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

Education Organization Chart

Department Chair: Dr. Laurel Rice

Vice Chair
Education:
Dr. Ellen Hartenbach

Education Committee:
Dr. Steve Rose, Chair
Dr. Laura Sabo, Co-Chair

Administrative Assistant:
Beckie Schimelpfenig

Medical Student
Clerkship Director:
Dr. Kathy Stewart

Program Coordinator:
Janet Short

Medical Student
Interest Group Coordinator:
Dr. Mary Landry

Residency Program
Director:
Dr. Laura Sabo

Associate Program
Director Clinical
Education:
Dr. Ryan McDonald

Associate Program
Director Academic
Education:
Dr. Jackie Ogutha

Resident Continuity
Clinic Director:
Dr. Cynthie Anderson

Program Coordinator:
Maria Katsoulidis

Administrative Assistant:
Beckie Schimelpfenig

Simulation Lab
Director:
Dr. John Street

MFM Fellowship
Director:
Dr. Dinesh Shah

Fellowship Coordinator:
Jenny Bright

Gyn Onc Fellowship
Director:
Dr. Steve Rose

Fellowship Coordinator:
Lori Lewis

Education Committee:
Dr. Steve Rose, Chair
Dr. Laura Sabo, Co-Chair

Administrative Assistant:
Beckie Schimelpfenig
Departmental Faculty and Committees

Chair
Laurel W. Rice, MD

Vice Chairs
Klaus Diem, MD, Clinical Operations and Finance
Ellen Hartenbach, MD, Education and Faculty Development
Ronald Magness, PhD, Research

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

Residency Program Director
Laura Sabo, MD

Associate Residency Program Directors
Ryan McDonald, MD
Jaccqueline Ogutha, MD

Resident Continuity Clinic Director
Cynthie Anderson, MD

Medical Student Clerkship Director
Katharina Stewart, MD

Residency Education Committee
Kristine Bathke, MD Laurel Rice, MD
Laura Berghahn, MD Laura Sabo, MD, chair
Sabine Droste, MD Maria Sandgren, MD
Ellen Hartenbach, MD Beckie Schimelpfenig
Brenda Jenkin, MD Mary Stoffel, MD
Maria Katsoulidis John Street, PhD
Mary Landry, MD Gary Waters, MD
Ryan McDonald, MD Chief Resident
Jaccqueline Ogutha, MD

Education Committee
Ryan McDonald, MD Barbara O’Connell, MD
Cynthia Brincat, MD Jaccqueline Ogutha, MD
Larry Charme, MD Stephen Rose, MD, chair
Sabine Droste, MD Laura Sabo, MD, co-chair
Catherine Hubbard, NP Beckie Schimelpfenig
Maria Katsoulidis Janet Short
Mary Landry, MD Katharina Stewart, MD
Doug Laube, MD John Street, PhD
Jay Lick, MD Kim Mackey, MD Chief Resident
*The Department of Obstetrics and Gynecology has a core group of faculty that comprises the Resident Education Committee.

The functions of this committee are:

- Ensure each resident is making continued advancement in the program
- Approve implementation of new curricula developed by the different subspecialties
- Review resident schedules, assignments, to ensure depth and breadth of the residents’ educational experience
- Participate in the annual review of the program, presented by the Program Director yearly
- Provide a venue for resident appeals, as outlined in the departmental policy regarding due process

It is expected that the committee will be made up of delegates from each of the various groups who have a significant educational role within the program. As a delegate from their group, it is expected that each representative would come to Resident Education Committee meetings able to fully represent the opinions and needs of their group or specialty. It is understandable for scheduling conflicts to cause a group’s representative to this committee to change over time. While additional faculty members may wish to participate in the discussions (or may even be called to participate), on issues of voting matters (such as a resident appeal) the committee votes are assigned as follows:

- Program Director (one vote)
- Assistant Program Directors (one each)
- Member of Gynecologic Oncology (one)
- Member of Gynecology (includes UW, Meriter, Urogynecology) (one)
- Member of Reproductive Endocrinology and Infertility (one)
- Member of Maternal Fetal Medicine (one)
- Member of UW General Obstetrics & Gynecology (one)
- Representative of University Health Services and Planned Parenthood (one)
- Representative of Dean (one)
- Representative of Associated Physicians (one)
- Representative of Madison Women’s Health (one)
- Resident Representatives (one)

In matters of resident appeals, the program director shall not have a vote. Committee decisions are based on a simple majority vote.

Please see the section on “Disciplinary Action, Appeals, and Grievances” (page 19) for more information regarding the resident appeals process.

Please reference the department intranet for the most current information on faculty and staff contact information: intranet.obgyn.wisc.edu
**Education and 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.

**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 health care 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 health care system effectively.

Learning Objectives

Learning Objectives for individual rotations are maintained on Med Hub and sent to residents before the start of each rotation. 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. Whenever appropriate, residents will be consulted in departmental program decisions, and are encouraged to make policy recommendations in open forum and through their representative to the Resident Education Committee.

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. 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 or 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, and 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 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, and during the care of outpatients 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.

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 Meriter Obstetrics Night Float, the PGY3 serves as the Chief Resident. Chief residents supervise the activities of the inpatient team (including ICU), in addition to caring for outpatients in any setting. Chief residents are responsible for providing leadership for the team, oversight of patient care and serving as consultants, scheduling of resident physicians 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.*
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 in which he/she was physically present for.
<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>• Interpretation of fetal heart rate tracing</td>
<td>PGY-1, after completion of certification program</td>
</tr>
<tr>
<td><strong>Gynecology</strong></td>
<td></td>
</tr>
<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.

**ACGME 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 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. 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 Maria Katsoulidis, the Residency Program Coordinator, 263-1228, or John Street, PhD, the Education Program Manager, 417-7906.
### Department Thursday Conference Schedule:

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 am</td>
<td>M&amp;M; third Thursday of each month Faculty and Resident Meetings</td>
</tr>
<tr>
<td>8:00 am</td>
<td>Resident Education Series</td>
</tr>
<tr>
<td>9:00 am</td>
<td>Resident Education Series</td>
</tr>
</tbody>
</table>

#### Summer Schedule (June-August)

- 7:00 am M&M; third Thursday of each month Faculty and Resident Meetings
- 8:00 am Resident Education Series
- 9:00 am Resident Education Series

#### Academic Year Schedule (September-May)

- 7:00 am M&M; third Thursday of each month Faculty and Resident Meetings
- 8:00 am Grand Rounds, Journal Club; third Thursday of each month Faculty and Resident steering committees
- 9:00 am-12:00 pm Resident Education Series

### Clinical Rotation Teaching 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>PreOp Conference</td>
<td>Meriter Cafeteria</td>
</tr>
<tr>
<td></td>
<td>7 am</td>
<td>Ob Sign-Out/PBL&amp;I</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>7:30 am</td>
<td>Low Risk Ob Didactics</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>7:30 am</td>
<td>Gen Ob Didactics</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>12 noon</td>
<td>Couples Clinic/IVF Conference</td>
<td>GFC Conference Room</td>
</tr>
<tr>
<td></td>
<td>6:00 pm</td>
<td>Onc Teaching Rounds</td>
<td>UWH-Onc Team Room</td>
</tr>
<tr>
<td>Tuesday</td>
<td>7 am</td>
<td>Ob Sign-Out/PBL&amp;I</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>7 am</td>
<td>Gyn Didactics</td>
<td>Meriter Cafeteria</td>
</tr>
<tr>
<td></td>
<td>7:30 am</td>
<td>Perinatal Conference</td>
<td>Meriter Hosp-Atrium</td>
</tr>
<tr>
<td></td>
<td>7:30 am</td>
<td>OB Education Conference (second Tuesday Of month)</td>
<td>SMH Bay 1</td>
</tr>
<tr>
<td></td>
<td>4:30 pm</td>
<td>Onc Professor Rounds</td>
<td>UWH-Onc Team Room</td>
</tr>
<tr>
<td>Wednesday</td>
<td>7 am</td>
<td>Ob Sign-Out/PBL&amp;I</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>7 am</td>
<td>Gyn Didactics</td>
<td>Meriter Cafeteria</td>
</tr>
<tr>
<td></td>
<td>7 am</td>
<td>Didactic Session (Shay)</td>
<td>SMH L&amp;D</td>
</tr>
<tr>
<td></td>
<td>7:30 am</td>
<td>MFM Didactics</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>12 noon</td>
<td>RCC High Risk Patient Conference</td>
<td>RCC-Meriter</td>
</tr>
<tr>
<td>Thursday</td>
<td>7 am</td>
<td>Morbidity &amp; Mortality Conf*/Resident Meetings</td>
<td>Bolz Auditorium</td>
</tr>
<tr>
<td></td>
<td>8 am</td>
<td>Grand Rounds*/Journal Club/Steering Comm.</td>
<td>Bolz Auditorium</td>
</tr>
<tr>
<td></td>
<td>9 am</td>
<td>Resident Education Series *</td>
<td>Bolz Auditorium</td>
</tr>
<tr>
<td></td>
<td>10 am</td>
<td>Simulation Lab</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td>Friday</td>
<td>7 am</td>
<td>Ob Sign-Out/PBL&amp;I</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>7 am</td>
<td>Gyn Didactics w/Diem</td>
<td>Meriter Cafeteria</td>
</tr>
<tr>
<td></td>
<td>7:30 am</td>
<td>Tracing Rounds</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>12 noon</td>
<td>UHS Didactics</td>
<td>UHS</td>
</tr>
</tbody>
</table>

*See Thursday conference schedule

Please reference the department intranet for the most up-to-date conference schedules: know.obgyn.wisc.edu
Presentations

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, but basic research based presentations, or topics dealing with adult education are also options (see list of past presentations below). We encourage identification of a faculty mentor for the talk.

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

Presentations should be about 45 minutes in duration. 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

Journal Club Preparation
Each PGY3 resident will lead Journal Club sometime during the academic year (Sept – May). Dr. Cynthia Anderson is the faculty supervisor.
Preparation:

1) Two weeks prior to the Journal Club date, email Dr. Anderson 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. Anderson 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).

Tips for Preparing a Didactic 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.

Presentation Resources
“Stop Annoying Your Audience” - by Peter de Jager  
Presentation Technology - UW-Madison DoIT Academic Technology

Research Projects

CREST - Academic Year ‘12 – ’13

PGY 1 - Design and Statistics

<table>
<thead>
<tr>
<th>Topic</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3 CREST Overview</td>
<td>Human subject training requirement is required to be in compliance with our Federal Wide Assurance. Your study submission will be blocked in the electronic submission upload from reaching IRB if training is not completed. All research staff must have active training before their protocol will upload for review. This includes initials and continuing reviews.</td>
</tr>
<tr>
<td>Ethics of Human Subject Research</td>
<td></td>
</tr>
<tr>
<td>Participant Consent</td>
<td></td>
</tr>
<tr>
<td>This is 2-3 session</td>
<td></td>
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</tbody>
</table>

What Courses Count?

University of Wisconsin and Meriter CITI Modules
If you have never taken a human subjects protection course, you will take the Basic Course. This takes about 4 hours to complete. If your training is about to expire, you will take the Refresher Course. 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.
Passing Score - 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.

<table>
<thead>
<tr>
<th>4</th>
<th>IRB Statistics</th>
<th>Catherine Rogers - HS IRB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Liz Michaels - Meriter IRB</td>
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<tr>
<td></td>
<td></td>
<td>Dr. Rick Chappell - Biostats Dept</td>
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</tbody>
</table>

| 5    | CREST Overview       | Hulley: Designing Clinical Research, Chapters 1&14            |


| 7 | Seminar (ICTR) | How to write and abstract |
| 8 | Progress Report | Establish Roles & Abstract |
| 9 | Progress Report | IRB Submission |
| 10 |  | Presentation to the Dept |
| 11 | Progress Report | Submission of Application for individual research projects |
| 12 | Progress Report | Discuss Meeting Submissions |

### PGY 2 - Design and Statistics

<table>
<thead>
<tr>
<th>Topic</th>
<th>Materials</th>
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</thead>
<tbody>
<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>
<tr>
<td>Topic</td>
<td>Materials</td>
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<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</td>
<td>Green Journal Website</td>
</tr>
<tr>
<td></td>
<td>(Journal will vary based upon group decisions)</td>
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<tr>
<td></td>
<td><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 (PDF)</td>
</tr>
<tr>
<td>11 Seeking Funding for Research</td>
<td>Hulley: Designing Clinical Research</td>
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<td>Chapter 19</td>
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<table>
<thead>
<tr>
<th>Topic</th>
<th>Materials</th>
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<tbody>
<tr>
<td>Introduction &amp; Methods</td>
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<tr>
<td>Endnote</td>
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<tr>
<td>Results and Discussion</td>
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<td>Submission</td>
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<td>Re-Submission</td>
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<tr>
<td>Closing Feedback and</td>
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<td>Encouragement</td>
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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.

4) 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. Any concerns should be promptly relayed to the Residency Program Coordinator who will arrange for the appropriate relief.

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 website. All residents and faculty are required to review the program annually and document their completion.

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
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.
   - 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.
   - 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.
   - Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
   - 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.
   - 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.
   - 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.
2) Intermediate-level residents (PGY-2) 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.
3) 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.
   - 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.
   - 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.
   - 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**
- 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.
- At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
- 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”.

**Department of Obstetric & Gynecology 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 you must leave by 6:00pm
- If you are in a C-section or delivery and stay past 8 pm, then you must come in late the following morning so that you have 10 hours off between shifts.
- If you are in a Gyn surgery and stay past 8:00 pm, then you must come in late the following morning so that you have 10 hours off between shifts. 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).
- Notify senior administrative chief resident and senior OB resident that night that you will be late the next day.

**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.
- No rounding should begin before 5:30 am, unless the patient is already awake.
- If you are in a C-section or delivery and leave after 6:00 am, then you must come in late the following morning so that you have at least four 24 hours off over 4 weeks and 14 hours off after a 24 hour call.
- Notify senior resident that day that you will be late the next day.

**UW work hours and call**

**10 Hour Rule**
- Monday – Friday, rounding begins at 6:00 am which means you must leave by 8:00 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, enter in the comments section on MedHub your reason for leaving late. This is an exception to the 10 hour rule; therefore you do not need to come in late for rounding the next day. Keep in mind, this should not happen often.

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

**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.
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.

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.

MedHub
Use only the following options:
- Planned Work Hours - this is for all scheduled hours including, in-house calls, regardless of the day of the week.
- UW Home: log scheduled hours Vacation - Your vacation is Monday-Friday, not Saturday through the following Sunday. This is logged by the Program Coordinator, then available for resident review, and you “agree.”
- 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.

Policy for Entering Duty Hours
- The Program Coordinator will monitor the timeliness of entering duty hours. If a resident gets behind in entering duty hours by 14 days, the Program Director will be notified. The Program Director will then contact the resident.
- The resident will have 24 hours to get their duty hours entered. If not caught up in this time, the resident will be relieved of service duties to bring duty hours up to date. Another resident may be called in to cover the service for the delinquent resident. After three violations, this will affect the score on their professional record and require a meeting with the program chair.
Policies

Attendance (for scheduled Didactic Conferences)
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. 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.

Arrival at core conferences is expected to be prompt. The Chair or Program Director may elect to track late arrivals) and to consider chronic non-attendance or late attendance in the annual resident performance evaluations.

In addition, approval of meeting time and departmental funding for the major senior meeting (up to $1,200) is contingent upon satisfactory (80+%) attendance at scheduled didactic sessions. The recommendation not to approve or fund a meeting request will be submitted for approval to the residency education committee and the full time faculty.

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 she is admitted to the hospital.
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.

Faculty-Initiated Evaluations
- Resident Global Evaluation – overall performance evaluation based on the six ACGME competencies.
- Resident Clinic Performance Evaluation – for use in the Residency Continuity Clinic, University Health Services, and Planned Parenthood.
- On-the-Fly Evaluation – an evaluation to quickly note praise or concern about resident performance.

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.
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 Competency Committee and/or qualified faculty.
- The remediation plan is reviewed with the resident. If necessary a mentor is selected.
- The Residency Education Committee, without resident members present, reviews the plan.
- 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.

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 Resident Education Committee. Residents also have the opportunity to share their perspectives on the program during their Semi-Annual Review meetings with the Program Director.
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 program faculty 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 Residency Education Committee (REC). The resident will be informed of the decision in writing within 10 days of the appeal submission.
4. The REC 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 REC 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
Salary and Benefits

Stipend Levels
Please visit the following webpage for the most current information on annual stipend rates:
UW Hospital and Clinics Graduate Medical Education (GME)

Professional Conferences
• During the four-year residency, each resident may be awarded one outside meeting. Approved meetings will be paid up to a maximum of $1200. The meeting approval is conditional on satisfactory progress in training, adequate recording of ACGME resident cases, and an 80% or better attendance record at scheduled conferences and didactic sessions.
• Only under unusual circumstances will meetings be approved during the first year of residency training.
• In addition to the meeting referred to above, with approval of the Resident Education Committee, residents may be reimbursed for travel expenses to a meeting where a paper is presented.
• Residents planning to attend a meeting may only do so with staff approval, following the same procedure as for a vacation request. An e-mail documenting approval by the director of the rotation and plans for cross-coverage must be sent to the program coordinator’s office.
• 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.
• Obtain travel expense reporting forms from the Residency Coordinator. Submit completed forms with receipts to the residency coordinator. Reimbursement will not be made unless proper travel expense reporting forms are used. 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.

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).

Resident Book/Educational Fund Policy
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. Each resident has $800.00 to spend on text(s) or other 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 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 on-line 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
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.

**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](http://www.abog.org) for more information.

**Vacation**

- Residents are allowed a total of 15 weekdays and up to 12 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, Vice-Chief Resident, a PGY-4, PGY-3, and PGY-2), 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.
- Vacations are explicitly discouraged during the first week of any rotation, during the week that the senior residents take the written Board examination, and during the dates of the CREOG in-training examination.

**Absence Request Procedure**

- Vacation time requests are solicited by the Chief Resident before each academic year. The final vacation schedule is approved by the Program Director.
- All non-vacation absences exceeding three working days must have the approval of colleagues in the affected call and rotation schedules, and must be approved by the senior resident (if applicable) on the affected rotation, and the attending (if applicable) in charge of the affected service. Final approval is granted by the Program Director or Department Chair.
- 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/etc. leave will not need to be made up.

**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.

**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.

**Resident Retreat**

Leave is granted for the resident retreat in August.

**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.

**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)

**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.

**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.
Sick Call Contacts by Service

**Meriter OB**

**Junior Days:**
1. Call OB R4 (If R4 is on vacation, call R3OB)
2. During the week, low risk OB coverage will be by single intern with senior residents helping to ensure adequate coverage on the floor.
3. If the other junior resident is on vacation, page Gyn team to see if PGY2 is available. If PGY2 is not available, R3 and R4 will cover the service.

**Junior Night Float:**
1. One of the day OB interns will need to do a 24 hour shift receiving the next day as a post-call day.
2. If single JR day team, call float resident to cover night shift.
3. If float unavailable, call PGY1 clinics resident.

**Senior Days:**
1. If R4OB is sick, call R3OB. If it is a Monday, RCC for R3OB will be covered by RCC Chief for all patients that cannot be rescheduled and R3OB will remain on the floor.
2. If R3OB is sick, call R4OB. If it is a Wednesday, RCC for R4OB will be covered by RCC Chief for all patients that cannot be rescheduled.
3. If the other senior is on vacation, page Chief Resident. Float is first call. If Float is unavailable, page MH Gyn 4 to see if PGY3 is available.

**Night Float:**
1. Call OB R4. Either R3OB or R4OB will cover NF and take the following day as a post call day.
2. If one senior is on vacation, call Float Resident.
3. If Float unavailable, call MH Gyn 4 to see if MH Gyn 4 or MH Gyn 3 are available to cover and take the next day as a post call day.

**Weekend Call:** Page Chief Resident. Residents called will be based on call schedule.

**Meriter GYN**

R2-3: Call Gyn R4. Float to be called first for uncovered Major surgeries only. If minor surgeries, call OB Chief to see if intern is available.

R4: Notify R3; if only one senior on service (other on vacation, etc) and Major surgeries are going to be uncovered, page Float resident and notify Chief Resident.

**SMH**

OB: Page Chief Resident. Float will be first call, followed by PGY2 on clinics.

NF: Page Chief Resident. Float will be first call. If float unavailable, consider UWNF (if has been to SMH already) or PGY2 on Clinics.

GYN: Page Chief Resident. Float is first call. 2nd call is to see if MH Gyn service can spare a resident. 3rd call is RCC Chief.

**Weekend Call:** Page Chief Resident. Residents called will be based on call schedule.

**Gyn Onc**

R1-2 call senior R3/4. It will function as a two person service for that day.

If other junior resident is on vacation (i.e. leaving a one resident service), Float is first call.

Second call is PG1 on Clinics.

Senior R3/R4: Page Chief Resident. Float is first call. Second call is RCC Chief.

**Weekend Call:** If junior, senior will take primary call; if senior, call fellow.

**UWNF**

Call Onc Senior R3/R4 (back up person will become primary)
Clinics 2
Call specified clinic; if Thursday, page Chief Resident.
1) Float will be first call.
2) If Float unavailable, SMOB 3 will stay at SMH and RCC Chief will see all SMOB 3 clinic patients that could not be rescheduled.

UHS/PP
Call clinic

REI
Call clinic; if surgeries to cover, page MH Gyn 4 to arrange coverage. If unable to cover via Gyn team, page Chief Resident.

UW GYN
Page Chief Resident. Float is first call.

U/S
Call Barb

TLC
Call senior resident on service

RCC
Call clinic and OB senior

*All absences must be reported to the program coordinator.

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.

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.

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.

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
Acceptable Case List Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>A&amp;P</td>
<td>Repair anterior and posterior colporrhaphy</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>
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<tr>
<td>gm</td>
<td>Grams</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>HCG</td>
<td>Human chorionic gonadotropin</td>
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<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>
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<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>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>

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