreviations

A&P	Repair-Anterior and posterior colporraphy
AB	Abortion
AIDS	Acquired immune deficiency syndrome
ASCUS	Atypical cells of undetermined significance
BSO	Bilateral salpingo-oophorectomy
BTL	Bilateral tubal ligation
CBC	Complete blood count
CD	Cesarean delivery
CIN	Cervical intraepithelial neoplasia
Cm	Centimeter
CT	Computerized tomography
D&C	Dilatation and curettage
D&E	Dilatation and evacuation
DEXA	Dual-energy x-ray absorptiometry
DHEAS	Dihydroepiandrosterone sulfate
DVT	Deep vein thrombosis
E	Estrogen
E2	Estradiol
EKG/ECG	Electrocardiogram
FSH	Follicle-stimulating hormone
GDM	Gestational diabetes mellitus
gm	Gram
HIV	Human immunodeficiency virus
HCG	Human chorionic gonadotropin
HPV	Human papillomavirus
HRT	Hormone replacement therapy
HSV	Herpes simplex virus
IM	Intramuscular
IUGR	Intrauterine growth restriction
IV	Intravenous
IUD	Intrauterine device
kg	Kilogram
LAVH	Laparoscopic assisted vaginal hysterectomy
LEEP	Loop electrosurgical procedure
LH	Luteinizing hormone
MRI	Magnetic resonance imaging
P	Progesterone
PAP	Papanicolaou smear
PPH	Postpartum hemorrhage
PROM	Premature rupture of membranes
PTL	Preterm labor
SAB	Spontaneous abortion
SROM	Spontaneous rupture of membranes
STD/STI	Sexually transmitted disease/infection
SVD	Spontaneous vaginal delivery
T	Testosterone
TAH	Total abdominal hysterectomy
TSH	Thyroid-stimulating hormone
TVH	Total vaginal hysterectomy
VBAC	Vaginal birth after cesarean delivery

Appendix C: Basic Oral Examination Topics

Obstetrics

Preconception/Antenatal Care

- Routine prenatal care (diet; life style; habits)
- Counseling
 - Genetic
 - Teratogenesis
 - Exercise
- Complications
 - Nausea and vomiting; hyperemesis
 - Early pregnancy loss
 - 2nd and 3rd trimester losses
 - Multifetal gestation
 - Hypertensive disorders unique to pregnancy
 - Pre-eclampsia
 - Eclampsia
 - Infectious diseases
 - HIV
 - Group A streptococcus
 - Misc. (varicella, pyelonephritis, CMV, toxoplasmosis, parvovirus, etc.)
 - Coexistent medical diseases
 - Cardiovascular
 - Chronic hypertension
 - Pulmonary
 - Renal
 - Gastrointestinal
 - Hematologic
 - Endocrine (includes thyroid)
 - Autoimmune (includes DM)
 - Neoplastic
 - Misc. (dermatologic, neurologic, etc.)
 - Surgical conditions (acute abd., adnexal & breast masses, etc.)
 - Psychiatric disorders
- Fetal assessment/Prenatal diagnosis
 - Abnormal fetal growth
 - Anomalies
 - Ultrasound
 - Abnormalities of AFV
 - Indications for testing
 - Isoimmunization

Intrapartum Care

- Normal
 - Induction and augmentation
 - Fetal monitoring (normal)
 - Term ROM

Abnormalities of labor

- Preterm labor and delivery
- Post-term
- Preterm ROM
- Fetal monitoring (abnormal)
- Dystocia
- Malpresentations (breech, face, brow, etc.)
- Cord problems (prolapse, knot, entanglement, etc.)
- Infections (chorioamnionitis, mastitis, etc.)
- Hemorrhage
 - Antepartum
 - Intrapartum
 - Postpartum
 - Coagulopathy (various causes)
- Thrombosis/Embolism

Operative

- Cesarean (primary, repeat, emergency, hysterectomy, VBAC)
- Forceps
- Vacuum
- Wound complications
- Complications of operative delivery
- Episiotomy and tears (perineal, cervix, vagina, vulva, hematoma)
 - Prevention
 - Repair
- Placental complications
 - Abruption
 - Previa
 - Accreta/percreta
- Anesthesia
- Immediate care of the newborn

Postpartum care

- Routine (includes lactation)
- Endomyometritis
- Other infections (mastitis, infected repairs, etc.)

Non-obstetric emergencies

- Trauma (MVA, etc.)

Gynecology

Diagnostic

- Ultrasonography
- D&C
- Diagnostic Laparoscopy
- Diagnostic Hysteroscopy

Preoperative Evaluation

- Routine evaluation
- Co-existing medical conditions (DM, CV, Pulm, thrombophilias, etc.)
- Psychiatric conditions
- Geriatric

Surgical Management

- Non-infectious benign conditions
 - Vulvovaginal/cervical (VIN, CIN, VAIN, masses, etc.)
 - Uterine (myomas, AUB, hyperplasia, etc.)
 - Tubal (ectopic, infertility, sterilization, etc.)
 - Adnexal masses
 - Pelvic relaxation (cystocele, rectocele, prolapse, etc.)
 - Fistulae (all)
 - Endometriosis and adenomyosis
 - Urinary and fecal incontinence
 - Pelvic pain
 - Acute (torsion, appendicitis, etc.)
 - Chronic (endometriosis, etc.)
- Infectious conditions
 - PID (salpingitis, tubo-ovarian abscess, TB, etc.)
 - Abscesses
- Pregnancy-associated
 - Spontaneous, complete, incomplete abortion (1st and 2nd trimester)
 - Benign trophoblastic disease
- Congenital anomalies (reproductive tract)

Surgical Procedures

- Minor
 - Operative Laparoscopy (including sterilization)
 - Operative Hysteroscopy
 - D&C
- Major
 - Hysterectomy (with and without oophorectomy)
 - Vaginal
 - Abdominal
 - Laparoscopic (total and LAVH)
 - Robotic
 - Pelvic floor repairs
 - Prolapse
 - Incontinence
 - Other repairs
 - Laparotomy

Surgical complications

- Hemorrhage
- Bowel injury (small and large)
- Urinary tract injury

Neoplasia

- Vulva & vagina
- Cervix
- Uterus
- Tube
- Ovary
- GTN
- Breast

Postoperative care and complications

- Routine (orders, diet, etc.)
- Embolism (including prevention)
- Gastrointestinal
 - Injury
 - Ileus
 - SBO
- Necrotizing fasciitis
- Wound
 - Normal care
 - Infection
 - Dehiscence
- Urinary tract
 - UTI
 - Fistulae
- Neurologic
- Fever
- Pain

Emergency Care

Office Practice / Women's Health

Routine care

- Age-appropriate screening
- Immunizations
- Lifestyle counseling (obesity, smoking, exercise, substance abuse, etc.)
- Perimenopause and menopause
- Family planning
 - Contraception
 - Sterilization
- Pediatric and Adolescent Care
 - Congenital anomalies
 - Menstrual disorders
 - Psychosocial
- Geriatric Care
- Obesity
- Genetic counseling (non-pregnancy related, eg BRCA)

Medical problems

- Breast disorders
 - Imaging
 - Benign
 - Malignant
- UTI
- Major diseases
 - CV (includes hypertension, MI, etc.)
 - Pulmonary
 - Gastrointestinal
 - Thrombophilias
 - Autoimmune (DM, lupus, etc.)
 - Endocrine (thyroid, adrenal)
 - Dyslipidemias
 - Osteopenia and osteoporosis
- Minor diseases
 - Headache
 - LBP
 - Irritable bowel
 - Arthritis
 - Bronchitis
- STI's
 - HIV
 - Syphilis
 - GC
 - Other

Gynecologic-specific disorders

- Endocrine
 - Primary and secondary amenorrhea
 - PCOS
 - Galactorrhea
 - Hirsutism

- Infertility (any cause)
 - Evaluation
 - Office treatment (clomid, etc.)
 - Other disorders of menstruation (AUB, PMS, migraine, dysmenorrhea, etc.)
- Vulvar conditions
 - Infectious diseases
 - VIN
 - Dermatoses (ulcers)
 - Chronic pain
- Vaginal conditions
 - Discharge
 - Septae
 - VAIN
- Cervix
 - Abnormal cytology
 - CIN (dysplasia, CIS)
 - Colposcopy
 - Infectious disease
 - Incompetence
- Uterus
 - Myomas
 - Polyps
 - Hyperplasia
- Ovary
 - Cystic masses
 - Solid masses
- Pelvic pain
 - Acute
 - Chronic
- Endometriosis
- Incontinence and pelvic floor defects
 - Bladder
 - Rectum
 - Prolapse
- Early pregnancy loss (spontaneous, recurrent)
- Other benign pelvic masses
- Reproductive tract cancer
 - Vulva
 - Cervix
 - Uterus
 - Ovary

Psychosocial

- Sexual dysfunction
- Domestic violence
- Sexual assault
- Psychiatric disorders (depression, eating disorders, etc.)
- LGBT issues
- Psychosomatic disorders

Office procedures

LEEP

Essure

IUD

Biopsies (vulva, vagina, cervix, endometrium, etc.)

Hysteroscopy

Ultrasonography

Cross Content**Basic science**

Physiology

Anatomy

Pathology

Microbiology

Immunology

Embryology

Pharmacology

Genetics

Ethics and professionalism**Epidemiology and evidence-based medicine****Systems-based practice****Patient safety****Communication (patients and peers) and Health Literacy**