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Mission Statement

Our mission at the University of Wisconsin, Department of Obstetrics and Gynecology, is to improve the quality of life for women in the state of Wisconsin and beyond by providing compassionate high quality patient care and by advancing knowledge through research, education and advocacy. We do so in an environment of collaboration, humility, integrity and respect.

Department Vision

- We will transform our department to support excellence in patient-centered care, service and advocacy for women’s reproductive health beyond existing structures and boundaries.
- We will provide a comprehensive educational experience motivating our medical students, graduate students, residents, and fellows to be lifelong learners in the field of women’s health.
- We commit to full departmental collaboration, integration and support to achieve outstanding basic, clinical and translational research.
- We will recruit, develop and retain departmental members to promote individual and collective success in the Department of Obstetrics and Gynecology, University of Wisconsin School of Medicine and Public Health.

Residency Program Mission

"To train outstanding obstetricians-gynecologists capable of becoming leaders in our field.”
Who is Who

Educational Programs Organization Chart

Department Chair: Dr. Laurel Rice

Vice Chair
Education: Dr. Ellen Hartenbach

Education Committee: Dr. Laura Sabo, Chair

Gyn Onc Fellowship Director: Dr. Steve Rose
- Fellowship Coordinator: Lori Lewis

MFM Fellowship Director: Dr. Dinesh Shah
- Fellowship Coordinator: Emily Mowry

Simulation Lab Director: Dr. Brent Dumermuth

Residency Program Director: Dr. Ellen Hartenbach
- Associate Program Director Clinical Education: Dr. Ryan McDonald
- Associate Program Director Academic Education: Dr. Jackie Ogutha
- Resident Continuity Clinic Director: Dr. Cynthie Anderson

Medical Student Clerkship Director: Dr. Kathy Stewart
- Program Coordinator: Janet Short

MFM Fellowship Coordinator: Emily Mowry

Gyn Onc Fellowship Coordinator: Lori Lewis

Fellowship Coordinator: Emily Mowry

Resident Continuity Clinic Director: Dr. Cynthie Anderson

Education Programs Manager Dr. John Street

MFM Fellowship Coordinator: Emily Mowry

Medical Student Interest Group Coordinator: Dr. Mary Landry

Education Programs Manager Dr. John Street

Program Coordinator: Janet Short

Medical Student Interest Group Coordinator: Dr. Mary Landry

Administrative Assistant: Beckie Schimelpfenig

Education Programs Manager Dr. John Street

Program Coordinator: Janet Short

Medical Student Interest Group Coordinator: Dr. Mary Landry

Administrative Assistant: Beckie Schimelpfenig
Departmental Faculty and Committees

Chair
Laurel W. Rice, MD

Leadership
Laurel W. Rice, MD
Klaus Diem, MD, Vice-Chair of Clinical Operations and Finance
Ellen Hartenbach, MD, Vice-Chair of Education and Faculty Development
Ronald Magness, PhD, Vice-Chair of Research
Jennifer Stevens, MPA, CPA, Administration

Executive Committee -Bold - Tenured
David Abbott, PhD      Brenda Jenkin, MD      Laurel Rice, MD
Greg Bills, MD         David Kushner, MD      Stephen Rose, MD
Ian Bird, PhD          Doug Laube, MD         Laura Sabo, MD
Klaus Diem, MD         Dan Lebovic, MD         Maria Sandgren, MD
Theresa Duello, PhD    Ronald Magness, PhD    Gloria Sarto, MD, PhD
Thaddeus Golos, PhD    Kim Miller, MD         Dinesh Shah, MD
Ellen Hartenbach, MD   Barbara O'Connell, MD  Katharina Stewart, MD
Joel Henry, MD         Manish Patankar, PhD    Jing Zheng, PhD

Division Directors
General Obstetrics and Gynecology          Greg Bills, MD
Benign Gynecology                          Klaus Diem, MD
Gynecologic Oncology                       David Kushner, MD
Maternal Fetal Medicine                    Dinesh Shah, MD
Reproductive Endocrinology and Infertility Dan Lebovic, MD
Reproductive Sciences                      Ronald Magness, PhD

Administration and Personnel
Ahmed Al-Niaimi, MD           Gloria Frane           Nicholas Schmuhl
Mary Jo Baumann, APNP         Mary Grummer           Jennifer Stevens, MPA, Co-Chair
Chad Craighill               Jay Lick, MD, Chair     Cheri Verdecchia
Sam Creydt                   Beth Koerber           Jessica Wirkus, APNP

Clinical Operations Committee
Eliza Bennett, MD            Terri Michael, APNP    Mindy Rose, APNP
Meghan Fitzgerald, APNP      Kim Miller, MD, Co-Chair  Amy Ruffin
Joel Henry, MD, Chair        Megan Ogden, MD        Aimee Tobin
Igor Iruretagoyena, MD       Kristen Sharp, MD

Education Committee
Dobie Giles, MD              Catherine Hubbard, NP   Barbara O'Connell, MD
Ellen Hartenbach, MD         Maria Katsoulishis      Jacqueline Ogutha, MD, Co-Chair
Mary Landry, MD              Doug Laube, MD          Laura Sabo, MD, Chair
Jay Lick, MD                 Ryan McDonald, MD
Beckie Schimelpfenig, Kathy Stewart, MD, Ryan Spencer, MD
Janet Short, John Street, PhD

**Faculty Development Committee**
Dave Abbott, PhD, Chair, Maria Sandgren, MD
Cynthie Anderson, MD, Doug Laube, MD, Chanel Tyler, MD, Co-Chair
Sarah Bradley, MD, Ron Magness, PhD, Julianne Zweifel, PhD
Christy Broadwell, MD, Lezli Redmond, MPH

**Finance Committee**
Greg Bills, MD, Co-Chair, David Kushner, MD, Teri Ott
Klaus Diem, MD, Chair, Dan Lebovic, MD, Dinesh Shah, MD
Brent Dumermuth, MD, Kim Miller, MD, Jennifer Stevens, MPA, CPA
Ellen Hartenbach, MD – ex-officio, Barbara O’Connell, MD, Megan Ogden, MD

**Ob-Gyn Quality Internal Review Committee (QIRC)**
Greg Bills, MD, Ryan McDonald, MD, Jennifer Stevens, MPA, CPA
Igor Iruretagoyena, MD, Kim Miller, MD, Aimee Tobin
Brenda Jenkin, MD, Stephen Rose, MD, Chair

**Research and Development Committee**
Cynthie Anderson, MD, Ronald Magness, PhD, Dinesh Shah, MD, co-chair
Lisa Barroilhet, MD, Teri Ott, Katharina Stewart, MD
Igor Iruretagoyena, MD, Manish Patankar, PhD, chair, Sarah Stewart
Dan Lebovic, MD, Gloria Sarto, MD, PhD, Jing Zheng, PhD

**Residency Program Director**--Ellen Hartenbach, MD
**Associate Residency Program Directors**--Ryan McDonald, MD, Jacqueline Ogutha, MD
**Arboretum Resident Clinic Director**--Cynthie Anderson, MD, MPH
**Medical Student Clerkship Director**--Katharina Stewart, MD

**Resident Research Committee**
Ian Bird, PhD, Manish Patankar, PhD, Chanel Tyler, MD
Ellen Hartenbach, MD, Laura Sabo, MD
Ron Magness, PhD, Dinesh Shah, MD

**Residency Program Evaluation Committee (PEC)**
Ellen Hartenbach, MD, chair, Ryan McDonald, MD, John Street, PhD
Maria Katsoulidis, Jacqueline Ogutha, MD, Chief Resident(s)
Clinical Competency Committee (CCC)

Kristine Bathke, MD  Brenda Jenkin, MD  Laura Sabo MD, Chair
Brent Dumermuth, MD  Dave Kushner, MD  Kate Sample, MD
Ellen Hartenbach, MD  Mary Landry, MD  Dinesh Shah, MD
Ryan McDonald, MD, Co-Chair  Jackie Ogutha, MD  Laura Berghahn MD

The functions of the CCC are:

- Assist the program director in monitoring the competence and professionalism of residents for the purpose of promotion and certification. Make recommendations to the program director with regard to: Advancement & Promotion, Discipline, Dismissal, Remediation, Certification
- Synthesize multiple different types of assessments into an evaluative statement about each resident’s competence.
- Provide assessment of resident performance as required by the ACGME and ABOG.
- Identify residents who are not progressing with their peers in one or more areas. The CCC is charged with establishing thresholds within the program. The CCC will use data garnered from assessment tools and faculty observations to assess resident progress in achieving the ACGME Educational Milestones for Obstetrics and Gynecology.
- Provide a group perspective on the residents’ progress in the residency program and will assist in early identification of areas of needed improvement. The CCC will make recommendations for struggling residents.
- Regularly discuss and consider issues that can affect resident performance, including, but not limited to: Inadequate rest, Stress, Anxiety, Depression, Substance abuse
- Fairly, consistently, and indiscriminately apply the Ob/Gyn Department and the UW GME office policies regarding disciplinary action, appeals, and grievances. Committee members may be asked by the Department Chair to participate in the appeals process.
- Make recommendations to the program on issues related to core competencies in resident education, including, but not limited to: Rotation curricula, Evaluation and assessment tools, Development of Milestones.

The functions of the PEC are:

- Discuss and consider issues that impact the teaching and learning environment, resident satisfaction, faculty satisfaction, and overall effectiveness of the training program
- Annually review the program using evaluations of faculty, residents, graduates and health professionals affiliated with the residency program and teaching services
- Assure that all ACGME standards are being met
- Develop and revise competency-based curriculum goals and objectives
- Review and develop additional competency based goals and objectives as appropriate
- Make recommendations to the program on issues related to core competencies in resident education, including, but not limited to rotation curricula.
- To review the program in terms of resident performance, graduate performance, faculty development, program quality
- Develop a plan for addressing deficiencies found during the annual review
The Accreditation Council for Graduate Medical Education (ACGME)

The Accreditation Council for Graduate Medical Education is a private, nonprofit council that evaluates and accredits residency programs in the United States. The mission of the ACGME is to improve health care by assessing and advancing the quality of resident physicians' education through exemplary accreditation.

Core Competencies, Education & Duties

Educational Goals

The University of Wisconsin Obstetrics and Gynecology Training Program endeavors to train compassionate professionals who have a comprehensive medical knowledge base of the specialty, can translate that knowledge into effective patient care, and communicate effectively with patients, their families and the healthcare team. We hope to train "lifelong learners" who will continually strive to improve their own practice, and who effectively use system resources for the benefit of their patients.

The ACGME has termed these goals the “Competencies” of Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and Systems-Based Practice. We will make an effort to not only teach, but also to evaluate these competencies.

Core Competencies

MEDICAL KNOWLEDGE (MK)
This is evidenced by a command of established and evolving knowledge in the biomedical, clinical and social sciences in the field of Ob-Gyn, and the application of that knowledge to the care and education of others.

This includes:

- an open-minded and analytical approach to acquiring new knowledge,
- the ability to access and critically evaluate current basic and clinical information and medical evidence, using the principles of evidence-based medicine,
- a lifelong commitment to daily learning in adherence to the principles of ABOG.

PATIENT CARE (PC)
The goal is to consistently deliver compassionate, appropriate and effective patient care. This includes the ability to:

- gather accurate, essential information from all sources,
- make informed recommendations about diagnostic and therapeutic options that are based on scientific evidence, clinical judgment and patient preference,
- develop, negotiate and implement effective plans for patient care,
- perform competently the diagnostic and surgical procedures common to the specialty.
PRACTICE-BASED LEARNING AND IMPROVEMENT (PBLI)
Also known as "reflective practice", this involves the ability to investigate, evaluate and improve patient care practices. Necessary tools include a sufficient understanding of information technology and other methodologies to access and manage information, and to support patient care decisions and their implementation.

Included in "reflective practice":

- a willingness to acknowledge and learn from one’s own mistakes,
- a commitment to analyze and evaluate processes that may result in medical errors,
- consistent efforts to continually improve patient care.

INTERPERSONAL AND COMMUNICATION SKILLS (ICS)
These skills enable physicians to establish and maintain therapeutically effective relationships with patients, their families and other members of the healthcare team.

Good communication skills include:

- effective listening, nonverbal, questioning and narrative skills,
- interaction with colleagues and consultants in a respectful and appropriate manner,
- maintenance of thorough, comprehensive patient “sign-out” practices,
- timely maintenance of complete and legible medical records.

PROFESSIONALISM (P)
This term defines characteristics that reflect a commitment to ethical practice, an understanding and sensitivity to diversity, a commitment to self improvement and the education of others, and a responsible attitude towards patients, the profession of Ob-Gyn and society.

Included is the ability to:

- behave with respect, compassion and altruism in all relationships,
- show commitment to the teaching of medical students, junior residents and support staff,
- demonstrate sensitivity and responsiveness to culture, religion, beliefs, sexual preferences, socioeconomic status, disability and behavior of co-workers and patients,
- be able to justify positions on medical ethics based on the underlying principles of non-malfeasance, beneficence and autonomy,
- adhere to principles of confidentiality, integrity and informed consent,
- identify and tactfully confront and remediate deficiencies in the performance of peers.

SYSTEMS-BASED PRACTICE (SBP)
This encompasses an understanding of, and a commitment to improve, the contexts and systems in which healthcare delivery takes place.

Included is the ability to:

- understand, access and utilize the resources, providers and systems necessary for optimal patient care,
- appreciate the limitations and opportunities inherent in various practice types and delivery systems,
- develop strategies to optimize care for the individual patient within the various systems,
- apply evidence-based cost-conscious strategies to patient care for prevention, diagnosis and treatment,
- work with other members of the healthcare team to assist patients and families to navigate the complex healthcare system effectively.
Milestones

As the ACGME began to move toward continuous accreditation, specialty groups developed outcomes-based milestones as a framework for determining resident and fellow performance within the six ACGME Core Competencies.

What are Milestones? Simply defined, a milestone is a significant point in development. For accreditation purposes, the Milestones are competency-based developmental outcomes (e.g., knowledge, skills, attitudes, and performance) that can be demonstrated progressively by residents from the beginning of their education through graduation to the unsupervised practice of their specialties.

Why Milestones?
First and foremost, the Milestones are designed to help all residencies produce highly competent physicians to meet the health and health care needs of the public. To this end, the

Milestones serve important purposes in program accreditation

- Allow for continuous monitoring of programs and lengthening of site visit cycles
- Public Accountability – report at a national level on aggregate competency outcomes by specialty
- Community of practice for evaluation and research, with focus on continuous improvement of graduate medical education

For residency programs, the Milestones will:

- Provide a rich descriptive, developmental framework for clinical competency committees
- Guide curriculum development of the residency or fellowship
- Support better assessment practices
- Enhance opportunities for early identification of struggling residents and fellows

And for residents, the Milestones will:

- Provide more explicit and transparent expectations of performance
- Support better self-directed assessment and learning
- Facilitate better feedback for professional development

How will the Milestones be used by the ACGME?

Residents’ performance on the Milestones will become a source of specialty-specific data for the specialty Review Committees to use in assessing the quality of residency programs and for facilitating improvements to program curricula and resident performance if and when needed. The Milestones will also be used by the ACGME to demonstrate accountability of the effectiveness of graduate medical education within ACGME-accredited programs in meeting the needs of the public.

See Appendix A for the complete Milestone document.
Learning Objectives

Learning Objectives for individual rotations are maintained on MedHub, our residency education management software, and sent to residents and faculty before the start of each rotation. In each learning objective document, you will find information on the following: goals and objectives of each rotation; milestones; duty hours and locations; conference and call schedules; vacation restrictions; lines of supervision; evaluation techniques; learning materials and resources.

We are committed to maintaining an environment in which residents and faculty can improve their knowledge and skills, and learn from each other. Residents will be incorporated into the department’s clinical, teaching and research activities in a supportive and collegial fashion.

It is our expectation that our residents will:
- Develop a personal program of self-study and professional growth.
- Conduct themselves in a professional manner by treating students, patients, nurses, faculty and ancillary staff with courtesy and respect.
- Assume responsibility for teaching and mentoring junior residents and students.
- Participate in safe, effective, and compassionate patient care under a level of faculty supervision that is commensurate with the resident’s training and ability.
- Apply cost containment measures in the provision of patient care.
- Participate in the emergent transport of patients in need of help.
- Participate in institutional programs and committees, especially those that relate to patient care and education.
- Adhere to established departmental and institutional policies, practices and procedures, which include accurate and timely completion of medical records.
- Adhere to resident duty hour standards.
- Keep accurate, current and well-organized logs of all in- and outpatient care experiences, as required by the ACGME.

Roles, Responsibility and Patient Care Activities for Trainees (Supervision)

Residents are physicians in training. They learn the skills necessary for their chosen specialty through didactic sessions, reading and providing patient care under the supervision of the Medical Staff (the attendings) and senior trainees, including fellows. As part of their training program, residents are given progressively greater responsibility according to their level of education, ability and experience, as part of a team of providers caring for patients which includes a supervising attending. Residents are expected to:

- Provide care in both the inpatient and outpatient settings, through direct patient care, consultative or diagnostic services.
- Evaluate patients, obtain the medical history and perform physical examinations to develop differential diagnoses, problem lists, and plans of care in conjunction with other trainees and the attending.
- Document the provision of patient care as required by hospital/clinic policy.
- Write orders for medications/ other therapeutic interventions and diagnostic studies as specified in the medical center bylaws and rules/regulations
- Interpret the results of laboratory and other diagnostic testing
- Request consultation for diagnostic studies, the evaluation by other physicians, physical/rehabilitation therapy, specialized nursing care, and social services.
- Participate in procedures performed at the bedside, in the operating room or procedure suite under appropriate supervision.
- Initiate and coordinate hospital admission and discharge planning.
Residents should discuss the patient’s status and plan of care with the attending, fellow and the team regularly. All residents help provide for the educational needs and supervision of any junior residents and medical students.

This document summarizes the Department of Obstetrics and Gynecology lines of supervision for residents in training at all sites. Specific supervision for individual rotations is documented in the rotation Learning Objectives.

The following is departmental policy:

1. ACGME Policy Excerpt: On an Obstetrics and Gynecology service, adequate supervision requires the 24-hour presence of faculty in the hospital except when residents are not assigned in-house call responsibilities. Faculty must be immediately available to the resident if clinical activity is taking place in the operating rooms and/or labor and delivery areas. Faculty must be within easy walking distance of patient care units. Clinical services provided in ambulatory (office) locations require on-site supervision. Open and generously used lines of two-way communication are important and should be encouraged.

2. The Chain of Command for patient care is: Junior Residents to Chief Resident/Fellow (when appropriate) to Attending. Our services are designed so that there is always an identified attending available and responsible for patient care. This attending must be notified on every admission or consult, and during the care of inpatients who are ill or who have potentially serious problems. Routine cases should involve early consultations if the resident is unsure of a plan of action.

3. An attending should be present for all operative cases and procedures.

4. An attending should be available for immediate consultation on the labor floor, and should attend all deliveries.

5. Charts should be reviewed by the chief resident/fellow or faculty. Documentation of care should accurately reflect the role of the faculty in the patient’s care and notations signed by the faculty when appropriate.

6. Although it is understood that residents will assume more responsibility as they proceed through the residency program, the attending should be consulted on any patient requiring surgery, ICU transfers, blood transfusions, or hospital admission as well as any about whom the resident has concern.

7. Backup to the attending assigned to the service are other attendings on the service, the chief of the division, and the department chair or vice chairs.

The specific role of each resident varies with clinical rotation, experience, years of clinical training, the patient’s illness and the clinical demands placed on the team. The following is a guide to the specific patient care responsibilities by year of clinical training.

**PGY 1**
They are primarily responsible for the care of patients under the guidance and supervision of the attending and senior trainees. They should be the point of first contact when questions or concerns arise about the care of their patients. PGY1 residents may provide care for inpatients, outpatients, or patients in the emergency department with appropriate supervision.

**PGY 2-3**
They should be the point of contact when questions or concerns arise about the care of their patients or when the PGY 1 is unable to address the clinical issues. PGY2-3s may serve as part of a team providing consultative services, or care for patients in the outpatient setting or emergency
department under the supervision of senior trainees and Medical Staff. These residents may coordinate the actions of the team, through interactions with nursing and other administrative staff. Along with the attending they support the educational needs of any junior residents and students.

**Chief Residents (PGY 3-4)**

The PGY-4 residents are considered chief residents. On UW Gynecology Oncology, the PGY3 serves as the Chief Resident. Chief residents supervise the activities of the inpatient team, in addition to caring for outpatients in any setting. Chief residents are responsible for providing leadership for the team, overseeing patient care, serving as consultants, scheduling or covering absences of resident physicians, scheduling didactics and overseeing the compliance with the ACGME work hours regulations of his/her team of residents. They participate in administrative committees as required by the Department. They coordinate admissions and/or transfers from other centers or services. They are responsible for promoting the education of junior trainees and students.

**Supervision of Invasive Procedures**

In a training program, as in any clinical practice, it is incumbent upon the physician to be aware of his/her own limitations in managing a given patient, and to consult a physician with more expertise when necessary. When a resident requires supervision, this may be provided by a qualified member of the medical staff or by a trainee who is authorized to perform the procedure independently. In all cases, the attending physician is ultimately responsible for the provision of care by trainees. When there is any doubt about the need for supervision, contact the attending.

For purposes of reimbursement of services (billing), attending faculty can only bill a professional fee for procedures in which he/she was physically present. This is a related but separate supervision issue- hence the attending physician should always be notified when a procedure is to be performed.

**I. No supervision required.**

- Dressing changes
- Suture and staple removal
- Vaginal pack removal
- Central venous catheter removal

**II. Supervision required.**

*Definition of Supervision: The Medical Staff member has been notified of a procedure and has deemed the resident qualified to perform the procedure independently.*

*Definition of Direct Supervision: The presence of a qualified Medical Staff member at the bedside.*

The following procedures require direct supervision by a qualified individual until the trainee has achieved the training level specified; thereafter, they require supervision. Again, for purposes of reimbursement of services (billing), attending faculty can only bill a professional fee for procedures for which he/she was physically present.

<table>
<thead>
<tr>
<th>Service and Procedure</th>
<th>Training level required for independent performance with supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obstetrics</strong></td>
<td></td>
</tr>
<tr>
<td>• Uncomplicated spontaneous vaginal delivery</td>
<td>PGY-1, after first month on Obstetrics</td>
</tr>
<tr>
<td>• Complicated spontaneous vaginal delivery</td>
<td>PGY-2</td>
</tr>
<tr>
<td>• Uncomplicated Episiotomy/laceration repair</td>
<td>PGY-1, after first 6 months on Obstetrics</td>
</tr>
<tr>
<td><strong>Service and Procedure</strong></td>
<td><strong>Training level required for</strong></td>
</tr>
<tr>
<td><strong>Training level required for</strong></td>
<td></td>
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<tr>
<td><strong>independent performance with supervision</strong></td>
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<tr>
<td><strong>supervision</strong></td>
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</tbody>
</table>
independent performance with supervision

<table>
<thead>
<tr>
<th>Obstetrics (cont.)</th>
<th>PGY-1, after completion of certification program</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Interpretation of fetal heart rate tracing</td>
<td>PGY-1, after completion of certification program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gynecology</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Simple outpatient procedures</td>
<td>PGY-1</td>
</tr>
<tr>
<td>• Minor gynecologic procedures</td>
<td>PGY-2</td>
</tr>
<tr>
<td>• Complex outpatient procedures</td>
<td>PGY-3</td>
</tr>
<tr>
<td>• Major gynecologic procedures</td>
<td>PGY-3</td>
</tr>
</tbody>
</table>

**III. Direct supervision by a qualified member of the medical staff required.**

*Definition of Direct Supervision: The presence of a qualified Medical Staff member at the bedside.*

- All obstetrical or gynecology surgical procedures performed in the Operating Room setting
- All office procedures including pregnancy termination procedures, endometrial biopsy, colposcopy, and IUD insertion
- All vaginal deliveries
- Amniocentesis and External Cephalic Version
- Consent for obstetrical or gynecologic procedures

**Emergency Procedures**

As stated in the UWMC bylaws, any procedure may be performed without supervision by any resident in the event of a life-threatening emergency situation. The assistance of more qualified individuals should be requested as soon as practically possible.

**HIPPA and Medical Records**

Please refer to the following web pages for information regarding the most current HIPPA and medical records practices: UWHC HIPAA Resources, UWMF HIPAA Resources and Medical Records

**Interpersonal Skills/Patient Satisfaction**

The physician-patient relationship is fundamental to providing effective healthcare. Physicians who build quality relationships with their patients are more likely to have satisfied patients. These physicians may also gain other unexpected dividends. For instance, there is evidence that patients tend to be more compliant with treatment plans when they share a quality relationship with their physician. Also, it has been found that patients who are treated respectfully are less likely to become plaintiffs in medical malpractice cases. Consider the following comments from Boston attorney Alice Burkin, who has represented malpractice clients for almost 20 years:

“I’d say the most important factor in many of our cases - besides negligence itself - is the quality of the doctor-patient relationship. People just don’t sue doctors they like... We’ve had people come in saying they want to sue some specialist, and we’ll say ‘We don’t think that doctor was negligent. We think it’s your primary care doctor who was at fault’ and the client will say, ‘I don’t care what she did. I love her, and I’m not suing her.’ The best way to avoid getting sued is to establish good relationships with your patients. The secret to creating those relationships is really very simple - it’s not rocket science. You have to treat your patients with respect. Take time to talk with them and, even more important, to listen.”
Researchers from Vanderbilt performed a six-year study in which they looked at complaints against 645 physicians. They found that 8% of these physicians generated over half of the malpractice suits. A follow-up study with 900 maternity patients found that doctors with high complaint and malpractice claim rates were characterized as rude, uncaring and inattentive, and failed to return phone calls. Treat your patients with respect and dignity because it is the professional thing to do.

Tips for Better Relationships with your Patients

- Review the patient’s chart before you enter the exam room.
- Address your patient by name.
- Sit down during the appointment.
- Focus on your patient. The appointment is important to them. Don’t take phone calls.
- Avoid the appearance of rushing the appointment. Don’t look at your watch.
- Ask about the patient’s family, work, weight loss, or prior health.
- Maintain eye contact.
- Convey alertness, interest, and attentiveness. Use nonverbal cues such as nodding.
- Listen without interrupting to your patient’s description of their problems and self-diagnosis.
- Ask them about their concerns.
- Rephrase what the patient says to indicate your understanding of his or her concerns.
- Speak in language they can understand. Avoid using jargon.
- Don’t talk about other patients you have seen that day.
- It’s OK to admit that you don’t know. Find the answer and get back to them in a timely manner.

1 Committee on Quality of Health Care in America, Institute of Medicine. 2001. Crossing the Quality Chasm: A New Health System for the 21st Century
3 Johns Hopkins’ Defining the Patient-Physician Relationship for the 21st Century; 3rd Annual Disease Management Outcomes Summit. October 30 – November 2, 2003 Phoenix, Arizona
## Didactics

### Thursday University Conference Schedule:

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
<th>Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 am</td>
<td>M&amp;M Faculty and Resident Meetings (3rd Thursday of each month)</td>
<td></td>
</tr>
<tr>
<td>8:00 am</td>
<td>Resident Education Series</td>
<td></td>
</tr>
<tr>
<td>9:00-10:00 am</td>
<td>Resident Education Series</td>
<td></td>
</tr>
</tbody>
</table>

Weekly schedules are maintained and emailed to the department by Beckie Schimelpfenig, Administrative Assistant. A yearly Thursday schedule can be found by logging into MedHub and looking in the Resources/Documents folder.

### Rotation Conference Schedule:

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Type</th>
<th>Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>6:30-7:30 am</td>
<td>Meriter Gyn PreOp Conference</td>
<td>Meriter Cafeteria</td>
</tr>
<tr>
<td></td>
<td>7:00 am</td>
<td>Meriter Ob Sign-Out/PBL&amp;I</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>7:30 am</td>
<td>Meriter Low Risk Ob Didactics</td>
<td>Meriter Cafeteria</td>
</tr>
<tr>
<td></td>
<td>12 noon</td>
<td>REI Couples Clinic/IVF Conference</td>
<td>GFC Conference Room</td>
</tr>
<tr>
<td>Tuesday</td>
<td>7:00 am</td>
<td>Meriter Ob Sign-Out/PBL&amp;I</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>7:00 am</td>
<td>Meriter Gyn Didactics</td>
<td>Meriter Cafeteria</td>
</tr>
<tr>
<td></td>
<td>7:30 am</td>
<td>Meriter Ob Perinatal Conference</td>
<td>Meriter Hosp-Atrium</td>
</tr>
<tr>
<td></td>
<td>7:30 am</td>
<td>SMOB Education Conference (second Tuesday Of month)</td>
<td>SMH Bay 1</td>
</tr>
<tr>
<td></td>
<td>5:00 pm</td>
<td>Onc Professor Rounds</td>
<td>UWH-Onc Team Room</td>
</tr>
<tr>
<td>Wednesday</td>
<td>7:00 am</td>
<td>Meriter Ob Sign-Out/PBL&amp;I</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>7:00 am</td>
<td>Meriter Gyn Case Review</td>
<td>Meriter Cafeteria</td>
</tr>
<tr>
<td></td>
<td>7:00 am</td>
<td>SMOB Didactic Session (Shay)</td>
<td>SMH L&amp;D</td>
</tr>
<tr>
<td></td>
<td>7:30 am</td>
<td>Meriter Ob MFM Didactics</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>12 noon</td>
<td>ARB High Risk Patient Conference</td>
<td>Arboretum Clinic</td>
</tr>
<tr>
<td>Thursday</td>
<td>7:00 am</td>
<td>Morbidity &amp; Mortality Conf/Resident Meetings</td>
<td>Bolz Auditorium</td>
</tr>
<tr>
<td></td>
<td>8:00 am</td>
<td>Grand Rounds*/Journal Club/Steering Comm.</td>
<td>Bolz Auditorium</td>
</tr>
<tr>
<td></td>
<td>9:00 am</td>
<td>Resident Education Series</td>
<td>Bolz Auditorium</td>
</tr>
<tr>
<td></td>
<td>10:00 am</td>
<td>Simulation Lab</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td>Friday</td>
<td>7:00 am</td>
<td>Meriter Ob Sign-Out/PBL&amp;I</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>7:00 am</td>
<td>Meriter Gyn Didactics w/ Dr. Diem</td>
<td>Meriter Cafeteria</td>
</tr>
<tr>
<td></td>
<td>7:30 am</td>
<td>Meriter Ob Tracing Rounds</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>12 noon</td>
<td>PGY-1 Clinics UHS Didactics</td>
<td>UHS</td>
</tr>
</tbody>
</table>
## Rotation Schedule by PG year with Rotation Faculty Supervisor

Rotation Schedule by PG year with Rotation Faculty Supervisor

Rotations are 1-2 four week blocks.

### PGY-1

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Hospital</th>
<th>Faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk Obstetrics Days</td>
<td>Meriter Hospital</td>
<td>Dr. Greg Bills</td>
</tr>
<tr>
<td>Gynecologic Oncology</td>
<td>UW Hospital</td>
<td>Dr. Dave Kushner</td>
</tr>
<tr>
<td>Clinics</td>
<td>University Health Services, Planned Parenthood</td>
<td>Dr. Mary Landry/Dr. Eliza Bennett</td>
</tr>
<tr>
<td>Low Risk Obstetrics Night Float</td>
<td>Meriter Hospital</td>
<td>Dr. Greg Bills</td>
</tr>
<tr>
<td>OB/Ultrasound</td>
<td>Meriter Hospital, Planned Parenthood, 20 S. Park Clinic</td>
<td>Dr. Igor Iruretagoyena</td>
</tr>
<tr>
<td>Benign Gynecology Surgery</td>
<td>Meriter Hospital</td>
<td>Dr. Klaus Diem</td>
</tr>
</tbody>
</table>

### PGY-2

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Hospital</th>
<th>Faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Risk Obstetrics</td>
<td>Meriter Hospital</td>
<td>Dr. Dinesh Shah</td>
</tr>
<tr>
<td>Benign Gynecologic Surgery</td>
<td>Meriter Hospital/UW Hospital</td>
<td>Dr. Klaus Diem</td>
</tr>
<tr>
<td>High Risk Obstetrics Night Float</td>
<td>St. Mary’s Hospital</td>
<td>Dr. Brian Stafeil</td>
</tr>
<tr>
<td>Gynecologic Oncology</td>
<td>UW Hospital</td>
<td>Dr. Dave Kushner</td>
</tr>
<tr>
<td>Ambulatory Gynecology Clinics</td>
<td>Various Ambulatory Sites</td>
<td>Dr. Ellen Hartenbach</td>
</tr>
<tr>
<td>Continuity Clinic</td>
<td>Arboretum Clinic</td>
<td>Dr. Cynthia Anderson</td>
</tr>
<tr>
<td>Reproductive Endocrinology and Infertility</td>
<td>Generations Fertility Clinic</td>
<td>Dr. Dan Lebovic</td>
</tr>
<tr>
<td>Gynecology Night Float</td>
<td>UW and Meriter Hospitals</td>
<td>Dr. Ellen Hartenbach</td>
</tr>
<tr>
<td>Benign Gynecology</td>
<td>UW Hospital/VA Hospital</td>
<td>Dr. Brenda Jenkin</td>
</tr>
</tbody>
</table>

### PGY-3

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Hospital</th>
<th>Faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynecology Night Float</td>
<td>UW Hospital / Meriter Hospital</td>
<td>Dr. Ellen Hartenbach</td>
</tr>
<tr>
<td>High Risk Obstetrics Senior Night Float</td>
<td>Meriter Hospital</td>
<td>Dr. Dinesh Shah</td>
</tr>
<tr>
<td>High Risk Obstetrics</td>
<td>St. Mary’s Hospital</td>
<td>Dr. Brian Stafeil</td>
</tr>
<tr>
<td>Benign Gynecologic Surgery</td>
<td>Meriter Hospital/UW Hospital</td>
<td>Dr. Klaus Diem</td>
</tr>
<tr>
<td>Elective Rotation</td>
<td>Various Sites, including Global Health rotations</td>
<td>Dr. Ellen Hartenbach</td>
</tr>
<tr>
<td>Continuity Clinic</td>
<td>Arboretum Clinic</td>
<td>Dr. Cynthia Anderson</td>
</tr>
<tr>
<td>Gynecologic Oncology</td>
<td>UW Hospital</td>
<td>Dr. Dave Kushner</td>
</tr>
<tr>
<td>Benign Gynecology</td>
<td>UW Hospital/VA Hospital</td>
<td>Dr. Brenda Jenkin</td>
</tr>
<tr>
<td>Urogynecology</td>
<td>UW Hospital/Meriter Hospital</td>
<td>Dr. Dobie Giles</td>
</tr>
</tbody>
</table>

### PGY-4

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Hospital</th>
<th>Faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief/Obstetrics</td>
<td>Meriter Hospital</td>
<td>Dr. Dinesh Shah</td>
</tr>
<tr>
<td>Benign Gynecologic Surgery</td>
<td>St. Mary’s Hospital</td>
<td>Dr. Kristine Bathke</td>
</tr>
<tr>
<td>Chief/Benign Gynecologic Surgery</td>
<td>Meriter Hospital</td>
<td>Dr. Klaus Diem</td>
</tr>
<tr>
<td>Chief/Benign Gynecology</td>
<td>UW Hospital / VA Hospital</td>
<td>Dr. Brenda Jenkin</td>
</tr>
<tr>
<td>Chief/Resident Continuity Clinic Float</td>
<td>Arboretum Clinic</td>
<td>Dr. Cynthia Anderson</td>
</tr>
<tr>
<td></td>
<td>Various Sites</td>
<td>Dr. Ellen Hartenbach</td>
</tr>
</tbody>
</table>
Simulation Lab

Residents have 24 hour access to the simulation lab with access to all training resources. Brent Dumermuth, MD, Simulation Lab Director, and John Street, Education Programs Manager, are available to assist residents with simulation independent study. In addition, all residents are given a laparoscopic box trainer which can be connected to a personal computer via web cam for home use.” As part of the Resident Education Series, Simulation lab sessions are scheduled throughout the academic year. See below for a list of teaching sessions.

Abdominal Hysterectomy
All residents: Practice proper Abdominal Hysterectomy technique on simulation models.

Anatomy Lab
All residents: Study of pelvic anatomy using 3D models and videos.

Breech Delivery
All residents: Practice on Noelle of proper technique for breech delivery.

Colposcopy and LEEP
Description: Review of proper technique and practice with colposcopy equipment.

Electro-surgery
All residents: Basic theory of electro-surgery and practice with electro-surgery equipment.

Endometrial Ablation
All residents: Hands on experience with different endometrial ablation techniques

Fundamentals of Laparoscopic Surgery (FLS) Testing
All residents: Complete several timed laparoscopic skill tests, including suturing.

Forceps/Vacuum Delivery
All residents: Practice on Noelle of proper technique for forceps/vacuum delivery.

Laparoscopic Entry and Exit
PGY1 & PGY2's: Review and practice of techniques and instruments for proper laparoscopic entry/exit.

Laparoscopic Suturing
All residents: Practice of laparoscopic suturing under faculty supervision.

Perineal Laceration Repair
PGY1 residents: Learn fundamentals of obstetric laceration repair on simulation models

Post-Partum Hemorrhage
All residents: Practice on Noelle of proper technique for post-partum hemorrhage, including suturing.

Robotic Surgery Simulation in OR
All residents: Practice on DaVinci robot in Meriter OR.

Shoulder Dystocia
All residents: Practice on Noelle of proper technique for shoulder dystocia.

Vaginal Hysterectomy
All residents: Practice proper Vaginal Hysterectomy technique on simulation models.
Online Modules

The American Institute of Ultrasound in Medicine (AIUM)
The Journal of Ultrasound in Medicine as well as the printed journal, online resource library and educational modules. All residents will have a yearly subscription.

American Society for Colposcopy and Cervical Pathology (ASCCP)
PGY-2 and PGY-4 residents will be assigned the ASCCP online exam.

American Society for Reproductive Medicine (ASRM)
ASRM has many resources available for health professionals including ASRM eLearn. Periodically, residents are expected to complete some of these online modules.

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)
The Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) is a 501(c)3 nonprofit membership organization that promotes the health of women and newborns. The PG-1’s will complete the online Fetal Heart Monitoring course.

The Foundation for Excellence in Women's Health Care: Life Long Learning
The Foundation for Excellence in Women's Health Care (www.excellence.org) is dedicated to improving the quality of women’s health care, through research, awards, grants and innovations in education.

Their website offers Excellence in Life-Long Learning (LLL™ Modules), and this program is designed to help Ob/Gyns stay up to date on new technologies, best practices and medical findings. All modules are downloaded into MedHub and residents complete the readings and quizzes on a quarterly basis.

The Foundation for Excellence in Women's Health Care: Pearls of Excellence
The Pearls of Excellence are the most challenging topics for Ob/Gyn certification.
The Excellence Foundation will review the data from the three oral Board certification exams, and compile a list of the ten to twelve most challenging topics. A short review and references will periodically be posted to their website: www.excellence.org/pearls.php

Graduate Medical Education (GME) modules
As part of the UW Health Improvement Network’s curricula in patient safety and quality improvement, the PG-1’s must complete Patient Safety Curriculum which is put out through Med Hub by the GME Office in November. They will have another one in February on Quality Improvement.

Safety and Infection Control which is required for all residents in January of each year.

SAFER (Sleep and Fatigue Education for Residents) will be done in either December or January of each year.
Disciplinary Action, Appeals, and Grievances

The following three sections explain the policies and procedures of the Obstetrics and Gynecology Residency Program and UW Graduate Medical Education Office concerning discipline, appeals, and grievances.

Disciplinary Policies and Procedures
The Program Director and Clinical Competency Committee decide whether a resident is promoted to the next level of training. Promotion is based on a resident’s satisfactory completion of assigned rotations and satisfactory performance on the CREOG in-training exam. A resident who is not progressing through the program at the expected rate may be assigned to one of the following categories: remediation, warning, probation, suspension, termination or non-renewal of contract.

The categories of remediation and warning are internal processes (i.e. processed only through the Residency Program and the UWHC Graduate Medical Education Office) and are non-reportable to state boards and national data banks. Probation, suspension, and termination or non-renewal of contract are reportable actions. Residents will receive written notification of any disciplinary action.

Suspension
In the interests of patient safety a resident may be suspended at any time by the Program Director, Department Chair, or Senior Vice President of Medical Affairs.

- Suspension is effective immediately.
- Any suspension imposed by the Program Director or Department Chair must be reviewed by the Senior Vice President of Medical Affairs.
- Following a review, the Senior Vice President of Medical Affairs will notify the resident of the review decision in writing. The resident has two days from that point to submit mitigating information.
- The Senior Vice President of Medical Affairs will review any additional information and decide within five days whether to continue or end the summary suspension. The resident will receive a written notice of this decision, which will outline the resident’s appeal rights.

Termination or Non-renewal
If the residency program decides not to promote, re-appoint, or graduate a resident, the resident will be informed in writing with an explanation of their appeal rights. Notification of the decision must be given to the resident a minimum of 4 months prior to the end of the current appointment. However, in exceptional circumstances, shorter notice of non-renewal may be necessary.

Appeals of Resident Evaluation, Discipline, Non-renewal or Dismissal Decisions
Residents may appeal:

- a negative semi-annual evaluation by the Program Director;
- a status change to warning, probation, suspension, or termination or non-renewal of contract.

The appeal policy of the UW Graduate Medical Education Office requires residents to exhaust the appeals process within their residency program before an institutional review is requested.
UW Ob-Gyn Internal Appeal Process:

1) A resident must complete and submit the appeal paperwork to the office of the department Chair within 10 days of notification of the negative evaluation or status change. Appeal paperwork is available from the Program Coordinator.

2) If the appeal is not filed within 10 days (not including weekends and holidays) the right to appeal is considered waived.

3) The Chair and one other faculty member (not the Program Director) review the appeal and may decide to uphold, reverse, alter the decision, or forward the appeal to the Clinical Competency Committee (CCC). The resident will be informed of the decision in writing within 10 days of the appeal submission.

4) The CCC decision must be made by a quorum of committee members with a simple majority vote and must be made within 10 days of the appeal's receipt from the department Chair. The CCC will notify the resident of its decision in writing.

5) Rejection of a resident appeal will explain the resident’s institutional appeal rights.

Resident Grievances
This section pertains to resident employment concerns and does not apply to academic or other disciplinary actions taken against the resident that could result in dismissal, non-renewal, non-promotion, or other actions that could threaten the resident’s career. Also, this process is not meant for allegations of discrimination based on sex, age, race, national origin or disability, which should be filed with the UWHC Human Resources Department. Examples of legitimate grievances include problems with the work environment, interactions with faculty or staff, and hospital policies or procedures.

Prior to submitting a grievance a resident may consider the following options to resolve conflicts:

The UW Graduate Medical Education Office supports the “Resident Confidential Complaint Hotline” (263-8013). Complaints are confidential and will be forwarded to the appropriate person(s) to address the issue.

The medical school provides an ombudsperson (265-9666) who is available to residents as a neutral, confidential resource for dealing with conflicts.

Policies and Procedures for Filing a Grievance:

1) Residents may not be penalized in any way for filing a grievance.

2) Departmental review and grievance processes must be completed before a resident may request an institutional review.

3) At any step of the process a resident may be accompanied by another member of the medical profession.

4) The resident completes and submits the grievance paperwork (available from the Program Coordinator) to the department Chair’s office.

5) The department Chair and at least one other faculty member will review the grievance and decide on a course of action within 10 days. The resident will be notified of that decision in writing.

6) If the resident is not satisfied with the department decision, he/she may file an appeal with the GME Appeals Committee within 10 days of the department’s written decision.

The GME Office has detailed procedures designed to provide residents with a full hearing of their grievance. A copy of these procedures is available to residents through the Residency Program Coordinator and UW GME office www.uwgme.org
Duty Hours

ACGME, RRC Obstetrics and Gynecology Common Program Requirements
GME Duty Hours Policy (revised July 1, 2011)

To ensure a culture of professionalism that supports patient safety and personal responsibility that is not compromised by diminished resident function resulting from excessive fatigue and stress. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in:

1) the safety and welfare of patients entrusted to their care;
2) patient- and family-centered care;
3) their fitness for duty;
4) management of their time before, during, and after clinical assignments;
5) recognition of impairment, including illness and fatigue, in themselves and in their peers;
6) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

Alertness Management/Fatigue Mitigation

1) The program must:
   a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;
   b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and,
   c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.

2) Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.

3) The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.

Stress and Fatigue Monitoring Policy
The Department places a high priority on close monitoring of stress, fatigue and sleep deprivation in its residents and faculty. Day-to-day monitoring of one’s self and colleagues is everyone’s responsibility, however, special attention must be paid by the Program Director, and Faculty to ensure both patient safety and the health and well-being of the Department. Residents should relay any concerns to the senior resident on service. If that person is not appropriate or is unavailable, the chief resident should be notified. If the chief resident cannot resolve the situation or find appropriate coverage, the Residency Program Director should be alerted. All faculty and residents must participate in annual instruction in the recognition of the signs of fatigue. The SAFER educational program developed by the American Academy of Sleep Medicine is available to all residents and faculty through the GME office. All residents and faculty are required to review the program annually and document their completion.
**Duty Hours overview**

**Maximum Hours of Work per Week**
Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

**Duty Hour Exceptions**
The Review Committee for Obstetrics and Gynecology will not consider requests for exceptions to the 80-hour limit to the residents’ work week.

**Moonlighting**
The Department does not allow Moonlighting by Resident Physicians. Exceptions may be made for PGY-2, PGY-3 and PGY-4 residents for certain internal moonlighting activities, and must be approved by the Program Director. Examples include UW Health Link Resident SuperUser. All clinical moonlighting hours plus training program duty hours will not exceed 80 hours per week. PGY-1 residents are not permitted to moonlight.

**Mandatory Time Free of Duty**
Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

**Maximum Duty Period Length**

1) Duty periods of PGY-1 residents must not exceed 16 hours in duration.
2) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.
3) Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.
4) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
5) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
6) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.
7) Under those circumstances, the resident must: appropriately hand over the care of all other patients to the team responsible for their continuing care; and, document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
8) The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

**Minimum Time Off between Scheduled Duty Periods**

1) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
   Intermediate-level residents (PGY-2) must have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.
2) Residents in the final years of education (PGY-3 and PGY-4) must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.
3) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

   a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

   b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

**Maximum Frequency of In-House Night Float**

Residents must not be scheduled for more than six consecutive nights of night float.

**Maximum In-House On-Call Frequency**

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

**At-Home Call**

1) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third night limitation, but must satisfy the requirement for one-day in-seven free of duty, when averaged over four weeks.

2) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

3) Residents are permitted to return to the hospital while on at home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

**Site-specific duty hour rules**

**Meriter and St. Mary’s work hours and call**

**10 Hour Rule**

- Monday - Friday, rounding begins at 6:00 am, which means residents should leave by 8:00pm and must leave by 10:00pm.
- If a resident is performing a C-section or delivery and stay past 8 pm, then the resident should come in late the following morning so that there are 10 hours off between shifts. The resident needs to communicate with the OB senior resident, night float resident, and administrative chief resident to coordinate this change in schedule.
- If a resident is performing a Gyn surgery and stay past 8:00 pm, then the resident should come in late the following morning so that there are 10 hours off between shifts. The resident needs to communicate with the senior Gyn resident, and administrative chief resident to coordinate this change in schedule. The 4th year resident may occasionally break this rule for exceptional learning cases (if this happens, enter in the comments section on MedHub why you left late).

**24 Hour Rule**

- Saturday, on-call resident will come in at 7:00 am to round.
- Sunday, on-call resident will come in at 5:45 am to round. Sign out will be completed by 6:00 am, and the Saturday call person will leave. PGY1s may stay longer to help with rounding as long as they have at least four 24 hour periods off averaged over 4 weeks.
- No rounding should begin before 5:00 am, unless the patient is already awake.
- If a resident is in a C-section or delivery and leave after 6:00 am after working a 24 hour Saturday call, the resident may need to come in late the following morning in order to ensure at least four
24 hour periods off averaged over 4 weeks and 14 hours off after a 24 hour call. If this is the case, the senior OB resident and administrative chief should be notified.

**UW work hours and call**

**10 Hour Rule**

- Monday – Friday, rounding begins at 6:00 am which means residents working during the day should leave by 8:00 pm, and must leave by 10:00 pm.
- The only exception is if the senior resident is in the OR with a great learning case. This should only be used by the senior resident. If this happens, the situation should be explained in the comments section on MedHub. This is an exception to the 10 hour rule; therefore residents should not come in late for rounding the next day, rather they should come in at the regular time. Keep in mind, this should not happen often.

*Note: Rotation-specific duty hour requirements are included in the rotation Learning Objectives in MedHub.*

**Policy for Entering Duty Hours**

Duty hours must be reviewed and submitted in MedHub on a weekly basis by Saturday. Residents have access to the current week and the previous week in MedHub after which they are locked out.

A compliance report will be run every Monday morning. See separate section “Entering Duty Hours” in Residency Program Manual for further information regarding duty hours.

If a resident gets behind in entering duty hours by 14 days, the Program Coordinator will send an email to all the residents highlighting those delinquent.

**General Rules**

- Do not falsify your MedHub entries. We need to be sure the system is set up so we never violate the work hour rules. We can’t tweak the system without knowing where it may be failing.
- Paperwork, OR dictations and discharge summaries/dictations are not valid reasons to stay late and break work hour rules. You need to take time during the day to do these. If you are having trouble getting dictations/summaries done, let the senior resident know. Many times you will have to pass off uncompleted work. Do the best you can to finish, but remember that you have to leave on time. So, learn to organize, be concise and pass it on.
- Planned Work Hours - this is for all scheduled hours including, in-house calls, regardless of the day of the week.
- Vacation: The Chief resident submits your time off schedule to the Program Coordinator, and the coordinator logs it into MedHub.
- Please count work hours as continuous if you finish night float at 8:00 am and start RCC at 8:30 am. Don’t log as two separate shifts, as this is flagged as not having 10 hours off between shifts. This should be considered planned work hours from start of night float shift at 6:00 pm until completion of RCC.

**Duty Hour Compliance Monitoring**

Senior level residents are responsible for ensuring adherence to duty hours for themselves and the junior residents on their teams.

If a Resident finds him/herself in a situation where s/he is approaching the limits of the requirements, s/he must notify his/her senior resident, the chief resident and/or Program Director immediately. Patterns of problems experienced by the Resident should be reported to the Program Director and/or the GME Office for correction. In addition, a GME Duty Hours Hotline is available at 608-263-8013 as another mechanism for reporting duty hours problems.
All residents are expected to log duty hours on each rotation in MedHub. To monitor program compliance, the GMEOC Duty Hours Subcommittee will review:

- Duty hour logs from MedHub
- ACGME Resident survey data;
- Data from annual program reviews
- Duty hour issues that arise from the internal reviews of the program and ACGME site visits.

In addition, the GMEOC or the GMEOC Duty Hours Subcommittee may require action plans and additional monitoring when corrective action is needed.

**Resources**

**Call rooms**
Call rooms are provided at all three hospitals. At UWHC, if there is not a previously assigned call room available for sleep, a Resident may call Bed Control at 263-8775 and ask for a call room in the “resident hotel system.”

**Safe Ride Home**
The GME office will reimburse a resident for a cab ride home in the case that s/he is too tired to safely drive themselves home following a duty period. Receipts should be turned in within 30 days of the ride. Submit your receipt and the following information to your program coordinator: name, date, time of day, program, and rotation or call name.

**Employee Assistance Program**
The EAP provider is National Employee Assistance Services (NEAS). NEAS counselors can be contacted 24 hours per day, 7 days per week by calling 1-800-634-6433.

**Department Psychologist**
The Department of Obstetrics & Gynecology has a counselor available to any resident needing assistance in coping with difficult or stressful situations. Please contact the Program Director, Chief resident or Program Coordinator for more information.

**Tips for Providers with Negative Outcomes**: log into MedHub (Resources/Documents folder) for this handout.
Electives

The Elective is a four-week rotation designed by the resident. There is no scheduled night-call, enabling the resident to make elective arrangements out of town, if desired. The University of Wisconsin Department of Obstetrics and Gynecology allows global health electives.

These customized electives must be approved by the program director, in consultation with the chair, and/or the Graduate Medical Education office. Proposed elective schedules must be submitted to the Program at least six weeks prior to the beginning of the elective rotation, accompanied by the resident’s written description of his/her desired learning objectives for each elective component. Longer advanced planning is required for a global health elective.

Preference will be given to residents seeking additional training experience in Ethiopia or within the state of Wisconsin. Outside electives must include experience required by ACGME and not attainable within the UW medical system.

All elective forms and deadlines can be found in MedHub (Resources/Documents) folder as well as past elective proposals.

Listed below are elective rotations that residents have completed.

Previously approved elective options:
Addis Ababa Fistula Hospital and Soddo Christian Hospital in Ethiopia
Anatomy Lab at the Medical Sciences center
Breast Clinic at UWH
Clinical and Cancer Genetics, Waisman Center & UW Cancer Center
Cytology Laboratory, Waisman Center & UW Cancer Center
Leogane Family Health Center in Haiti
Mammography at UWH
Newborn Intensive Care Unit (NICU) at Meriter Hospital
Obstetrical Ultrasound/Pelvic floor physical therapy at Meriter Hospital & Clinics
Outpatient gynecology cases at St. Mary’s Hospital
Pelvic Dissection at UW Department of Anatomy
Planned Parenthood
Research elective
Sexually Transmitted Disease Clinic at Student Health Service
St. Paul’s Hospital Millennium Medical School in Addis Ababa, Ethiopia
Radiology at UWH
Evaluation Process

Overview
The primary purpose of the evaluation process is to support the professional development of our residents. Evaluations supply the performance feedback that residents apply to improve their daily practice. We believe that our evaluation process is effective because it is fair, comprehensive, timely, and efficient.

- **Fair.** The evaluation process is impartial and transparent. The workings of the evaluation process are open for review (see link below). Evaluations contain the name of the faculty evaluator and the evaluations are available for resident review immediately after submission.

- **Comprehensive.** The evaluation system is structured to provide a broad cross-section of faculty perspectives on resident performance, which serves to reinforce fairness.

- **Timely.** Faculty members are encouraged to submit their evaluations in a timely manner so that residents can incorporate the feedback into their daily practice. To reinforce timeliness, evaluations cannot be submitted more than 30 days after the end of a rotation.

- **Efficient.** The system is streamlined to avoid overburdening faculty and staff with evaluation requests, which we believe results in higher evaluation return rates and a clearer picture of resident performance.

Residents are evaluated by faculty, peers, professional associates and patients. An overview our evaluation system along with explanations for each evaluation and examples of the evaluation forms can be found via the following link:
https://know.obgyn.wisc.edu/sites/resident-program-evaluation/SitePages/index.aspx

Evaluation Timing
At the beginning of each rotation faculty members receive an email notifying them of the residents they will be evaluating. Mid-way through the rotation faculty members receive their evaluation requests through Medhub, our online evaluation system. We encourage faculty to submit evaluations within 2 weeks of the rotation’s conclusion.

Faculty members are not limited to the regularly-scheduled evaluations or their list of assigned residents. They have the option to initiate an evaluation for any resident they have supervised during the rotation. At any time faculty can initiate any of the four evaluations listed below to evaluate resident performance.

Types of Evaluations

**Faculty-Initiated Evaluations**
- Resident and OB/GYN Milestones Evaluation – overall performance evaluation based on the six ACGME competencies.
- On-the-Fly Evaluation – an evaluation to quickly note praise or concern about resident performance.
Peer Evaluations

- Senior Evaluation of Junior Residents on Service: At the end of the Meriter OB and UW Gynecology Oncology rotations, the senior residents complete this evaluation on the performance of junior residents on their service. Its purpose is to provide a peer perspective on a resident's performance.
- Junior Evaluation of Senior Residents on Service: At the end of the Meriter OB and UW Gynecology Oncology rotations, the junior residents complete this evaluation on the performance of the senior resident on the service. Its purpose is to provide a peer perspective on the teaching and leadership of the senior resident. This is an anonymous evaluation.

Professional Associate Evaluations
This evaluation is completed by mid-level providers on the Gynecology Oncology staff, nursing staff of the Arboretum Resident Clinic, and the lead ultrasonographer on the Ultrasound rotations to provide additional perspectives on resident performance.

Patient Evaluations
Patients in the Resident Continuity Clinic may complete this evaluation of their resident physician. The 9-question survey is completed via an iPad and is automatically uploaded to a department server. These evaluations are shared with residents every six months during the semi-annual review.

Evaluation of the Program Faculty by Residents
In December and June, residents have the opportunity to evaluate the faculty. Time is allocated during Thursday morning's reserved educational time for residents to complete faculty evaluations. These evaluations are anonymous and faculty members do not have access to any of the evaluations until at least three have been submitted for them.

Evaluation of the Residency Program by Residents and Faculty
The program recognizes that resident and faculty input is essential to continual improvement. In January, faculty and residents complete an anonymous evaluation of the residency program. The feedback from this evaluation is highly valued and informs changes to the residency program.

Residents are also encouraged to share concerns and suggestions for program improvement with senior residents on their service, the administrative chief resident, or the Program Director. Concerns and suggestions will be reviewed by the Residency Administrative Group. Residents also have the opportunity to share their perspectives on the program during their Semi-Annual Review meetings with the Program Director.

Semi-annual evaluation review
Twice a year in January and July, residents meet individually with the Program Director to review their performance for the previous six months. Prior to the meeting residents review their performance evaluations and develop learning goals for the next six months.

Remediation
In selecting residents, the program makes a commitment to fully support the resident's development into a competent Ob/Gyn physician. Since individuals arrive with varied backgrounds, aptitudes, and skill sets, it is expected that each resident will travel a unique path in their professional development. Remediation is an educational resource that we provide to residents when they need additional support.

When performance deficits are noted, in most cases residents are able to make necessary corrections on their own. Remediation exists for residents requiring direct, formal educational support from the program. While residents are encouraged to seek support on their own, it is sometimes necessary for the residency program to initiate a remediation program based on clinical evaluations, faculty and staff reports, or CREOG exam results.
The process for remediation typically proceeds as follows:

- Program Director meets with the resident to review evaluations and receive their feedback.
- A preliminary remediation plan with a timeline and performance benchmarks is developed by the Program Director with the Clinical Competency Committee and/or qualified faculty.
- The remediation plan is reviewed with the resident. If necessary, a mentor is selected.
- The Program Director monitors resident progress towards meeting benchmarks.
- When remediation goals are met the Program Director documents such in the resident record/and or in the semi-annual evaluation.

Remediation is a process of educational support that is routinely extended to residents in need. However, repeated remediation may indicate a resident’s inability or unwillingness to handle the challenges of residency. This may require moving the resident to probation status. An explanation of this process can be found below under disciplinary action, appeals and grievances.

Exams

**CREOG In-Training Exam**
Each January, residents take the Council on Resident Education in Obstetrics and Gynecology (CREOG) In-Training Exam. This is a required event, so resident leave is not approved during this time. The CREOG exam lasts several hours and consists of more than 300 multiple choice questions.

Exam results provide an objective measure of a resident’s medical knowledge and the Standard Score Compared to Year (SSCY) compares residents to their peers nationally in the same training year. Research has also found a correlation between CREOG scores and success on the ABOG written board exam, so the exam is an important milestone in a resident’s preparation for board certification.

**Mock Oral Exams**
The objective of mock orals is for the residents to gain an understanding of the oral board process, not to test their knowledge. It is more about the experience of compiling a case list, practicing professional composure, defending clinical decision making and answering oral board style questions. The exams are held annually in the spring for PGY4 residents and faculty who plan to take oral boards in the near future.

**Resident Oral Reviews**
At the end of the academic year each resident is given a case-based oral exam. Each year focuses on a different aspect of our specialty. Residents in the first three years receive a study guide at the beginning of the year to help in their preparation of the exam.

- Resident Oral Review - Obstetrics, PGY-1
- Resident Oral Review - Gynecology, PGY-2
- Resident Oral Review - Primary Care, PGY-3
Family Planning

Resident training in family planning is emphasized in our program. First and second year residents rotate at Planned Parenthood to participate in counseling and office terminations. Residents gain exposure and experience with contraceptive counseling in multiple ambulatory clinic settings. Residents are trained in placement of intrauterine devices and certified in Nexplanon. Residents are also trained in hysteroscopic and laparoscopic sterilization techniques. For more information, please see the Learning objectives and opt out form.

Global Health Track

The Interdisciplinary Global Health Track is a new part of our training program. The goal of the global health track is to provide select, self-motivated trainees with the opportunity to incorporate global health education into their residency training. Of the first-year resident class, we will accept one self-motivated applicant to the track where they will be joined by residents and fellows from the Departments of Pediatrics, Family Medicine, Emergency Medicine, and Surgery.

The interdisciplinary global health track will serve to enrich the training experience of residents interested in global health and has the ability to meet the needs of a variety of residents; from those who desire a new perspective on health worldwide to those who plan to have a career focused on global health work. Those enrolled in the global health track will participate in one week per year of protected didactic sessions, small group work, and case-based learning during the PGY1-3 years. Some independent study will be required. They will attend campus seminars and lectures on global health related topics, network with faculty from across the campus, collaborate with colleagues in the US and abroad, and have the ability to focus their scholarly project (required for all residents) on global health related issues. Additionally, they will have the option of participating in either a local or international global health rotation during their elective month as a third-year resident. Enrollment in the global health track is not a requirement for an international global health elective, but is strongly encouraged. As the global health track has the ability to be tailored to the individual interests of the resident, participants in the track should be self-motivated and driven.

Policies and Procedures

Professionalism and Personal Conduct Policy

Professionalism is demonstrated as a sense of responsibility and professional attitude, timely completion of documentation and program requirements, integrity and respect for self and others.

Residents are expected to demonstrate professionalism by adhering to the following expectations. The residency program will assist each resident in meeting these goals, however, it is ultimately the resident’s responsibility to comply with these policies, with or without prompting from the residency administrative personnel.

Absences

The American Board of Obstetrics and Gynecology (ABOG) has determined that absences of more than eight weeks in either of the first three years of training, more than six weeks in the senior resident year, or absences totaling more than 20 weeks require an extension of the training period.
by the amount of time in excess of the above listed limits. The additional training must be completed by September 30 to receive permission to take the written examination of The American Board of Obstetrics and Gynecology (ABOG) in June of PGY-4. Absences include vacations, sick leave, jury duty, maternity or paternity leave, time off for fellowship or job interviews. Attendance at scientific meetings or postgraduate courses approved by the Program Director is not considered an absence in this context.

**Planned absences:** An absence request form, housed on MedHub in the Resources/Documents/Forums folder must be completed, signed and submitted to the Program Coordinator at least 30 days prior to the scheduled absence.

**Unplanned absences:**

**Phone:** As soon as you suspect that you may be unable to work, let the appropriate senior residents know. Refer to the “Sick Call Contacts by Service” document on page .... (i.e., If you are sick at 10:00 pm, make a phone call). Be considerate; please do not call after 11 PM or before 5 AM. However, on a team service, it would be helpful to let the nightfloat person know during those hours.

**Email:** Whenever you will miss work for any reason, you should email the chief resident and the program coordinator. If you will be missing Resident Continuity Clinic, you should contact the RCC chief first thing in the morning.

**Attendance**
The “core” didactic series of conferences occurs for the benefit of resident education. Residents are excused from routine clinical activities at all three hospitals during M&M, Grand Rounds, and Resident Didactics (Thursday University). Therefore, absences from these conferences will be excused only for illness, vacations, out of town rotations, coverage of high acuity emergency cases, or resident continuity clinic patient care. A minimum of 80% attendance is required each PGY year.

Arrival at core conferences is expected to be prompt. A sign-in sheet will be available at M & M. The resident is expected to sign in once for M & M, and once on the days when Simulation lab sessions are held. A separate sign-in sheet will be provided in the lab.

**Case logs**
The ACGME Resident Case Log is an online system that allows residents to keep an electronic record of their clinical experience. These clinical statistics are required by the Accreditation Council for Graduate Medical Education (ACGME) and they will be an important document for you when you apply for hospital credentialing after graduation.

Each resident is responsible for keeping an accurate, up-to-date record of their clinical experience. Instructions for entering cases are available on line. Also, consult your fellow residents when “stats” questions arise, to ensure that you gain full credit for your clinical experience. Residents should keep their case log updated on a continuous basis. The Residency Program Coordinator will be monitoring the Case Log system to ensure timely record keeping.

Residents are expected to log cases by Wednesday night. Cases will be downloaded from the ACGME website on Thursday morning. The case list is sent to Dr. Rice who selects which cases will be discussed the following week. The list of cases for discussion to residents & faculty is emailed by Friday morning.

If cases are not appropriately logged on a weekly basis, the resident’s name will be listed (in red) on the weekly completed M&M list distributed department-wide.

The ACGME Residency Review Committee for Obstetrics and Gynecology has set minimum numbers for the key procedural skills that trainees must master prior to graduation. There are times when the Program Director may need to reassign surgical cases to ensure that residents meet the minimum requirement for a given procedure.
Reporting of Duty hours (also see “Duty Hours” section on page...)
Duty hours must be reviewed and submitted in MedHub on a weekly basis by Saturday. Residents have access to the current week and the previous week in MedHub after which they are locked out.

To reduce the resident’s administrative burden, the program coordinator will prepopulate duty hours upon the creation of the academic schedule each year. The resident will automatically see his/her duty hours without having to enter them, and will only have to edit the hours worked, and press submit. A compliance report will be run every Monday morning. See separate section “Entering Duty Hours” in Residency Program Manual for further information regarding duty hours.

If a resident gets behind in entering duty hours by 14 days, the Program Coordinator will send an email to all the residents highlighting those delinquent.

Evaluations
Residents are expected to complete departmental evaluations throughout the year in a timely fashion. This includes evaluations of faculty, the residency program, peer residents, and medical students.

Email notifications with a deadline will be sent throughout the academic year by the residency or medical student education administrative staff. Residents are expected to complete the required evaluation(s) by this said deadline.

GME annual curriculum and ACGME surveys
Residents are expected to complete all GME modules, including but not limited to Business of Medicine, Sleep Alertness, and Fatigue Education in Residency (SAFER) Curriculum, Safety and Infection control, Quality Improvement modules, and all required ACGME requests, i.e. Resident Survey.

Medical Records
Residents are expected to maintain all appropriate and reasonable medical records in a timely fashion. A resident who is identified as having delinquent medical records (any record considered delinquent by hospital bylaws) will be notified and given five (5) days to report to the hospital to complete the records.

Violations
The following constitute a violation:
• Failure to report an absence
• Less than 80% attendance in a six month period
• Failure to record weekly cases, name appears in red on the M&M email
• Locked out of MedHub for failure to update weekly duty hours
• Non-completion of a requested evaluation within the deadline
• Final reminder from the residency program to complete a GME module, ACGME request
• Non-completion of medical records within 5 days after warning from medical records

Violations will be considered part of resident performance and subject to the GME Evaluation, Discipline, Promotion, Non-Renewal or Dismissal of Residents Policy.

Violations will be monitored by academic year.

After two violations in a six month period the resident will be considered in remediation status. The resident will be relieved of clinical duty until the violation is addressed. The resident’s service, including supervising faculty and resident peers, will be notified of the absence.
After three violations in a six month period, the resident will receive a written warning that further violations may result in probation. The resident will be relieved of clinical duty until the violation is addressed. The resident's service, including supervising faculty and resident peers, will be notified of absence. The resident may be assigned an additional 12 hour call.

After four violations in a six month period, the resident may be placed on probationary status in the program. The resident will be relieved of clinical duty until the violation is addressed. The resident’s service including supervising faculty and resident peers will be notified of absence. The resident may be assigned an additional 24 hour call.

Calls will be scheduled at the discretion of the chief resident(s). If you are unable to do the assigned call, you will personally be responsible for trading that call.

Remediation and warnings are internal processes and thus, non-reportable. Probation can be reportable to state boards and national data banks.

**ACOG Junior Fellowship**

The department sponsors each of its residents as a junior fellow of the American College of Obstetrics and Gynecology. Please obtain the application form from the program coordinator. The department pays both the application fee and annual dues during your residency. With Junior Fellowship comes a subscription to Obstetrics & Gynecology (The Green Journal).

**Book/Educational Fund Policy**

Each resident has $1000.00 to spend on printed or electronic educational materials any time during residency. Additionally during PGY-4, if a resident did not make use of meeting money, they may request up to $600.00 in reimbursement for the purchase of educational materials.

The purpose of the Resident Book/Educational Fund Policy is to provide guidelines about the period in which a resident should use their funds and to define what items a resident may obtain with these funds.

The purpose of the Book/Educational Funds was originally to assist residents with the cost of textbooks for use while in residency and during preparation for Board Examinations. Over the years, "learning materials" has evolved from simply books and journals to software and other online sources of information. Because "learning materials" has grown to encompass so much more, we believe it is necessary to be more specific about the definition of the term and to provide limits on acceptable items that may be obtained from the Book/Educational fund.

**Acceptable Purchased or Reimbursed Items**

- Books, journals, and other Ob/Gyn related periodicals
- Membership to professional organizations
- Academic related software
- Computers, laptops, and electronic devices
- Medical License fees

Residents should order textbooks through the Residency Coordinator. We get a discount from the University Bookstore, and do not pay tax on those purchases. Other items may be purchased by the resident and reimbursement requested.
Period of Fund Use

- The purchase of books, journals, other periodicals and software must be completed by June 1 of the PGY4 year.
- Computers, laptops, and electronic devices must be purchased before the beginning of the PG-4 year. Reimbursement requests should be submitted within one month of purchase.

Property purchased or reimbursed remains the property of the department for its useful life, as determined by the department.

Board Review Course Policy

- Residents will be granted up to five (5) days in the PGY-4 year to attend a board study course, scheduling permitting.
- The PGY-4 residents must submit their requests for course attendance to the chief resident at the same time that vacation requests are solicited.
- To facilitate scheduling and coverage issues, no more than two PGY-4 residents may be absent at the same time.
- As long as the resident is not in remediation, warning, or probationary status, the resident may attend a board study course and use conference funds if available. If the resident no longer has conference funds available, the resident will be responsible for the entire cost of the course.
- Five Thursday University slots will be designated for PGY-4 board study preparation. One each in March, April and May and two in June. Specific days subject to annual Thursday University scheduling.

Conferences

- During years two through four of residency, each resident may be awarded one outside meeting. Approved meetings will be paid up to a maximum of $1200.
- As long as the resident is not in remediation, warning, or probationary status, the resident may attend a conference or board review course and use conference funds, if available.
- In addition to the meeting referred to above, with approval of the Program Director and faculty mentor, residents may be reimbursed for travel expenses to a meeting where a paper or poster is presented during any of the four years of training. These expenses will be covered by the department and will not count towards the resident conference fund.
- A travel approval form must be completed and submitted at least 30 days prior to the absence.

Travel Reimbursement

- Prior to traveling, please see Program Coordinator for a checklist of items needed for reimbursement.
- Transportation will be reimbursed at coach fare. Mileage will be reimbursed at the going rate up to the equivalent coach air fare. Receipts will be required for any reimbursement.
- Hotel accommodations: Single occupancy rate will be allowed. Receipt is required. If a spouse accompanies the resident and a double room is used, only the single occupancy rate will be reimbursed.
- Meals: Up to $30/day will be allowed. Meals should be itemized individually by the day. Reasonable amounts for meals will be allowed, no receipt required, unless over $25.
- Submit all itemized receipts to the Program coordinator. Expenses must be submitted for reimbursement within 6 months.
- Instead of the meeting, a qualifying senior resident in good standing may request up to $600 in reimbursement for the one-time purchase of books, CDs or other educational materials.
Time off Policies

National Rules
The American Board of Obstetrics and Gynecology (ABOG) has determined that absences of more than eight weeks in either of the first three years of training, more than six weeks in the senior resident year, or absences totaling more than 20 weeks require an extension of the training period by the amount of time in excess of the above listed limits. The additional training must be completed by September 30 to receive permission to take the written examination of The American Board of Obstetrics and Gynecology (ABOG) in June of PGY-4. Absences include vacations, sick leave, jury duty, maternity or paternity leave, time off for fellowship or job interviews. Attendance at scientific meetings or postgraduate courses approved by the Program Director is not considered an absence in this context. Please visit www.abog.org for more information.

Absence Request Procedure
• All absences must be reported to the Program Coordinator. See below for “Sick Call Contacts by Service” for specifics on rotations.
• An absence request form, used for all non-vacation absences, is housed on MedHub in the Resources/Documents folder. The form must be completed, signed and submitted to the Program Coordinator at least 30 days prior to the scheduled absence.
• All non-vacation absences must have the approval of colleagues in the affected call and rotation schedules, and must be approved by the senior resident on the affected rotation, and the attending in charge of the affected service. Final approval is granted by the Program Director.
• Vacation time requests are solicited by the Chief Resident before each academic year. The final vacation schedule is approved by the Program Director.
• Conflicting vacation requests will be resolved giving preference to seniority.
• Absences may not be scheduled more than one year in advance.
• Reasons for disapproval of any absence request will be communicated to the resident in writing.
  • Absences without approval will be taken without pay, and may result in disciplinary action.
  • Call missed due to family/medical leave, etc. will not need to be made up.

Bereavement Leave
In the event of the death of a resident’s spouse/partner, or the child, parent, grandparent, brother, sister, grandchild, (or spouse of any of them), of either the resident or his/her spouse, or any other person living in the resident’s household, the resident is granted time off with pay to attend the funeral and/or make arrangements necessitated by the death. However, time off with pay cannot exceed three (3) workdays. Reasonable additional time off without pay may be granted in accordance with religious or personal requirements and must be reported to the GME Office by the resident and program.

Career Development Leave
A total of 5 work days are allowed off for interviews. If more time is needed, the resident must use vacation time. Time off must be requested as follows: Up to three working days require only approval by the attending physician with administrative duties for the affected rotation (this will usually be the division director). All affected residents must agree to cover, and the absence request must be communicated to the program coordinator (via e-mail). Absences in excess of three consecutive days or more than 5 days in aggregate must also be approved by the program director.

Family Leave
UWHC will grant unpaid family leave (leave due to birth of a child, adoption or a serious health condition of a spouse, parent or child, which necessitates the Resident’s care) in compliance with state and federal laws (see medical leave section regarding paid medical leave after childbirth). In order to meet notice requirements, the resident must contact the GME Office as soon as possible after deciding that he/she intends to take family leave.
Holidays
Legal holidays are observed, but require clinical coverage like weekends. Observation of religious holidays varies from hospital to hospital. When scheduling demands do not preclude it, legal holidays are time off with pay as per the guidelines in the current U.W. Madison Staff Benefits publication. Residents of faiths other than the Christian one may request holiday time off in lieu of observed Christian holidays. Appropriate arrangements are to be made well in advance with the Program Director and the Chief Resident.

Jury Duty Leave
Residents may take time off without loss of pay during regularly scheduled hours of work for jury duty. However, when not impaneled for actual service, but instead on call, the Resident shall report back to work unless authorized otherwise by his/her Program Director. Residents needing time off for jury duty must provide advance notice to their Program Director and provide a copy of the jury summons. UWHC: Refer to www.uwgme.org

Medical Leave
There is no provision for regular paid sick leave for residents. The hospital will grant unpaid medical leave in compliance with applicable state and federal laws. Any medical leave of more than 3 days requires being cleared to return to work through UWHC Employee Health (UWHC Fitness for Duty: Health Service Clearance to Return to Work/Continue Work Policy# 9.22).

The Program Director may approve up to one week of paid medical leave per year if needed. For any leave exceeding one week, the resident and program must notify the GME Office and fill out the appropriate leave forms.

Paid medical leave will never exceed six months (at which time the hospital provided disability insurance will begin), and in some instances may not cover the entire length of absence. For any leave exceeding the initial week approved by the Program Director, the resident and program must notify the GME Office. In the event of a short-term disability (i.e. a temporary inability to work as a result of illness, injury, childbirth, etc), the hospital may grant paid leave for a “usual and customary” recovery period. Paid leave after childbirth shall be four weeks, unless the resident has continuing medical complications certified by her treating physician. All cases will be individually evaluated by the Senior Vice President for Medical Affairs / Associate Dean for Hospital Affairs and the Program Director to determine disability, reasonable recovery period, follow-up requirements, and whether some portion of the leave will be paid.

Military Leave
Residents may take time off for military service as required by federal and state statutes. The resident is required to provide advance documentation verifying the assignment and pay to the GME Office.
UWHC will pay the excess of a resident’s standard wages over military base pay for military leaves of three (3) to thirty (30) days to attend military schools and training. For residents who are recalled to active duty, UWHC will pay the difference between the resident’s wages and the active duty military pay for up to one year (average hospital pay over the past year minus military pay). For the first month of recall, UWHC will pay the difference between the resident’s base pay and hospital pay. For the next eleven months, UWHC will pay the difference between the resident’s total monthly military pay (limited to base pay, basic allowance for housing and basic allowance for subsistence) and the resident’s hospital pay. If the resident’s active duty pay is more than his/her hospital pay, UWHC will not compensate any wages.

Resident Retreat
Leave is granted for the Summer resident retreat in August and Winter retreat in February.
Personal Leave
A resident may be granted a leave of absence without pay at the discretion of the Program Director. All unpaid leaves must be reported to the GME Office by the resident and program.

Professional Meetings
One week’s absence may be granted per year for PGY 2-4. Additional leave may be requested if the resident is invited to present original work at a reputable professional meeting. Meeting requests should be submitted following the absence request procedure. Any missed call must be made up. Rotations that do not allow vacations also do not allow absences for meetings. (See Resident Learning Objectives)

Unused Vacation Time
Vacation time exists to be used and not “banked”, but occasionally all allotted vacation time cannot be used during a given year. In that event, the resident may submit a written vacation carry over request (e-mail is ok) for approval by the Program Director. Vacation carry over may not exceed half of the annual allotment, and must be used up by January 1. Carry over vacation may be limited to no call rotations. Payment for accrued and unused vacation time will be granted upon termination up to a maximum of seven and one half working days. The weekend vacation allotment is not payable.

Vacation
- Residents are allowed a total of 15 weekdays and up to 6 weekend days of vacation per year.
- Scheduling is maximized to allow residents time with their families during the holiday season and is coordinated by the scheduling committee (represented by the Chief Resident(s), a PGY-4, PGY-3, and PGY-2 and PGY-1), ensuring that coverage needs for the affected services are adequately met.
- Vacations are subject to the guidelines established by the scheduling committee and approval by the Program Director or Department Chair. (See Resident Curriculum Objectives)
- A maximum of five weekdays may be taken off during a single rotation, unless special arrangements have been made.
- Vacation scheduling rules and regulations are distributed each year by the Chief Resident. Some highlights are as follows:

  No vacations during night float.
  No vacations during the first week of a team rotation (MH OB, ONC).
  No more than one resident off any service/team at a time (may make exception for intern).
  No more than one vacation on any service throughout the year.
  No vacation during the dates of the CREOG in-training examination.

Sick Call Contacts by Service
As soon as you suspect that you may be unable to work, let the appropriate senior residents know. (i.e.- If you are sick at 10 PM, call). Be considerate; please do not call after 11 PM or before 5 AM. However, on a team service, it would be helpful to let the nightfloat person know during those hours.
Whenever you will miss work for any reason, you should email the program coordinator, Maria (katsoulidis@wisc.edu) and the chief resident. If you will be missing RCC, you should contact the RCC chief first thing in the morning.

<table>
<thead>
<tr>
<th>Sites</th>
<th>Service</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any hospital</td>
<td>Weekend Call</td>
<td>Call chief resident. Residents will be called based on existing call schedule and potential availability (call-free residents first.)</td>
</tr>
<tr>
<td>Meriter OB</td>
<td>Junior Days</td>
<td>1) Call OB R4 (or whoever is covering if on vacation)</td>
</tr>
</tbody>
</table>
2) During the week, low risk OB coverage will be by single 
   intern with senior residents helping to ensure adequate 
   coverage 
3) If the other junior resident is on vacation (or off that day), 
   OB R4 to page GYN team (1313) to see if R1 is available.

| Meriter OB | Junior Night Float | Call OB R4 as soon as possible. Order of coverage based on 
   availability will be: Float, Clinics 2, OR REI 2 (depending on float 
   availability and day of the week.) |
|-----------|-------------------|------------------------------------------------------------------------------------------------------------------|
| Meriter OB | Senior Days       | 1) If OB R4 is sick, call OB R2 to notify, and float (if possibly 
   available.) If it is a Monday, RCC for R2 will be covered by 
   RCC chief for all patients that cannot be rescheduled. 
   2) If OB R2 is sick, call OB R4 to notify. If it is a Wednesday, 
      RCC for R4 will be covered by RCC chief for all patients that 
      cannot be rescheduled. 
   3) If you are unable to contact the other senior on service or 
      have other coverage concerns, call chief resident. Order of 
      coverage based on availability will be: Float, GYN 3/2, 
      Clinics or REI 2 (depending on float availability and day of 
      the week.) |
| Meriter OB | Senior Night Float | Call OB R4 as soon as possible. Float will cover if available, 
   otherwise R4 or R2 on service OR RCC 4 will cover night and 
   take the following day off postcall. |
| Meriter GYN | R1, R2, R3       | Call GYN R4 (or whoever is covering if on vacation). If major 
   surgeries will go uncovered, every attempt will be made to find 
   coverage in the following order: Float, RCC chief, OB team. |
| Meriter GYN | R4              | Call OB R3/R2 to notify. If major surgeries will go uncovered, 
   call float if available and notify chief resident. |
| St. Mary's Hospital | OB/GYN | Call float if available, chief resident if float unavailable. Order of 
   coverage based on availability will be: Float, MH GYN resident if 
   can be spared, REI 2, Clinics 2, or RCC chief. Notify NF resident 
   of potential for delayed sign-out. |
| St. Mary's Hospital | Night Float | Call Chief resident. If available, float will cover. If unavailable, 
   consider services that could be absent the next day postcall: 
   REI 2, Clinics 2, RCC chief, ONC 2, or Urogyn. Notify SM OB 
   resident of potential for delayed sign-out. |
| UW | Onc R1, R2       | Call ONC R3. No additional coverage for the day, service will 
   function as only two residents. If the other junior resident is on 
   vacation, float is first call. Second call would be Clinics 1. |
| UW | Onc R3           | Call Chief resident. If available, float will cover. If unavailable, 
   RCC chief will cover. |
| UW | Night Float      | Call ONC R3. R2 will likely take 24 hour, and would have to 
   leave post call if up all night. |
| UW | GYN             | Call the other resident on your service. Will generally go 
   uncovered, if one of you has RCC that day, contact RCC chief |
and chief resident.

<table>
<thead>
<tr>
<th>UW</th>
<th>Urogyn</th>
<th>Call urogynecology attendings to let them know. Will generally go uncovered. If cases to cover at Meriter, call GYN 4. If cases to cover at UW, call chief resident.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinics</td>
<td>ARB Chief</td>
<td>Call clinic to inform staff. Call Float or OB chief to ask for R2 help for high risk clinic and coverage for patient issues.</td>
</tr>
<tr>
<td>Clinics</td>
<td>1/2</td>
<td>Call specific clinic (UHS, PP, or other) to inform staff. Call chief resident to let them know.</td>
</tr>
<tr>
<td>Clinics</td>
<td>REI</td>
<td>Call clinic to inform staff. If surgery to cover, call GYN 4 to arrange</td>
</tr>
<tr>
<td>Clinics</td>
<td>Ultrasound</td>
<td>Call Barb Trampe</td>
</tr>
</tbody>
</table>

**Chief or Co-Chief Resident Selection Policy**

**Scope:** There are two available positions, Administrative chief or Educational chief, however one person may assume both roles. Duties include administrative and educational responsibilities that provide some oversight and guidance of junior residents, enhancement of the residency program educational experience and communication between residents, faculty and department administration.

- The chief resident will convene with residents, faculty and administrators within the department as well as those in collaborating departments with respect to mutual needs.
- Act as resident advocate.
- Works closely with Education Chief Resident, Program Director, Education Manager and Program Coordinator with respect to the residency program needs.
- Interacts with the Department Chair and Division Directors when appropriate.

**Selection:** Resident must express interest in the PGY3 year. In February of each year, all residents vote for one of the PGY3 residents. If there are two clear vote recipients, they will be given the option to co-chief (Administrative chief or Educational chief). The selection of the chief resident(s) must be approval by the Department Division Directors.

**Term of Appointment:** One year, March 1 of PGY-3 year to May 1 of PGY-4 year. Transition with new Administrative Chief Resident from March 1 – May 1.

**Stipend:** $2000 paid by the GME office to be shared between the two Chief Residents. Parking pass for lower level at Meriter. (Shared between co-chiefs)

**Supervision /Evaluation of Performance:** The residency Program Director will evaluate performance based on the criteria of the job description and will be available for the support of the chief resident in his/her role.

**Nondiscrimination**

The Department is committed to providing equivalent educational experiences to all its residents, regardless of race, gender, ethnic origin or training level. The Department also recognizes that patients have a choice with respect to their healthcare providers. Therefore, if a patient declines the involvement of a particular resident in her care, the patient will no longer be cared for on the UW Ob-Gyn teaching service. There are no provisions for having another resident of different
gender, race, ethnic origin or training level cover the responsibilities of the originally assigned resident, regardless of clinical activity or resident availability, with the exception of an emergency. Questions about clinical care are to be routed directly to the patient’s attending.

Attending physicians are encouraged to discuss this policy with their patient, before s/he is admitted to the hospital.

## Presentations

### Case Presentation

**M & M:** Residents present cases, that have been chosen by Dr. Rice or other faculty, to faculty, residents and medical students at the weekly conference. Residents are expected to have a good understanding of the case, review the pertinent literature and reflect on systems issues that impacted the case. After their presentation, they will answer questions posed by those in attendance. PGY1s will not present during the first 6 months of residency, rather their senior resident will present their cases. In the second 6 months of the PGY1 year, the residents are expected to present cases with the assistance of their senior resident.

### Grand Rounds

Sometime during the PGY-4 year, each resident will be asked to present the Departmental Grand Rounds. Typically, topics have been clinical, addressing issues of interest or controversy. Also basic research based presentations, or topics dealing with adult education are options (see list of past presentations below). We encourage identification of a faculty mentor for the talk.

Presentations should be carefully prepared, be about 45 minutes, and based on an exhaustive review of the current literature. AV materials should be legible. Power point presentations are encouraged.

Handouts are optional, but a list of selected references should be available for distribution.

### Past presentations:

- Fetal Physiology and Pharmacokinetics of Oxytocin
- Interventions for Obesity
- The Role of Generalist in Treatment of Endometrial Cancer
- Diminished Ovarian Reserve: Etiologies, Testing, and Treatment
- Sexual Dysfunction in Women: Bringing it out of the Bedroom
- Migraines Headaches and Application to the female Patient
- Morbidity and Mortality Conference: History, Relevance, and Potential for Change
- Ob Dermatology 101: Normal and Pathologic Skin Changes during Pregnancy
- Everything You Always Wanted to Know about GBS but were Afraid to Ask
- Complimentary & Alternative Medicine in Women's Health
- Abortion and Stigma: The Impact on Patients, Providers and Policy
- HIV 101, Survey of a Modern Epidemic
- Antiphospholipid Antibody Syndrome and Pregnancy
- The ABC’s of PMS and PMDD
- Oral Health in Pregnancy

### Tips for Preparing your Grand Rounds Presentation

- Select a topic or area of interest and a faculty advisor will assist you in pertinent references, and points to be emphasized during the early stages of formulating the talk.
- Prepare visual aids designed to clarify and emphasize critical concepts (see below).
- Conduct an exhaustive review of recent and classical literature regarding the topic.
- Organize your presentation so that a listener will be apprised of significant principles as well as supporting data.
- Emphasize physiological and pathophysiological principles whenever possible.
• Rehearse your presentation.
• Limit the presentation to no more than 45 minutes to allow for adequate discussion.
• No more than one slide per minute should be planned. LESS IS MORE!
• Discuss the prepared presentation with your advisor so he/she will know what material has been selected and can make final suggestions.
• Prepare a selected bibliography; the Education Administrative Assistant will type and copy, if and only if, material is turned in five business days before Grand Rounds presentation.
• Rehearse the presentation again--reorganize to provide continuity and appropriate emphasis.
• Arrive early enough to have slides and visual aids ready for presentation.
• The program coordinator and administrative assistant are available for assistance with PowerPoint.

Journal Club
Each PGY-2 resident will lead Journal Club sometime during the academic year (Sept – May).
Dr. Christina Broadwell is the faculty supervisor. Preparation:
1) Two weeks prior to the Journal Club date, email Dr. Broadwell 2-3 articles that you would like to discuss. Please ATTACH the PDF files to the email, do not just include a link to the article. In the body of the email, please mention what research methodology or statistical method used in the articles that you would like to discuss. This will allow an appropriate Grimes chapter to accompany the chosen article. The articles should be about something you are interested in, but please make your choices with the guidance of your mentors/senior residents.
2) Dr. Broadwell will help you decide on one of the articles and select a Grimes chapter that is relevant.
3) At least one week prior to the Journal Club date, please send a list of questions that you think are interesting about the article that you will be presenting, to be used when we break into small groups.
4) Within the week leading up to Journal Club, either via email or in person, one or both of us will discuss the article with you and help you finalize your questions.
5) On the day of journal club, you will run the journal club session (introduce why you chose it, choose someone to give a 5 minute summary, introduce your questions, help people in small groups to get at the issues, and run the discussion after we regroup).

Paper/Poster Presentation (external)
If a resident's poster is accepted for presentation, the resident may request permission to attend the meeting. With approval of the faculty mentor and program director, residents may be reimbursed for travel expenses to a meeting where a paper or poster is presented. These expenses will be covered by the department and will not count towards the resident conference fund.

Resident Continuity Clinic (ARB) Presentations: Primary Care Curriculum
Sometime during the PGY-4 year, each resident will develop one module to include one or two topics, and present on Thursday morning from 11:00 – 12:00. Didactic modules will start with knowledge assessment using case-based scenarios and the audience response system (ARS) followed by presentation of guidelines and discussion of cases. Clinic-based modules will be developed in coordination with clinic staff and Arboretum clinic faculty.

Resident Continuity Clinic (ARB) Presentations: Chief Mini-Quality Improvement projects
As a PGY-4, you will present during the last Friday noon care conference during your second Arboretum clinic Chief block. This 10 minute project presentation will occur prior to the last weekly Arboretum clinic Patient Care Conference, and is designed to improve patient flow and service delivery in the Arboretum clinic. All Arboretum clinic faculty and residents are invited to attend.

Both presentations are part of your Arboretum clinic learning portfolio. All documents can be found in MedHub (Resources/Documents).
Research Projects

Completion of a research project is a requirement for graduation. The department has a formal curriculum so that each resident class performs a RCT as a team. Several topics are suggested to the incoming PGY1 class and a topic and faculty mentor are chosen early in the year so that the clinical trial design and the IRB can be completed during the PGY1 year.

In addition, many of the department's clinical and basic scientists are available to mentor a resident's project for individuals that chose to pursue an independent project. This is particularly encouraged for residents interested in pursuing subspecialty fellowship training.

<table>
<thead>
<tr>
<th>PGY 1 - Design and Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Topic</strong></td>
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<tr>
<td>--------</td>
</tr>
<tr>
<td><strong>1-3</strong></td>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>What Courses Count?</strong></td>
</tr>
<tr>
<td>University of Wisconsin and Meriter CITI Modules If you have never taken a human subjects protection course, you will take the <strong>Basic Course</strong>. This takes about 4 hours to complete. If your training is about to expire, you will take the <strong>Refresher Course</strong>. This takes about 1-2 hours to complete. You are encouraged to use multiple log in sessions. This system will save your answers to the quizzes. <strong>Passing Score</strong> - You need an aggregate score of 80% for all the quizzes. A running tally is compiled in the Grade Book. If you want to improve a score on a quiz, you may repeat any quiz in which you didn't score 100% correct.</td>
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<td><strong>4</strong></td>
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<td><strong>6</strong></td>
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<td>Class</td>
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<td>7</td>
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<td>11</td>
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<tr>
<td>12</td>
</tr>
</tbody>
</table>

**PGY 2 - Design and Statistics**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Authorship</td>
<td>International Committee of Medical Journal Editors website: <a href="http://www.icmje.org/">http://www.icmje.org/</a></td>
</tr>
<tr>
<td>2 Preparation of Research Day Presentation</td>
<td>How to prepare an oral presentation</td>
</tr>
<tr>
<td>3 Progress Report</td>
<td>How to Prepare a Poster</td>
</tr>
<tr>
<td>4 Progress Report</td>
<td>Assign Roles for Resident Research Day</td>
</tr>
<tr>
<td>5 Progress Report</td>
<td>FINAL PRESENTATIONS</td>
</tr>
</tbody>
</table>

**PGY 3 – Scientific Writing**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Preparing to Write</td>
<td>Successful Scientific Writing: Chapter 1</td>
</tr>
<tr>
<td>2 Composing First Drafts</td>
<td>Successful Scientific Writing: Chapter 2</td>
</tr>
<tr>
<td>3 Instructions to Authors (Journal will vary based upon group decisions)</td>
<td>Green Journal Website <a href="http://journals.lww.com/greenjournal/pages/default.aspx">http://journals.lww.com/greenjournal/pages/default.aspx</a></td>
</tr>
<tr>
<td>4 Visual Support for the Written Word</td>
<td>Successful Scientific Writing: Chapter 3</td>
</tr>
<tr>
<td>5 Visual Support for the Spoken Word</td>
<td>Successful Scientific Writing: Chapter 4</td>
</tr>
<tr>
<td>6 Revising to Increase Coherence</td>
<td>Successful Scientific Writing: Chapter 5</td>
</tr>
<tr>
<td>7 Improving Word Choice and Syntax Style</td>
<td>Successful Scientific Writing: Chapter 6</td>
</tr>
<tr>
<td>8 Attending to Grammar, Number and other Mechanics</td>
<td>Successful Scientific Writing: Chapter 7</td>
</tr>
<tr>
<td>9 The Rest of the Story</td>
<td>Successful Scientific Writing: Chapter 8</td>
</tr>
<tr>
<td>10 Selecting a Journal</td>
<td>Preparing for Publication: Factors to Consider in Selecting a Journal for Publication Becker Medical Library, February 2010</td>
</tr>
<tr>
<td>11 Seeking Funding for Research</td>
<td>Hulley: Designing Clinical Research Chapter 19</td>
</tr>
</tbody>
</table>
Resident Case Log System

Overview and Requirements

The Accreditation Council for Graduate Medical Education (ACGME) Resident Case Log is an online system that allows residents to keep an electronic record of their clinical experience, and utilizes Common Procedural Terminology (CPT) codes. These clinical statistics are required by the ACGME and are part of the information considered for program accreditation. They will be an important document for you when you apply for hospital credentialing after graduation.

Graduating resident procedure case logs are reported side-by-side with the newly established minimum thresholds for obstetrics and gynecology residency education. The new minimums will reflect the lowest acceptable clinical volume of procedures performed per resident for program accreditation. A program will be considered in compliance if each resident in the program achieves the minimum number of procedures for each listed procedure or category.

Be assured that reporting of surgical education does not end once minimum numbers are achieved by a resident—these numbers do not constitute a final target number, but rather reflect what the ACGME believes is merely an acceptable minimal exposure during residency. Residents should continue to enter all surgical activity during their educational programs, even if they have personally achieved these minimum numbers.

Achievement of the minimum numbers of listed procedures does not signify achievement of an individual resident’s competence in a particular listed procedure. In most cases, a resident will need to perform an additional number of the listed procedures before he or she is deemed competent in each procedure by the program director. Moreover, the listed procedures represent only a fraction of the total operative experience expected of a resident within the designated program length.

Each resident is responsible for keeping an accurate, up-to-date record of their clinical experience. Instructions for entering cases are available online. Also, consult your fellow residents when “stats” questions arise, to ensure that you gain full credit for your clinical experience.

Residents should keep their case log updated on a continuous basis, and are expected to log cases by Wednesday night. Cases will be downloaded from the ACGME website on Thursday morning. The case list is sent to Dr. Rice who selects which cases will be discussed the following week. The list of cases for discussion to residents & faculty is emailed by Friday morning.

If cases are not appropriately logged on a weekly basis, the resident’s name will be listed (in red) on the weekly completed M&M list distributed department-wide.

The Residency Program Coordinator will be monitoring the Case Log system to ensure timely record keeping. If you have questions regarding the Case Log system, contact the Education Office.

Minimum Thresholds in Obstetrics and Gynecology

<table>
<thead>
<tr>
<th>Category</th>
<th>Minimum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous vaginal delivery</td>
<td>200</td>
</tr>
<tr>
<td>Cesarean delivery</td>
<td>145</td>
</tr>
<tr>
<td>Operative vaginal delivery</td>
<td>15</td>
</tr>
<tr>
<td>Obstetric ultrasound**</td>
<td>50</td>
</tr>
<tr>
<td>Abdominal hysterectomy</td>
<td>35</td>
</tr>
<tr>
<td>Vaginal hysterectomy</td>
<td>15</td>
</tr>
<tr>
<td>Procedure</td>
<td>Credits</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Laparoscopic hysterectomy</td>
<td>20</td>
</tr>
<tr>
<td>Incontinence and pelvic floor procedures</td>
<td>25</td>
</tr>
<tr>
<td>(excluding cystoscopy)</td>
<td></td>
</tr>
<tr>
<td>Cystoscopy</td>
<td>10</td>
</tr>
<tr>
<td>Laparoscopy</td>
<td>60</td>
</tr>
<tr>
<td>Hysteroscopy</td>
<td>40</td>
</tr>
<tr>
<td>Abortions</td>
<td>20</td>
</tr>
<tr>
<td>Transvaginal ultrasound</td>
<td>50</td>
</tr>
<tr>
<td>Surgery for invasive cancer</td>
<td>25</td>
</tr>
</tbody>
</table>

**Obstetric ultrasounds include fetal biometry performed at over 14 weeks’ gestation**

### Acceptable Case List Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;P</td>
<td>Repair anterior and posterior colporrhaphy</td>
</tr>
<tr>
<td>HRT</td>
<td>Hormone replacement therapy</td>
</tr>
<tr>
<td>AB</td>
<td>Abortion</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>BSO</td>
<td>Bilateral salpingo-oophorectomy</td>
</tr>
<tr>
<td>CD</td>
<td>Cesarean Delivery</td>
</tr>
<tr>
<td>cm</td>
<td>Centimeter</td>
</tr>
<tr>
<td>D&amp;C</td>
<td>Dilation and curettage</td>
</tr>
<tr>
<td>D&amp;E</td>
<td>Dilation and evacuation</td>
</tr>
<tr>
<td>DHEAS</td>
<td>Dihydroepiandrosterone sulfate</td>
</tr>
<tr>
<td>E</td>
<td>Estrogen</td>
</tr>
<tr>
<td>E2</td>
<td>Estradiol</td>
</tr>
<tr>
<td>FSH</td>
<td>Follicle stimulating hormone</td>
</tr>
<tr>
<td>gm</td>
<td>Grams</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>HCG</td>
<td>Human chorionic gonadotropin</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papillomavirus</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine device</td>
</tr>
<tr>
<td>kg</td>
<td>Kilogram</td>
</tr>
<tr>
<td>LH</td>
<td>Luteinizing hormone</td>
</tr>
<tr>
<td>P</td>
<td>Progesterone</td>
</tr>
<tr>
<td>PAP</td>
<td>Papanicolaou smear</td>
</tr>
<tr>
<td>PROM</td>
<td>Premature rupture of membranes</td>
</tr>
<tr>
<td>PTL</td>
<td>Preterm labor</td>
</tr>
<tr>
<td>SAB</td>
<td>Spontaneous abortion</td>
</tr>
<tr>
<td>SVD</td>
<td>Spontaneous vaginal delivery</td>
</tr>
<tr>
<td>T</td>
<td>Testosterone</td>
</tr>
<tr>
<td>TAH</td>
<td>Total abdominal hysterectomy</td>
</tr>
<tr>
<td>TSH</td>
<td>Thyroid stimulating hormone</td>
</tr>
<tr>
<td>TVH</td>
<td>Total vaginal hysterectomy</td>
</tr>
<tr>
<td>VBAC</td>
<td>Vaginal birth after cesarean</td>
</tr>
</tbody>
</table>

2012 Bulletin for Basic Certification in Obstetrics and Gynecology The American Board of Obstetrics and Gynecology, Inc.
Resident Continuity Clinic

In July, 2013, the Resident Continuity Clinic moved to a new facility, UW Health Arboretum Obstetrics & Gynecology at 1102 South Park Street. At the PGY-2-PGY-4 training levels, each resident has one half day each week in the Resident Continuity outpatient clinic. A team of residents is assigned each afternoon. The resident clinics are designed to function with a great deal of autonomy. Ob-Gyn generalist faculty members are available on site for staffing and consultation.

Each PGY-2 through PGY-4 resident is required to do chart reviews. All senior residents are required to complete a learning portfolio as well as a presentation. More information can be found in the Presentations section of this manual and in MedHub (Resources/Documents) folder.

Beginning in July of 2014, PGY-1 residents will be assigned to a centering prenatal group and will be excused from their clinical service to attend the group visits.

As required by the ACGME, each resident must complete a minimum of 120 half-days of residency clinic prior to graduation. Each resident is required to login for each clinic half-day.

There is now an easy "Clock-in" feature on the iPad at the clinic checkout desk. Instructions are posted above each computer. You will receive a report every 6 months tracking your individual totals.
The Obstetrics and Gynecology Milestone Project

A Joint Initiative of
The Accreditation Council for Graduate Medical Education,
The American Board of Obstetrics and Gynecology,
and
The American College of Obstetrics and Gynecology

September 2013
The Obstetrics and Gynecology Milestone Project

The Milestones are designed only for use in evaluation of resident physicians in the context of their participation in ACGME-accredited residency or fellowship programs. The Milestones provide a framework for the assessment of the development of the resident physician in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.
Obstetrics and Gynecology Milestones

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*Acknowledgements. The authors, all of whom participated in milestone development as members of the Obstetrics and Gynecology Milestone Working Group, wish to thank the members of the original Obstetrics and Gynecology Working Group for their contributions to this work: Haywood L. Brown, MD; Tamara T. Chao, MD; Missy Fleming, PhD; Diane Hartmann, MD; Frank Ling, MD; Krista Reagan, MD; Jeffrey M. Rothenberg, MD; Andrew Satin, MD; Howard Shaw, MD; David Soper, MD; Ronald C. Strickler, MD; Susan Swing, PhD.
Milestone Reporting

This document presents milestones designed for programs to use in semi-annual review of resident performance and reporting to the ACGME. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for resident performance as a resident moves from entry into residency through graduation. In the initial years of implementation, the Review Committee will examine milestone performance data for each program’s residents as one element in the Next Accreditation System (NAS) to determine whether residents overall are progressing.

For each period, review and reporting will involve selecting milestone levels that best describe each resident’s current performance and attributes. Milestones are arranged into numbered levels. Tracking from Level 1 to Level 5 is synonymous with moving from novice to expert. These levels do not correspond with post-graduate year of education.

Selection of a level implies that the resident substantially demonstrates the milestones in that level, as well as those in lower levels (see the diagram on page v).

**Level 1:** The resident demonstrates milestones expected of an incoming resident.

**Level 2:** The resident is advancing and demonstrates additional milestones, but is not yet performing at a mid-residency level.

**Level 3:** The resident continues to advance and demonstrate additional milestones, consistently including the majority of milestones targeted for residency.

**Level 4:** The resident has advanced so that he or she now substantially demonstrates the milestones targeted for residency. This level is designed as the graduation target.

**Level 5:** The resident has advanced beyond performance targets set for residency and is demonstrating “aspirational” goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional residents will reach this level.
**Additional Notes**

Level 4 is designed as the graduation target but does not represent a graduation requirement. Making decisions about readiness for graduation is the purview of the residency program director. Study of milestone performance data will be required before the ACGME and its partners will be able to determine whether milestones in the first four levels appropriately represent the developmental framework, and whether milestone data are of sufficient quality to be used for high-stakes decisions.

Examples are provided with some milestones. Please note that the examples are not the required element or outcome; they are provided as a way to share the intent of the element.

Some milestone descriptions include statements about performing independently. These activities must occur in conformity to the ACGME supervision guidelines, as well as institutional and program policies. For example, a resident who performs a procedure independently must, at a minimum, be supervised through oversight.

Answers to Frequently Asked Questions about the NAS and milestones are available on the ACGME’s NAS microsite:
The diagram below presents an example set of milestones for one sub-competency in the same format as the milestone report worksheet. For each reporting period, a resident’s performance on the milestones for each sub-competency will be indicated by:

- selecting the level of milestones that best describes that resident’s performance in relation to the milestones
- for Patient Care and Medical Knowledge milestones, selecting the option that says the resident has “Not yet rotated”
- for Interpersonal and Communication Skills, Practice-based Learning and Improvement, Professionalism, and Systems-based Practice, selecting the option that says the resident has “Not yet achieved Level 1”

<table>
<thead>
<tr>
<th>Respect for Patient Privacy, Autonomy, Patient/Physician Relationship — Professionalism</th>
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<tbody>
<tr>
<td><strong>Level 1</strong></td>
</tr>
<tr>
<td>Understands the importance of respect for patient privacy and autonomy</td>
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<tr>
<td>Understands the ethical principles of appropriate patient-physician relationships</td>
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<tr>
<td>Demonstrates understanding of ethical principles including boundary issues and consciously applies them in patient care</td>
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Selecting a response box in the middle of a level implies that milestones in that level and in lower levels have been substantially demonstrated.

Selecting a response box on the line in between levels indicates that milestones in lower levels have been substantially demonstrated as well as some milestones in the higher level(s).
<table>
<thead>
<tr>
<th>Level 1</th>
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<th>Level 4</th>
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</thead>
<tbody>
<tr>
<td>Demonstrates basic knowledge of normal antepartum care for women with uncomplicated pregnancies</td>
<td>Provides complete antepartum care for women with uncomplicated pregnancies</td>
<td>Manages common medical complications (e.g., hypertension, diabetes, infectious diseases)</td>
<td>Demonstrates a comprehensive understanding of the varying patterns of presentation and treatment options for a variety of medical and obstetrical complications</td>
<td>Manages patients with complex and atypical medical and obstetrical complications</td>
</tr>
<tr>
<td>Recognizes basic risk factors, symptoms, and signs of common medical complications (e.g., hypertension, diabetes, infectious diseases)</td>
<td>Manages common obstetrical complications (e.g., previous Cesarean section, abnormal fetal growth, multifetal gestation)</td>
<td>Recognizes atypical presentations of medical and obstetrical complications; identifies indications for consultation, referral, and/or transfer of care for patients with medical and obstetrical complications</td>
<td>Effectively supervises and educates lower level residents in antepartum care</td>
<td>Applies innovative approaches to complex and atypical antepartum conditions and implements treatment plans based on emerging evidence</td>
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<tr>
<td>Recognizes basic risk factors, symptoms, and signs of common obstetrical conditions (e.g., post-term gestation, abnormal placentation, third trimester bleeding)</td>
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<tbody>
<tr>
<td>Demonstrates basic knowledge of routine/uncomplicated intrapartum obstetrical care including, conduct of normal labor</td>
<td>Provides intrapartum obstetrical care for women with uncomplicated pregnancies (e.g., identification of fetal lie, interpretation of fetal heart rate monitoring, and tocodynamometry)</td>
<td>Manages abnormal labor</td>
<td>Provides care for women with complex intrapartum complications and conditions</td>
<td>Applies innovative approaches to complex and atypical intrapartum conditions and implements treatment plans based on emerging evidence</td>
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<tr>
<td>Differentiates between normal and abnormal labor</td>
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<td>Differentiates between normal and abnormal labor</td>
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<tr>
<td>Recognizes intrapartum complications (e.g., chorioamnionitis, shoulder dystocia)</td>
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<td>Provides care for women with uncomplicated pregnancies (e.g., cord prolapse, placental abruption)</td>
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<td>Identifies indications for consultation, referral, and/or transfer of care for patients with intrapartum complications</td>
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<td>Effectively supervises and educates lower-level residents in intrapartum care</td>
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<td>Collaborates and provides consultation to other members of the health care team in intrapartum care</td>
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<tbody>
<tr>
<td><strong>Demonstrates basic knowledge of normal postpartum care</strong></td>
<td><strong>Provides postpartum care for women with uncomplicated pregnancies, including lactation counseling</strong></td>
<td><strong>Manages common postpartum complications</strong></td>
<td><strong>Manages patients with complex complications of the postpartum period (e.g., septic pelvic thrombophlebitis, pulmonary embolism)</strong></td>
<td><strong>Applies innovative approaches to complex and atypical postpartum conditions and implements treatment plans based on emerging evidence</strong></td>
</tr>
<tr>
<td>Recognizes basic risk factors, symptoms, and signs, of common postpartum complications (e.g., postpartum hemorrhage, infection, venous thromboembolism, depression)</td>
<td>Correctly interprets the results of obstetric pathology and laboratory reports to ascertain the etiology of obstetrical outcomes</td>
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<td>Determines the need for consultation, referral, or transfer for patients with complex complications in the postpartum period</td>
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<td>Counsels patients about the risk of recurrence of antepartum, intrapartum, and postpartum complications (e.g., preeclampsia, pre-term delivery, shoulder dystocia, depression)</td>
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<td>Effectively supervises and educates lower-level residents in postpartum care</td>
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<td>Collaborates and provides consultation to other members of the health care team in postpartum care</td>
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<tr>
<th>Obstetrical Technical Skills — Patient Care</th>
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<td><strong>Level 1</strong></td>
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<tr>
<td>Demonstrates basic surgical principles, including use of universal precautions and aseptic technique</td>
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<tr>
<td>Performs basic procedures, including speculum examination and cervical examination</td>
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<tr>
<th>Immediate Care of the Newborn — Patient Care</th>
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<tr>
<td><strong>Level 1</strong></td>
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<tr>
<td>Performs initial warming and drying of a non-depressed infant</td>
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**Gynecology Technical Skills: Laparotomy (e.g., Hysterectomy, Myomectomy, Adnexectomy) — Patient Care**

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<tbody>
<tr>
<td>Demonstrates knowledge of basic abdominal and pelvic anatomy</td>
<td>Works effectively as a surgical assistant</td>
<td>Demonstrates appropriate tissue handling, request for instruments, and flow of the procedure</td>
<td>Independently performs gynecologic procedures</td>
<td>Applies innovative and complex approaches to laparotomy and implements treatment plans based on emerging evidence</td>
</tr>
<tr>
<td>Demonstrates basic surgical principles, including use of universal precautions and aseptic technique</td>
<td>Performs simple abdominal incision and closure</td>
<td>Understands and uses various forms of energy sources used in surgery</td>
<td>Demonstrates good intraoperative decision making, including the ability to modify a surgical plan based on operative findings</td>
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</tr>
<tr>
<td>Positions patient appropriately for surgery</td>
<td>Demonstrates basic surgical skills, including:</td>
<td>Performs uncomplicated gynecologic procedures</td>
<td>Demonstrates the ability to recognize and manage surgical complications, including the appropriate use of intraoperative consultation</td>
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<tr>
<td></td>
<td>• knot tying</td>
<td>Recognizes surgical complications and formulates an initial management plan</td>
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<td></td>
<td>• simple suturing</td>
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<td></td>
<td>• suture and staple removal</td>
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# Gynecology Technical Skills: Vaginal Surgery (e.g., Vaginal Hysterectomy, Colporrhaphy, Mid-urethral Sling) — Patient Care

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<tbody>
<tr>
<td>Demonstrates knowledge of basic pelvic anatomy</td>
<td>Works effectively as a surgical assistant</td>
<td>Displays appropriate tissue handling, request for instruments, and flow of the procedure</td>
<td>Independently performs vaginal procedures</td>
<td>Applies innovative and complex approaches to vaginal surgery and implements treatment plans based on emerging evidence</td>
</tr>
<tr>
<td>Demonstrates basic surgical principles, including use of universal precautions and aseptic technique</td>
<td>Performs simple vaginal or vulvar incision and repair</td>
<td>Understands and uses various forms of energy sources used in surgery</td>
<td>Demonstrates good intra-operative decision making, including the ability to modify a surgical plan based on operative findings</td>
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<tr>
<td>Positions patient appropriately for surgery</td>
<td>Demonstrates basic surgical skills, including: knot tying and simple suturing</td>
<td>Performs uncomplicated procedures</td>
<td>Recognizes surgical complications and formulates an initial management plan</td>
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<td></td>
<td></td>
<td>Recognizes surgical complications and formulates an initial management plan</td>
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### Gynecology Technical Skills: Endoscopy (Laparoscopy, Hysteroscopy, Cystoscopy) — Patient Care

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<tbody>
<tr>
<td>Demonstrates basic understanding of abdominal and pelvic anatomy</td>
<td>Assembles endoscopic instruments and checks proper functioning</td>
<td>Performs diagnostic procedures</td>
<td>Performs operative endoscopy independently (e.g., hysterectomy, myomectomy)</td>
<td>Applies innovative and complex approaches to endoscopy and implements treatment plans based on emerging evidence</td>
</tr>
<tr>
<td>Demonstrates basic surgical principles, including use of universal precautions and aseptic technique</td>
<td>Performs proper insertion of endoscopic instruments</td>
<td>Performs operative procedures</td>
<td>Demonstrates good intra-operative decision making, including the ability to modify surgical plan based on operative findings</td>
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</tr>
<tr>
<td>Positions patient appropriately for surgery</td>
<td>Demonstrates an understanding of the indications for endoscopy</td>
<td>Displays appropriate tissue handling, request for instruments, and flow of the procedure</td>
<td>Recognizes and manages surgical complications, including the appropriate use of intra-operative consultation</td>
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<td></td>
<td>Uses various forms of energy sources used in surgery</td>
<td>Applies an evidence-based approach to the adoption of new technologies</td>
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<td>Recognizes complications and formulates an initial management plan</td>
<td>Effectively supervises and educates lower-level residents regarding endoscopy</td>
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<td>Collaborates and provides consultation to other members of the health care team regarding endoscopy</td>
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### Peri-operative Care — Medical Knowledge

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</table>
| Demonstrates knowledge of basic abdominal and pelvic anatomy | Demonstrates knowledge of:  
- relevant surgical anatomy  
- common procedural indications  
- comorbidities relevant to gynecologic surgery  
- prophylactic strategies to reduce post-operative complications | Demonstrates knowledge about the management of:  
- medical comorbidities relevant to gynecologic surgery  
- appropriate procedural options for the relevant gynecological condition | Demonstrates advanced knowledge necessary for management of medically complex patients  
Demonstrates the ability to recognize and manage peri-operative complications | Applies innovative approaches to complex and atypical peri-operative care  
Effectively supervises and educates lower-level residents regarding peri-operative care  
Collaborates and provides consultation to other members of the team regarding peri-operative care  
Manages or co-manages critically-ill patients requiring care in an intensive care unit |

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<tbody>
<tr>
<td>Demonstrates a basic understanding of patients presenting with</td>
<td>Demonstrates the ability to formulate a differential diagnosis</td>
<td>Demonstrates the ability to:</td>
<td>Demonstrates an in-depth knowledge regarding patients presenting with</td>
<td>Leads a multidisciplinary team for care of patients with chronic pelvic</td>
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<tr>
<td>abdominal/pelvic pain regarding:</td>
<td>Demonstrates an understanding of initial:</td>
<td>• utilize focused diagnostic approaches</td>
<td>abdominal and pelvic pain relevant to:</td>
<td>pain</td>
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<tr>
<td>• risk factors</td>
<td>• evaluation</td>
<td>• formulate comprehensive management plans</td>
<td>• varying patterns of presentation</td>
<td>Applies innovative approaches to complex and atypical abdominal/pelvic</td>
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<tr>
<td>• signs and symptoms</td>
<td>• treatment options</td>
<td></td>
<td>• treatment options</td>
<td>pain and implements treatment plans based on emerging evidence</td>
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<td>• refractory pelvic pain</td>
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<td>Manages patients with complex and atypical chronic pelvic pain</td>
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<td>Demonstrates the ability to formulate comprehensive plans of</td>
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<td>management for patients with multiple and/or complex comorbidities</td>
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<tr>
<td><strong>Demonstrates basic knowledge</strong> about what constitutes normal and abnormal uterine bleeding</td>
<td><strong>Demonstrates the ability to</strong> formulate a differential diagnosis</td>
<td><strong>Demonstrates in-depth knowledge</strong> of the physiology of the normal menstrual cycle</td>
<td><strong>Demonstrates an in-depth knowledge</strong> regarding patients presenting with abnormal uterine bleeding relevant to:</td>
<td><strong>Applies innovative approaches</strong> to complex and atypical abnormal uterine bleeding and implements treatment plans based on emerging evidence</td>
</tr>
<tr>
<td><strong>Verbalizes the phases of the normal menstrual cycle</strong></td>
<td><strong>Demonstrates an understanding of initial:</strong></td>
<td><strong>Demonstrates the ability to:</strong></td>
<td><strong>varying patterns of presentation</strong></td>
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<tr>
<td></td>
<td>• evaluation</td>
<td>• utilize focused diagnostic approaches</td>
<td>• comprehensive treatment options</td>
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<tr>
<td></td>
<td>• treatment options</td>
<td>• formulate a comprehensive management plan</td>
<td>• refractory bleeding</td>
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<td><strong>Demonstrates the ability to</strong> formulate comprehensive management plans for patients with multiple and/or complex comorbidities</td>
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<td><strong>Effectively supervises and educates lower-level residents regarding abnormal bleeding</strong></td>
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<td></td>
<td><strong>Collaborates and provides consultation to other members of the health care team regarding abnormal uterine bleeding</strong></td>
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### Pelvic Mass — Medical Knowledge

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</thead>
</table>
| Demonstrates a basic understanding of patients presenting with a pelvic mass, including:  
- differential diagnosis  
- signs and symptoms | Demonstrates the ability to formulate a focused differential diagnosis | Demonstrates the ability to:  
- utilize focused diagnostic approaches  
- formulate a comprehensive management plan | Demonstrates an in-depth knowledge regarding patients presenting with a pelvic mass relevant to:  
- varying patterns of presentation  
- comprehensive treatment options  
- determines the need for consultation, referral, or transfer of patients | Applies innovative approaches to complex and atypical pelvic mass and implements treatment plans based on emerging evidence |

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**Pelvic Floor Disorders (Urinary Incontinence, Pelvic Prolapse, Anal Incontinence) — Medical Knowledge**

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</thead>
<tbody>
<tr>
<td>Demonstrates basic knowledge of normal pelvic floor anatomy</td>
<td>Demonstrates knowledge of basic pelvic floor physiology and functional anatomy</td>
<td>Demonstrates knowledge of abnormal pelvic floor anatomy and physiology</td>
<td>For patients with uncomplicated pelvic floor disorders:</td>
<td>Effectively supervises and educates lower-level residents regarding complex and atypical pelvic floor disorders</td>
</tr>
</tbody>
</table>

- **Level 1**
  - Demonstrates basic knowledge of normal pelvic floor anatomy

- **Level 2**
  - Demonstrates knowledge of basic pelvic floor physiology and functional anatomy

- **Level 3**
  - Demonstrates a basic understanding of patients presenting with pelvic floor disorders relevant to:
    - risk factors
    - symptoms
    - physical exam findings
  - Demonstrates the ability to formulate a differential diagnosis

- **Level 4**
  - Formulates an initial plan of management for patients with uncomplicated pelvic floor disorders

- **Level 5**
  - For patients with uncomplicated pelvic floor disorders:
    - utilizes focused diagnostic approaches
    - uses non-surgical and surgical therapies
    - formulates comprehensive management plans for patients with comorbidities
    - determines the need for consultation, referral, or transfer of patients

**Comments:** Not yet rotated
## First Trimester Bleeding — Medical Knowledge

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<tbody>
<tr>
<td>Demonstrates basic understanding of normal early pregnancy development, including implantation, early embryology, and placental development</td>
<td>Demonstrates the ability to formulate a differential diagnosis (e.g., ectopic pregnancy, spontaneous abortion, non-obstetric etiologies)</td>
<td>Counsels patients regarding natural history and treatment options</td>
<td>Manages patients with complications of first trimester bleeding or its management (e.g., hemorrhage, infection)</td>
<td>Applies innovative approaches to complex or atypical first trimester bleeding and implements treatment plans based on emerging evidence</td>
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<td>Utilizes non-surgical and surgical methods to manage patients with:</td>
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<td>Effectively supervises and educates lower-level residents regarding first trimester bleeding</td>
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<td></td>
<td>• ectopic pregnancy</td>
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<td>Collaborates and provides consultation to other members of the healthcare team regarding first trimester bleeding</td>
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<td></td>
<td>• abortion (spontaneous, induced)</td>
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<td></td>
<td>• other etiologies</td>
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<td></td>
<td>Demonstrates an understanding of complications related to first trimester bleeding and its management</td>
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## Office Practice Milestones

### Family Planning — Patient Care

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<tbody>
<tr>
<td><strong>Verbalizes basic knowledge about common contraceptive options</strong></td>
<td><strong>Demonstrates a basic understanding of the effectiveness, risks, benefits, complications, and contraindications of contraception, including emergency contraception, and pregnancy termination</strong></td>
<td><strong>Counsels on the effectiveness, risks, benefits, and contraindications of available forms of contraception</strong></td>
<td><strong>Formulates comprehensive management plans for patients with medical diseases complicating their use of contraceptive methods</strong></td>
<td><strong>Applies innovative and complex approaches to family planning and implements treatment plans based on emerging evidence</strong></td>
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<td><strong>Counsels on the effectiveness, risks, benefits, and contraindications for male and female sterilization</strong></td>
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<td><strong>Performs intra-uterine and implantable contraceptive placement</strong></td>
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<td></td>
<td><strong>Demonstrates ability to perform basic first trimester uterine evacuation (medical and surgical)</strong></td>
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<tr>
<td>Demonstrates an understanding of common non-reproductive medical disorders</td>
<td>Performs history and physical, forms a differential diagnosis, and evaluates for common non-reproductive medical disorders (e.g., chronic hypertension, obesity, depression)</td>
<td>Interprets test results and screens for related conditions of non-reproductive medical disorders (e.g., metabolic syndrome, BRCA mutation, eating disorders)</td>
<td>Initiates management plans for patients with complex non-reproductive medical disorders (e.g., osteoporosis, metabolic syndrome, BRCA mutation, eating disorders, human immunodeficiency virus [HIV] infection) and provides referrals</td>
<td>Provides on-going, comprehensive care for patients with complex and atypical non-reproductive medical disorders</td>
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### Health Care Maintenance and Disease Prevention — Medical Knowledge

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<tbody>
<tr>
<td>Demonstrates knowledge of the characteristics of a good screening test</td>
<td>Demonstrates knowledge of evidence-based, age-appropriate guidelines for women’s health maintenance and disease prevention (e.g., breast screening, cervical cancer screening)</td>
<td>Interprets age- and risk-appropriate tests (e.g., bone mineral density, mammogram, lipids, thyroid studies)</td>
<td>Formulates comprehensive management plans for high-risk patients (e.g., vulnerable populations)</td>
<td>Manages patients with highly complex medical diseases for health care maintenance and disease prevention</td>
</tr>
<tr>
<td>Demonstrates knowledge of indications and limitations of commonly used screening tests</td>
<td>Recommends age- and risk-appropriate vaccinations</td>
<td>Develops patient-centered management plans to maintain health and prevent disease</td>
<td>Monitors one’s own outcomes to improve practice</td>
<td>Applies innovative and complex approaches to health care maintenance and disease prevention and implements treatment plans based on emerging evidence</td>
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### Systems-based Practice Milestones

#### Patient Safety and Systems Approach to Medical Errors: Participate in identifying system errors and implementing potential systems solutions — Systems-based Practice

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<tr>
<td>Recognizes limitations and failures of a team approach (e.g., hand-offs, miscommunication) in health care as the leading cause of preventable patient harm</td>
<td>Demonstrates knowledge of institutional surveillance systems to monitor for patient safety (e.g., surgical site infection, medical error reporting)</td>
<td>Participates in patient safety reporting and analyzing systems</td>
<td>Reports errors and near-misses to the institutional surveillance system and superiors</td>
<td>Contributes to peer-reviewed medical literature</td>
</tr>
<tr>
<td>Participates in “time-out”</td>
<td>Demonstrates knowledge of national patient safety standards, as well as their use/application in the institution</td>
<td>Participates in team drills</td>
<td>Recognizes when root cause analysis is necessary, and is capable of participating in root cause analysis</td>
<td>Organizes and leads institutional QI/patient safety projects</td>
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<td>Appropriately utilizes checklists to promote patient safety (e.g., medication reconciliation)</td>
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<td>Actively participates in quality improvement (QI)/patient safety projects</td>
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<td>Demonstrates knowledge of the epidemiology of medical errors and the differences between near misses, medical errors, and sentinel events</td>
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<tr>
<td>Understands the importance of providing cost-effective care</td>
<td>Is aware of common socioeconomic barriers that impact patient care</td>
<td>Demonstrates the incorporation of cost awareness into clinical judgment and decision making</td>
<td>Practices cost-effective care (e.g., formulary drugs, generic drugs, tailoring of diagnostic tests)</td>
<td>Participates in advocacy or health care legislation locally, regionally, or nationally</td>
</tr>
<tr>
<td>Understands the role of physicians in advocating for appropriate women’s health care</td>
<td>Demonstrates an awareness of the need for coordination of patient care and patient advocacy</td>
<td>Coordinates and advocates for needed resources to facilitate patient care (e.g., effective discharge planning)</td>
<td>Analyzes patient care options from a quality of life (QOL)/cost-of-care perspective, and includes in patient counseling</td>
<td>Effectively communicates within health care systems to advocate for the needs of patient populations</td>
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<td>Effectively communicates within his or her own hospital/clinic to advocate for patient needs</td>
<td>Demonstrates an understanding of the political economics of health care legislation locally, regionally, and nationally</td>
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### Practice-based Learning and Improvement Milestones

#### Self-directed Learning/Critical Appraisal of Medical Literature — Practice-based Learning and Improvement

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<tr>
<td>Demonstrates an understanding of critical appraisal of the literature</td>
<td>Identifies resources (e.g., texts, search engines) to answer questions while providing patient care</td>
<td>Applies patient-appropriate use of evidence-based on review articles or guidelines on common topics in practice</td>
<td>Tailors evidence-based practice based on the values and preferences of each patient</td>
<td>Designs a hypothesis-driven or hypothesis-generating study</td>
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<tr>
<td>Demonstrates responsiveness to constructive feedback</td>
<td>Recognizes limits of knowledge, expertise, and technical skills</td>
<td>Critically reviews and interprets the literature with the ability to identify study aims, hypotheses, design, and biases</td>
<td>Reads and assesses strength of evidence in current literature and applies it to one’s own practice</td>
<td>Contributes to peer-reviewed medical literature</td>
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<td>Describes commonly used study designs (e.g., randomized controlled trial (RCT), cohort; case-control, cross-sectional)</td>
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### Quality Improvement Process: Systematically analyze practice using quality improvement methods and implement changes with the goal of practice improvement — Practice-based Learning and Improvement

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<tbody>
<tr>
<td>Has a commitment to self-evaluation, lifelong learning, and patient safety</td>
<td>Demonstrates understanding of the basic concepts of QI</td>
<td>References and utilizes national standards or guidelines in patient care plans</td>
<td>Participates in departmental or institutional QI process/committees</td>
<td>Analyzes department or institutional outcomes</td>
</tr>
<tr>
<td></td>
<td>Reads appropriate information, as assigned by the program or related to patient-specific topics</td>
<td>Identifies quality of care issues within one’s own practice with a systems-based approach</td>
<td>Implements changes with a goal of practice improvement</td>
<td>Contributes to peer-reviewed medical literature</td>
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<td>Organizes and leads effective institutional QI/patient safety projects</td>
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### Compassion, Integrity, and Respect for Others — Professionalism

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<tbody>
<tr>
<td><strong>Understands the importance of compassion, integrity, and respect for others</strong></td>
<td>Consistently shows compassion, integrity, and respect in typical situations with patients, peers, and members of the health care team</td>
<td>Consistently shows compassion, integrity, and respect for patients who decline medical advice or request un-indicated tests or treatments, for patients who have psychiatric comorbidities, and for team members in circumstances of conflict or high stress</td>
<td>Consistently models compassion, integrity, and respect for others</td>
<td>Assumes long-term or leadership role in community outreach activities to improve the health of vulnerable populations</td>
</tr>
<tr>
<td><strong>Demonstrates sensitivity and responsiveness to patients</strong></td>
<td>Consistently demonstrates sensitivity and responsiveness to diversity of patients’ ages, cultures, races, religions, abilities, or sexual orientations</td>
<td>Modifies one’s own behavior based on feedback to improve his or her ability to demonstrate compassion, integrity, and respect for others</td>
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<td>Accepts constructive feedback to improve his or her ability to demonstrate compassion, integrity, and respect for others</td>
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<tr>
<td>Understands that physicians are accountable to patients, society, and the profession</td>
<td>Acts with honesty and truthfulness</td>
<td>Understands the signs and symptoms of fatigue, stress, and substance abuse</td>
<td>Recognizes signs and symptoms of fatigue, stress, and substance abuse</td>
<td>Coaches others to improve punctuality and responsiveness; offers assistance to ensure patient care duties are completed in a timely fashion</td>
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<tr>
<td>Understands the importance of respect for patient privacy and autonomy</td>
<td>Shows respect for patient privacy</td>
<td>Assesses a patient’s capacity for medical decision making</td>
<td>Successfully navigates ethically complex clinical issues involving patient autonomy</td>
<td>Successfully leads others through complex and atypical clinical issues involving patient autonomy</td>
</tr>
<tr>
<td>Understands the ethical principles of appropriate patient-physician relationships</td>
<td>Elicits patient goals for care, and patient preferences regarding treatment alternatives</td>
<td>Successfully navigates conflicts between patient preferences that are discordant with personal beliefs</td>
<td>Balances patient privacy with ethical and legal requirements in complex circumstances</td>
<td>Longitudinally participates on hospital ethics committee</td>
</tr>
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<td></td>
<td>Demonstrates an understanding of ethical principles, including boundary issues, and consciously applies them in patient care</td>
<td>Efficiently counsels patients to help align treatment decisions with individual preferences</td>
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**Comments:** Not yet achieved Level 1
| Communication with Patients and Families — Interpersonal and Communication Skills |
|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| **Level 1**                                    | **Level 2**                                    | **Level 3**                                    | **Level 4**                                    | **Level 5**                                    |
| Demonstrates adequate listening skills         | Checks for patient and family understanding of illness and management plan | Communicates effectively in stressful, emergent, and complex situations | Delivers bad news to families about complications or death | Capable of effective communication in the most challenging situations, and invites participation from all stakeholders |
| Communicates effectively in routine clinical situations | Allows for opportunities for patient questions | Capable of delivering bad news to patients and families regarding poor prognoses | Capable of informing patients and families about a medical error that caused harm | |
| For hospitalized patients, maintains communication with patient and family regarding plan of care | | Communicates effectively with patients and families across a broad range of socio-economic and cultural backgrounds | Incorporates risk management in this process | |
| | | | Role models effective communication to junior colleagues | |
| | | | Participates in education of patients and families | |

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<tr>
<td>Understands the importance of relationship development, information gathering and sharing, and teamwork</td>
<td>Demonstrates an understanding of the roles of health care team members, and communicates effectively within the team</td>
<td>Works effectively in interprofessional and interdisciplinary health care teams</td>
<td>Leads inter-professional and interdisciplinary health care teams to achieve optimal outcomes</td>
<td>Educates other health care professionals regarding obstetrics and gynecology</td>
</tr>
<tr>
<td>Demonstrates an understanding of transitions of care and team debriefing</td>
<td>Participates in effective transitions of care and team debriefing</td>
<td>Communicates effectively with physicians and other health care professionals regarding patient care</td>
<td>Responds to requests for consultation in a timely manner and communicates recommendations to the requesting team</td>
<td>Provides effective consultation in complex and atypical patients</td>
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### Informed Consent and Shared Decision Making — Interpersonal and Communication Skills

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<td>Understands the importance of informed consent</td>
<td>Begins to engage patients in shared decision making, and obtains informed consent for basic procedures</td>
<td>Uses appropriate, easy-to-understand language in all phases of communication, utilizing an interpreter where necessary</td>
<td>Organizes and participates in multidisciplinary family/patient/team member conferences</td>
<td>Models and coaches shared decision making in complex and highly stressful situations</td>
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<td>Engages in shared decision making, incorporating patients’ and families’ cultural frameworks</td>
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<td>Leads multidisciplinary family/patient/team member conferences</td>
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<td>Obtains informed consent for complex procedures</td>
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