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Appendix A
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. Jackie Ogutha, Chair

Gyn Onc Fellowship
Director: Dr. Steve Rose

Fellowship Coordinator: Lori Lewis

MFM Fellowship
Director: Dr. Dinesh Shah

Fellowship Coordinator: Angie Skaggs

Simulation Lab Director:
Dr. Joel Henry
Dr. Cara King

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

Associate Clerkship Director:
Dr. Cara King

Program Coordinator:
Janet Short

Medical Student Interest Group Coordinator:
Dr. Mary Landry

Education Programs Manager
Dr. John Street

Program Coordinator:
Maria Katsoulidis

Administrative Assistant:
Beckie Schimelpfenig
Faculty Organization Chart

Department of Obstetrics and Gynecology
Faculty Organization Chart

Jenni Stevens
Department Administrator

Laurel Rice
Chair

Klaus Diem
Vice Chair, Finance & Clinical Operations

Ellen Hatenbach
Vice Chair, Education & Faculty Development

Ian Bird
Vice Chair, Integrated Graduate Training

Ronald Magness
Vice Chair, Research

Gynecology
Debbie Giles
Director

Generalists
Greg Bills
Director

Reproductive Endocrinology
Dan Lebowitz
Director

Maternal Fetal Medicine
Jesus Iruretagoyena
Director

Cancerology
David Kushner
Director

Resident Clinic
Cynthia Anderson
Director

Research

Education

Haidi Brown
Klaus Diem
Debbie Giles
Cara King
Mary Landry
Douglas Laube

Cynthia Anderson
Lisa Balkovec
Greg Bills
Sarah Bradley
Dolores Ennspeak
Jill Henry
Jay Luck
Ryan McDonald
Kim Miller
Megan Ogden
Jacqueline Ogilvia
Kris Sharpe
Josie Thomas
Marka Williams

Christina Brandwell
Aleksandar Matic-Pustic

Jesus Iruretagoyena
Dinesh Shah
Kathy Stewart
Charles Tyler

Ahmad Alshakeh
Lisa Balkovec
Ellen Hatenbach
David Kushner
Laurel Rice
Steven Rose
Ryan Spencer

Dolores Ennspeak
Jay Luck
Kim Miller
Kris Sharpe

Residency Director
Ellen Hatenbach
Student Clerkship
Kathy Stewart

David Abbott
Ian Bird
Theresa Duszko
Theresa Eiles
Ronald Magness
Manish Patankar
Gloria Santos
Ziming Yu
Jing Zheng

Follows
Danielle Bierda
Justin Bohrer

Follows
Laura Huffman
Elin Medlin
Departmental Faculty and Committees

Chair
Laurel W. Rice, MD

Leadership
Laurel W. Rice, MD
Ian Bird, PhD, Vice-Chair of Integrated Graduate Training
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  Joel Henry, MD  Laurel Rice, MD
Greg Bills, MD  David Kushner, MD  Stephen Rose, MD
Ian Bird, PhD  Doug Laube, MD  Gloria Sarto, MD, PhD
Klaus Diem, MD  Dan Lebovic, MD  Dinesh Shah, MD
Theresa Duello, PhD  Ronald Magness, PhD  Katharina Stewart, MD
Thaddeus Golos, PhD  Kim Miller, MD  Jing Zheng, PhD
Ellen Hartenbach, MD  Manish Patankar, PhD

Division Directors

General Obstetrics and Gynecology  Greg Bills, MD
Benign Gynecology  Dobie Giles, MD
Gynecologic Oncology  David Kushner, MD
Maternal Fetal Medicine  Igor Iruretagoyena, 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, DO, Chair  Cheri Verdecchia
Sam Creydt  Beth Koerber

Clinical Operations Committee

Eliza Bennett, MD  Terri Michael, APNP  Mindy Rose, APNP
Meghan Peterson, 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 Maria Katsoulidis Beckie Schimelpfenig
Ellen Hartenbach, MD Doug Laube, MD Janet Short
Cara King, DO Ryan McDonald, MD Kathy Stewart, MD
Mary Landry, MD Jacqueline Ogutha, MD, John Street, PhD
Catherine Hubbard, NP Chair Ryan Spencer, MD

Faculty Development Committee
Dave Abbott, PhD, Chair Deborah Ehre nthal, MD Chanel Tyler, MD, Co-Chair
Cynthie Anderson, MD Doug Laube, MD Julianne Zweifel, PhD
Sarah Bradley, MD Ron Magness, 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
Ellen Hartenbach, MD – ex-officio Kim Miller, MD Jennifer Stevens, MPA, CPA
Megan Ogden, MD

Ob-Gyn Quality Internal Review Committee (QIRC)
Past Chair

Greg Bills, MD Kim Miller, MD Aimee Tobin
Igor Iruretagoyena, MD Stephen Rose, MD, Chair
Ryan McDonald, MD Jennifer Stevens, MPA, CPA

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
Associate Clerkship Director – Cara King, DO

Resident Research Committee
Cynthie Anderson, MD, MPH Eliza Bennett, MD Aleksandar Stanic-Kostic, MD, PhD
Ian Bird, PhD Dan Lebovic, MD, chair
Lisa Barroilhet, MD

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

- 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 Program Evaluation Committee (PEC) functions include:

- 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 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.
**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.
Summary of Milestone Topics in Obstetrics & Gynecology

OBSTETRICS MILESTONES

Antepartum Care and Complications of Pregnancy - (PC)
Care of Patients in the Intrapartum Period - (PC)
Care of Patients in the Postpartum Period - (PC)
Obstetrical Technical Skills - (PC)
Immediate Care of the Newborn - (PC)

GYNECOLOGY MILESTONES

Gynecology Technical Skills: Laparotomy - (PC)
Gynecology Technical Skills: Vaginal Surgery - (PC)
Gynecology Technical Skills: Endoscopy - (PC)
Peri-operative Care - (MK)
Abdominal/Pelvic Pain - (MK)
Abnormal Uterine Bleeding - (MK)
Pelvic Mass - (MK)
Pelvic Floor Disorders - (MK)
First Trimester Bleeding - (MK)

OFFICE PRACTICE MILESTONES

Family Planning - (PC)
Ambulatory Gynecology - (PC)
Care of the Patient with Non-Reproductive Medical Disorders - (PC)
Health Care Maintenance and Disease Prevention - (MK)
Abdominal/Pelvic Pain - (MK)
Abnormal Uterine Bleeding - (MK)
Pelvic Mass - (MK)
Pelvic Floor Disorders - (MK)
First Trimester Bleeding - (MK)

SYSTEMS-BASED PRACTICE MILESTONES

Patient Safety and Systems Approach to Medical Errors
Cost-effective Care and Patient Advocacy

PRACTICE-BASED LEARNING AND IMPROVEMENT MILESTONES

Self-directed Learning/Critical Appraisal of Medical Literature
Quality Improvement Process

PROFESSIONALISM MILESTONES

Compassion, Integrity, and Respect for Others
Accountability and Responsiveness to the Needs of Patients, Society, and the Profession
Respect for Patient Privacy, Autonomy, Patient-Physician Relationship

INTERPERSONAL AND COMMUNICATION SKILL MILESTONES

Communication with Patients and Families
Communication with Physicians and Other Health Professionals and Teamwork
Informed Consent and Shared Decision Making

See Appendix A for the complete Milestone document.
### Clinical rotations

**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>Location</th>
<th>Supervisor</th>
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</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>
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<th>Rotation</th>
<th>Location</th>
<th>Supervisor</th>
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<tbody>
<tr>
<td>High Risk Obstetrics</td>
<td>Meriter Hospital</td>
<td>Dr. Igor Iruretagoyena</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. Cynthie 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. Dobie Giles</td>
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#### PGY-3

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<th>Location</th>
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</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. Igor Iruretagoyena</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. Cynthie 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. Dobie Giles</td>
</tr>
<tr>
<td>Urogynecology</td>
<td>UW Hospital/Meriter Hospital</td>
<td>Dr. Dobie Giles</td>
</tr>
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</table>

#### PGY-4

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<th>Rotation</th>
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<th>Supervisor</th>
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</thead>
<tbody>
<tr>
<td>Chief/Obstetrics</td>
<td>Meriter Hospital</td>
<td>Dr. Igor Iruretagoyena</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. Dobie Giles</td>
</tr>
<tr>
<td>Chief/Resident Continuity Clinic Float</td>
<td>Arboretum Clinic</td>
<td>Dr. Cynthie Anderson</td>
</tr>
<tr>
<td></td>
<td>Various Sites</td>
<td>Dr. Ellen Hartenbach</td>
</tr>
</tbody>
</table>
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.

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>Obstetrics</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>Service and Procedure</td>
<td>Training level required for independent performance with supervision</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Obstetrics (cont.)</td>
<td></td>
</tr>
<tr>
<td>• Interpretation of fetal heart rate tracing</td>
<td>PGY-1, after completion of certification program</td>
</tr>
<tr>
<td>Gynecology</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.

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.⁴

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.⁵ 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.

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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*


Thursday University

Overview

Thursday University is the name applied to the residency program’s weekly educational sessions on Thursday morning. These events include M&M, Grand Rounds, lectures, simulation labs, Journal Club, and resident workshops. Also scheduled are times for independent learning, administrative tasks, computer training, and various resident meetings. Thursday University runs year-round from 7:00 – 12:00 noon.

<table>
<thead>
<tr>
<th>Thursday University</th>
<th>7:00 am</th>
<th>M&amp;M Faculty and Resident Meetings (3rd Thurs of each month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 am</td>
<td>Grand Rounds (Sept-May) Journal Club (6 times/year) Faculty &amp; Resident steering committees (3rd Thurs of each month) Resident Didactics</td>
<td></td>
</tr>
<tr>
<td>9:00 am - 12:00 pm</td>
<td>Resident Didactics Simulation Labs Program Director meetings Research meetings Administrative time Independent learning</td>
<td></td>
</tr>
</tbody>
</table>

Weekly schedules are maintained by Beckie Schimelpfenig, Administrative Assistant. Weekly and yearly Thursday schedules can be found on Google Calendar and Google Docs respectively.

Core Lecture Series 2014 – 2016

Low Risk Obstetrics (Generalist Division)

1. Normal labor management
2. Post term pregnancy
3. Anemia of pregnancy
4. Hypertensive disease of pregnancy (GHTN, pre-eclampsia basics)
5. Preterm labor diagnosis and management
6. Malpresentation (breech, face presentation, mentum posterior etc)
7. Antepartum hemorrhage – placenta previa, abruption etc
8. Asthma in pregnancy
9. Acute GI disorders (appendicitis, cholelithiasis, cholecystitis, pancreatitis)
10. Multiple gestations (input on guidelines from MFM)
11. Urinary tract infections and pyelonephritis (input on guidelines from MFM)

Urogynecology (Urogynecology Division)

1. Anatomy of the female pelvis (alternate with Gynecology Oncology as part of anatomy lab)
2. Obstetrics and pelvic floor dysfunction
3. Office evaluation of urinary incontinence and Urodynamics
4. Operative injuries and Cystoscopy
5. Normal micturition and voiding dysfunction
6. Non-surgical and surgical management of stress incontinence
7. Surgery for anterior, posterior, and apical prolapse
8. Management of urge incontinence
9. Interstitial cystitis and pelvic pain

**Gynecology (Generalist Division and UW Gynecology)**

1. Abnormal uterine bleeding
2. Vaginal and vulvar infections
3. Vulvar dystrophies, dermatoses, pain syndromes
4. Sexually transmitted infections
5. Pelvic inflammatory disease
6. Pelvic masses – fibroids, cystic and solid masses, TOAs, torsion, cysts/benign neoplasms, diverticulitis, appendicitis
7. Chronic pelvic pain
8. Benign breast disease – masses, discharge, pain, infection, asymmetry, excessive size, underdevelopment
9. First trimester pregnancy failure – SABs, ectopic pregnancy
10. Menopause and Hormonal replacement therapy
11. Polycystic ovarian syndrome for the generalist
12. Endometrial hyperplasia, treatment, and follow up
13. Cervical, Vulvar and Vaginal dysplasia management
14. Pediatric and Adolescent gynecology

**Oncology (Gynecology Oncology Division)**

1. Genetics and Cancer
2. Carcinoma of the breast
3. Vulvar and vaginal malignancies
4. Cervical Cancer
5. Carcinoma of the uterus
6. Ovarian and tubal carcinoma
7. Gestational trophoblastic disease
8. Critical care, pre-and post-op care
9. Radiation therapy and Chemotherapy

**Reproductive Endocrinology and Infertility (REI Division)**

1. Physiology of the normal menstrual cycle
2. Developmental anomalies of the urogenital tract
3. Primary and Secondary amenorrhea (POI)
4. Endometriosis
5. Hyperprolactinemia
6. Hirsutism and PCOS beyond the generalist
7. Recurrent pregnancy loss
8. Primary and secondary infertility
9. Ethics of Assisted Reproductive Technologies
Simulation Lab

In its eighth year of operation, our 1100 square foot simulation lab is located in Meriter Hospital and provides a wide range of simulation training for our residents. The simulation curriculum consists of over 30 individual labs presented in a two-year revolving curriculum. Typically, 15-18 sim labs are presented each year.

Since independent practice is crucial to skill development, residents have 24/7 access to the simulation lab. Dr. Joel Henry (Obstetrics) and Dr. Cara King (Gynecology), Co-Directors of the Simulation Lab, provide faculty leadership for the lab. John Street, Education Program Manager, manages day-to-day operations and provides logistical support for Thursday sim labs. Below is a partial list of sim labs from our two-year curriculum.

Obstetrics:

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

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

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.

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

Gynecology:

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

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.

Laparoscopic Suturing
All residents: Develop laparoscopic suturing skills with faculty instruction.

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

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

To augment the clinical and academic curriculum, various on-line educational activities are assigned over the course of the year.

**The Foundation for Exxcellence in Women's Health Care: Life Long Learning**
The Foundation for Exxcellence in Women’s Health Care ([www.exxcellence.org](http://www.exxcellence.org)) is dedicated to improving the quality of women's health care, through research, awards, grants and innovations in education. Their website offers Exxcellence 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.

**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.

**Fundamentals of Laparoscopic Surgery PGY1**
The American College of Surgeons and the Society of American Gastrointestinal and Endoscopic Surgeons developed FLS for surgical residents. We have adapted the program for training our first year residents to advance their surgical skills early in their residency. FLS is a comprehensive educational program that includes online instruction and cognitive assessment, as well as manual skills testing. Our residents complete the online portion of the FLS program during the first half of their PGY1 year. Throughout the year they practice the five FLS skills to prepare for passing a manual skills testing in May. PGY1 residents are required to pass the skills test, which is conducted in our sim lab and proctored by our faculty. Our residents are not required to pass the official FLS skills test at a national testing center, but they are fully prepared to do so if they choose.

**Robotic Surgery Training Modules PGY2**
Our robotic surgical training program was developed in conjunction with Intuitive Surgical, makers of the da Vinci robotic surgical system. The da Vinci surgical robot is the robotic device used at our program’s three hospitals. The Robotic Surgical Training Pathway is a four-phase program that begins in the PGY2 year. The program consists of online training and assessment, manual skills practice and testing on the da Vinci simulator, and the surgical application of robotic surgical skills in the OR under the supervision of department faculty. Upon successful completion of the robotic surgical training, residents receive a certificate attesting to their ability to conduct robotic surgery independently.

**American Society for Colposcopy and Cervical Pathology (ASCCP)**
The ASCCP is the premier national organization for education and evidence based guidelines for cervical cancer screening. PGY-2 and PGY4 residents will be assigned the ASCCP online exam.
**Recruitment season**

During recruitment season (November & December), residents not assigned to interviewing or visiting with student applicants will be assigned to complete on-line educational activities during Thursday University.

**American Institute of Ultrasound in Medicine (AIUM)**
24/7 online access to 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 Reproductive Medicine (ASRM)**
ASRM has many resources available for health professionals including ASRM eLearn. Residents are expected to complete some of these online modules.

**The Foundation for Exxcellence in Women's Health Care: Pearls of Exxcellence**
The Pearls of Exxcellence are the most challenging topics for Ob/Gyn certification. The Exxcellence 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.exxcellence.org/pearls.php](http://www.exxcellence.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) is required annually.
Rotation Conference Schedule:

Educational sessions that occur on the various rotations rather than as a group on Thursday morning.

<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 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></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>6:45 am</td>
<td>SMOB Didactic Session (Stafeil)</td>
<td>SMH L&amp;D</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>7:00 am</td>
<td>Meriter Gyn Case Review</td>
<td>Meriter Cafeteria</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>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>
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<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>8:00 am</td>
<td>ARB High Risk Patient Conference</td>
<td>Arboretum Clinic</td>
</tr>
<tr>
<td></td>
<td>12 noon</td>
<td>PGY-1 Clinics UHS Didactics</td>
<td>UHS</td>
</tr>
</tbody>
</table>
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.

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**

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 8:00 pm and must leave by 10:00 pm.
• 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, the Program Coordinator will Email that resident asking for hours missing.

**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 Resident clinic 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 your clinic.

**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 GMEC Duty Hours Subcommittee will review:

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

In addition, the GMEC or the GMEC 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 log into MedHub (Resources/Documents folder) 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 in the PGY3 year that is 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 encourages a global health electives in Ethiopia. All electives will be approved on a case by case basis. The UW GME office is willing to support outside electives that focus on gaining skills not available within UW Health as well as global health work. Experiences within UW Health are designed by the resident to gain additional skills based on their interests.

These customized electives must be approved by the program director, in consultation with the chair, and/or the Graduate Medical Education office. Proposed outside elective requests must be submitted to the Program Director prior to the GME deadline, accompanied by the resident’s written description of his/her desired learning objectives for each elective component. Longer advanced planning is required for any elective outside UW Health.

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 UWHC
Clinical and Cancer Genetics, Waisman Center & UW Cancer Center
Cytology Laboratory, Waisman Center & UW Cancer Center
Leogane Family Health Center in Haiti
Mammography at UWHC
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 UWHC
Plastic Surgery at UWHC
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 asked to submit their evaluations within 2 weeks of completion of the rotation 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
The faculty is assigned a list of residents to evaluate throughout the year and receive evaluation requests through Medhub at the end of each rotation. To maximize evaluation accuracy and fairness, faculty members are encouraged to submit their evaluations within 2 weeks of the rotation’s conclusion. Since added time tends to diminish evaluation validity, evaluations are not accepted beyond one month after 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 at any time for any resident they have supervised

Clinical Evaluations of Resident Performance

Faculty-Initiated Evaluations

- Milestones Evaluations in Obstetrics, Gynecology or Office Practice. These are competency-based evaluations using OB/Gyn Milestones Surgical Skills Evaluations. Competency-based evaluation of performance on particular surgical procedures.
- On-the-Fly Evaluation – an evaluation to quickly note praise or concern about resident performance.
Resident Peer Evaluations

- Senior Evaluation of Junior Residents on Service: At the end of the Meriter OB and UWHC Gynecology Oncology rotations, the senior residents complete this evaluation on the performance of junior residents on their service.
- Junior Evaluation of Senior Residents on Service:
  - At the end of the Meriter OB and UWHC Gynecology Oncology rotations, junior residents complete an anonymous peer evaluation on the teaching and leadership of the senior resident on the service.

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

Patient Evaluations
Patients at the Arboretum Resident Clinic have an opportunity to complete an evaluation of their resident physician (PGY2-4’s). These evaluations are shared with residents during the Semi-Annual Review.

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 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
Mock oral exams are held annually in the spring for PGY4 residents and junior faculty who plan to take oral boards in the near future. The objective of mock orals is for residents and junior faculty to gain a better understanding of the oral board process. In taking the mock orals, participants compile a case list, defend their clinical decision making, and answer oral board style questions. This experience also provides an opportunity for participants to practice maintaining professional composure under the stress of this simulated exam.

Resident Oral Reviews
In the spring, residents (PGY1-2) are tested individually with a case-based oral exam. Each resident training year focuses on a different aspect of our specialty. Residents receive a study guide at the beginning of the year to help in their preparation for the exam.

- Resident Oral Review - Obstetrics, PGY-1 (conducted by PGY3 residents)
- Resident Oral Review - Gynecology, PGY-2 (conducted by PGY4 residents)
Semi-Annual Review

Prior to the Semi-Annual Evaluation Review, the Clinical Competency Committee (CCC) meets to review the progress of each resident. These findings, including decisions on remediation or change in resident status, are reviewed during the Semi-Annual Review in January and July.

During the Semi-Annual Review residents meet individually with the Program Director to review their performance for the previous six months. In preparation for the meeting, residents review their performance evaluations for the prior six months 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 education plan with a timeline and performance benchmarks is developed by the Program Director with the Clinical Competency Committee and/or qualified faculty.
- The education 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 in the section describing disciplinary action, appeals and grievances.
Evaluation of the Residency Program

Our residency program is committed to continual improvement and we use feedback from a number of sources to guide program improvement efforts. The Program Evaluation Committee (PEC) meets annually to review program performance and submits a written report detailing their findings with regard to resident and graduate performance, faculty performance and program quality. Included in the report is an action plan that addresses important issues highlighted by the committee. The PEC draws upon the following sources to evaluate residency program performance.

Residency Program Performance Dashboard
This document utilizes 27 metrics that track key elements of resident, faculty, and program performance leading to a cumulative program performance score. The color-coded dashboard displays performance across four years and is an important analytical tool for the Education Committee, PEC, and program administration in determining the next best steps in program improvement.

ACGME Annual Program Evaluation
Each year, residents and program faculty complete a program evaluation survey from the ACGME that focuses on crucial areas of program performance.

Evaluation of the Residency Program by Residents and Faculty
In March, faculty and residents complete an anonymous program-developed evaluation of the residency program. This program evaluation is much more detailed than the annual ACGME program survey. Feedback from this survey is highly valued by the program administration.

Residents are encouraged to share concerns and suggestions for program improvement with senior residents on their service, the administrative chief resident, and the Program Director. Concerns and suggestions are periodically 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.

Evaluation of the Program Faculty by Residents
In March, residents have the opportunity to evaluate each of the program faculty through a program-designed evaluation. These anonymous evaluations are sent via Medhub. Faculty can view the feedback only after three evaluations have been submitted.
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 now in its third year. 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 any 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 are 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 (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 Arboretum 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 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.

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)
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.

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 is supplied with an iPad mini and an electronic version of Williams Obstetrics and Williams Gynecology. This electronic educational platform is offered to facilitate easy access to information during clinical hours, facilitate after-hours independent study and allow for sharing of resources among residents. In addition, each resident has $800.00 to spend on printed or electronic educational materials any time during residency.

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.
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.

Refer to the 2015-2016 UWHC Appointment Information for Residents document found in MedHub for information on the following leaves:

Family/medical leave
Sick leave
Personal leave
Bereavement Leave
Military leave
Vacation
Professional meetings
Holiday leave
Career Development leave
Witness leave
Jury Duty leave
Time off to vote
Exam leave
**Resident Retreat**
Leave is granted for the Summer resident retreat in August and Winter retreat in February.

**Vacation**
Vacation scheduling rules and regulations are distributed each year by the Chief Resident. Some highlights are as follows:

Residents are entitled to a total of 15 weekdays and up to 6 weekend days of vacation per year.
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 (katsoulidis@wisc.edu) and the chief resident(s). If you will be missing continuity clinic, you should contact the Arboretum 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>
</tbody>
</table>
| Meriter OB        | Junior Days | 1) Call OB R4 (or whoever is covering if on vacation)  
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.) |
<p>| 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 |</p>
<table>
<thead>
<tr>
<th>Location</th>
<th>Team</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meriter GYN</strong></td>
<td>R1, R2, R3</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Meriter GYN</strong></td>
<td>R4</td>
<td>Call OB R3/R2 to notify. If major surgeries will go uncovered, call float if available and notify chief resident.</td>
</tr>
<tr>
<td><strong>St. Mary's Hospital</strong></td>
<td>OB/GYN</td>
<td>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.</td>
</tr>
<tr>
<td><strong>St. Mary's Hospital</strong></td>
<td>Night Float</td>
<td>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.</td>
</tr>
<tr>
<td><strong>UW</strong></td>
<td>Onc R1, R2</td>
<td>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.</td>
</tr>
<tr>
<td><strong>UW</strong></td>
<td>Onc R3</td>
<td>Call Chief resident. If available, float will cover. If unavailable, RCC chief will cover.</td>
</tr>
<tr>
<td><strong>UW</strong></td>
<td>Night Float</td>
<td>Call ONC R3. R2 will likely take 24 hour, and would have to leave post call if up all night.</td>
</tr>
<tr>
<td><strong>UW</strong></td>
<td>GYN</td>
<td>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.</td>
</tr>
<tr>
<td><strong>UW</strong></td>
<td>Urogyn</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Clinics</strong></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><strong>Clinics</strong></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><strong>Clinics</strong></td>
<td>REI</td>
<td>Call clinic to inform staff. If surgery to cover, call GYN 4 to arrange</td>
</tr>
<tr>
<td><strong>Clinics</strong></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 January or 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, Program Director and Chair.

Term of Appointment: One year, March 1 of PGY3 year to May 1 of PGY4 year. Transition with new Administrative Chief Resident from March 1 – May 1.

Stipend: $3000 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

Morbidity and Mortality: Residents present cases that have been chosen by Dr. Rice (or designee) 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.

Weekly M&M Format

- **Summary Statement** – One-liner describing the case
- **Pertinent History** – Include only history that is relevant to the case at hand (no need to mention full medical, social or family history unless pertinent)
- **Summary of Clinical Management** – Labor course/presentation to the ED/preop evaluation. Specific surgical details (do not mention most parts of the case, only those that are not standard procedure).
- **Outcome** – Post-op course, pathology
- **Discussion** –
  a) What would you do differently, if anything, in the future?
  b) 1-2 key clinical learning points
  c) Systems based issue (if applicable)

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
**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.
- 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.

4) Within the week leading up to Journal Club, contact Dr. Broadwell to 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, and facilitate discussion).
Format for Journal Club Presentation

Picking the paper

• Pick a clinical topic that interests you and/or has been a source of conversation among your colleagues
• The report should be original research. No reviews, meta-analyses, decision analyses or cost-effectiveness analyses. Choose a randomized control trial, case control or cohort study rather than a paper with only descriptive statistics.
• Find something provocative. A paper that might change the way we manage clinical scenarios because the conclusions support another approach.

Be prepared

• Read the article critically. Write out what the authors did, what results they got, and what they concluded. (see below for outline of “critique of a medical report”)
• Think about each of the decisions the investigators made in designing the study, and what they concluded from the results. Were these good design decisions? Were the conclusions reasonable? What are possible problems with the design?
• Pick out a few MAIN POINTS OR CONCEPTS that you think are most important in reading this study critically. Examples of these sorts of concepts are: bias in measurement of outcome, loss to follow-up, unrepresentative subjects, effect size/number-needed to treat, confidence intervals for negative studies, etc.

Get others prepared

• Send out the paper a week in advance.
• Bring extra copies of the article to the session.

Leading the discussion

• Review the factual information before proceeding to discussion of judgment and interpretation. Spend the first few minutes explaining why you chose the article. Then take about 20 minutes going through what the authors of the study did, what results they got, and what they think are the conclusions
• The second half of the discussion can center on whether the design and results justify their conclusions.

Critical Reading of the Medical Literature: Structured Review of Articles

1) What was the purpose of the study?
2) List the study’s hypothesis and comment on whether they are directly stated or implied.
3) Basic description of study design:
   a. What kind of study was it
   b. Describe the study population (use of sampling, defined eligibility criteria, etc.)
   c. Identify potential problems with design (selection bias, inappropriate comparison groups, etc.)
4) Describe the intervention(s) or treatment(s), if any
5) Data collection
   a. What was measured
   b. How and when were data collected?
   c. Identify any problems with data and data collection (factors measured, factors poorly measured, subjects lost to follow-up, etc.)
6) Is the plan for data analysis clear and reasonable?
7) Results:
   a. Discuss the presentation of the data (content and clarity of tables and text).
   b. List and discuss important result:
   c. Discuss the investigators’ interpretations and conclusions:
8) Overall critique of the study:
   a. Did the investigators accomplish what they set out to do?
   b. Summarize both successes/innovations and fatal flaws/major problems in design, methodology, or interpretations. What would you do differently?
9) Is the study relevant for clinical practice?
10) Are the results generalizable?
11) Overall summary rating of the paper
   3-4  Severe limitations in interpreting results of drawing conclusions
   5-6  Questionable confidence in results or conclusions
   7-8  Worth reading, but some limitations
   9-10 Outstanding contribution
12) Justification

**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:**

**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).

**Presentation Resources**

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

Dr. Dan Lebovic is the Faculty Coordinator for the Resident Research Program (revamped, January 2015)

Completion of a scholarly research project is a requirement for graduation. The department has a formal curriculum that has residents complete a scholarly project in the form of a clinical question that is explored in a structured literature critique.

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.

To quote Dr. Grimes/Schulz:

We anticipate that the new Resident Research Requirement “will help you professionally in several ways. If interested in research, you will be able to design and conduct sound epidemiologic studies. You will also be able to read medical literature more critically. You will also be better prepared to have your own work published. By incorporating epidemiologic principles into your clinical practice, you will inevitably become a better physician.”

Overview of Resident Research Requirements for Accreditation Council for Graduate Medical Education (ACGME)

Background

While we aim to meet the needs of a variety of learners, the purpose of this program curriculum is to meet the foundational needs of the residents, including those who are not interested in pursuing academic or research careers. The curriculum provides a foundation for those who wish to do additional research or more complex research projects.

All resident research programs must meet the ACGME program requirements:

IV.B.1. The curriculum must advance residents’ knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (CORE)
IV.B.2. Residents should participate in scholarly activity. (CORE)
IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities. (DETAIL)

Residents must demonstrate the ability to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. (OUTCOME)

Residents are expected to develop skills and habits to be able to meet the following goals:

IV.A.5.c).4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
IV.A.5.c).6) locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems; (OUTCOME)
IV.A.5.c).7) use information technology to optimize learning
It is important that the program provide first and foremost a strong, basic support to meet the needs of all residents and provide a solid foundation for those who wished to engage in research with greater intensity. Finally, the program requires that each resident pursue a clinical question as their research project or scholarly project and present his/her findings at Research Day during the Spring of their third year.

**Summary of Resident Scholarly Research Program**

A. **Mission statement:**

_To enhance the critical thinking skills of residents as clinicians, and to facilitate scholarly thinking, creativity and excitement in coalescing existing knowledge in women's health leading to better patient care and confidence in interpreting such questions in the future._

B. **2 new faculty roles:**

a. **Resident Research Advisor (RRA)** – Works with all residents to develop a clinical question that is then paired with a Research Mentor to guide further investigation and final paper/presentation.

b. **Research Mentors** (selected by resident, with guidance from RRA, as someone with expertise and/or interest in the resident’s selected field of question/research). S/he guides the research project. A resident can have more than one Research Mentor in order to guide the clinical question project and an optional, supplemental directed research project.

C. Division Directors will serve as go-to persons for refining research and scholarly projects.

D. Research and scholarly projects can include **LITERATURE CRITIQUE**, quantitative research, qualitative research, meta-analysis, decision analysis, educational research, and quality improvement projects.

E. Developed a core curriculum for the program, and defined how and when each topic will be delivered. (see Core Curriculum Components (I) supplementary material)

F. Established several key deliverables for the resident research projects, including a project description, framing the clinical query by the second year, a summary document delivered to the research mentor prior to the presentation in the third year, and a larger goal (but not requirement) of a published manuscript in the fourth year. (see Resident Research Timeline (II) supplementary material).

G. Structure added to the journal club meetings by producing a short list of questions to cover at every journal club to ensure that key research topics and content are covered, and guidance for journal club participants on summarizing an article to present at journal club. (see Guidelines for Grand Rounds and Journal Club Meetings (IV) supplementary material)

**Documents & Guidelines**

I. Core Curriculum Components, Timing, and Key Delivery Mechanisms

II. Residency Research Timeline

III. Research Mentor Responsibilities

IV. Guidelines for Grand Rounds and Journal Club Meetings (Dr. Broadwell)

   a. Includes handout for participants- Critical Reading of the Medical Literature: Structured Review of Articles)

V. Format for LITERATURE CRITIQUE
I. Core Curriculum Components, Timing and Delivery Mechanisms

The table below describes the curriculum topic, the primary mode for delivering that education, when the topic will be covered and opportunities for augmenting the topic. Several of the didactic sessions may be recorded and archived as podcasts.

<table>
<thead>
<tr>
<th>Curriculum Topic</th>
<th>Primary Delivery Mechanism</th>
<th>Timing</th>
<th>Additional Mechanisms/ Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research Ethics / IRB</td>
<td>Didactic: (TBD)</td>
<td>Summer/Fall First Year</td>
<td>• Research Mentor</td>
</tr>
<tr>
<td>Comprehensive Literature Review (including managing references and library resources)</td>
<td>Didactic: EBLING Librarian Heidi Marleau</td>
<td>Summer/Fall First Year</td>
<td>• Journal Club, • Research Mentor</td>
</tr>
<tr>
<td>Health Services Research introduction</td>
<td>Dr. Deb Ehrenthal</td>
<td>Summer/Fall First Year</td>
<td>• Research Mentor</td>
</tr>
<tr>
<td>Basic Science: <strong>Techniques Used Daily in Diagnostics</strong> (may include: Agglutination, Elisa/Elispot, Western blot, Bioplex, Flow Cytometry, PCR/QPCR); <strong>Concepts Moving Into Practice</strong> (May include: Genome, Epigenome, Proteome, Glycome, Reactome, Microbiome, Metagenome, Pangenome)</td>
<td>Didactic: Dr. Stanic</td>
<td>Summer/Fall First Year</td>
<td>• Research Mentor if resident research is in basic science</td>
</tr>
<tr>
<td>Types of Research and clinical study designs</td>
<td>Didactic: Dr. Broadwell</td>
<td>To be covered in Journal Club</td>
<td>• Journal Club, • Grand Rounds: (i.e.: having Grand Rounds speakers “label” the type of study design they are presenting), • Research Mentor</td>
</tr>
</tbody>
</table>
II. Residency Research Timeline

This timeline is intended to serve as a guide to assure that each resident meets learning and project benchmarks to complete the required research components of their training. Some changes to the timeline may need to be made based on the resident's selected research, rotation schedule or other issues as needed. It is imperative that all residents focus during their first year on connecting with faculty who will guide them through this process and identify a clinical question to explore as a LITERATURE CRITIQUE and possibly a specific research project of interest.

*Whether or not the resident does a traditional research project they will also produce a literature critique (most likely on their research project).

First Year
1. Take CITI test and receive IRB training
2. Identify mentor
3. Identify working title of clinical question
4. Perform literature search and present (~5 mins) to Research Project committee in the Spring of PGY 1
5. Meet with Research Mentor at least once every three months or via email starting in Jan

Residents should utilize this year to identify potential Research Mentors and clinical query ideas, and begin your study of core research components. Descriptions about other key research networks and major studies are also available from the Division Directors. The Residency Research Advisor will help identify potential Research Mentors who connect with resident clinical Q area of interest as well as any potential research desire.

• By October 1: Meet with Resident Research Advisor: Arrange a time to meet with the RRA. If you already have ideas about areas of interest for research this is an ideal time to ask about names of potential Research Mentors with whom to schedule introductory meetings. Plan to meet at least twice a year with the RRA.

Second Year
1. Continue to make contact with Research Mentor Q3 months
2. Write the INTRODUCTION and FRAME THE CLINICAL QUERY by October of PGY 2
   Present the research plan to the entire faculty during Thursday conference to vet the idea and get further input

During this year, residents should be continuing to learn about different components of research through didactics, journal club, grand rounds, etc.

Third Year
• February 1
  o Submit the 1st draft of your SUMMARY of LITERATURE (SoL) for Research Day to your Research Mentor and Resident Research Advisor for feedback
• March 1
  o Submit a final copy of your SoL to your Research Mentor and Resident Research Advisor for feedback
• April 1 – Submit rough draft of PPT slides to Research Mentor and to RRA. Be ready for the “practice run” presentation session which will happen roughly 3 weeks before Resident Research Day. This date will be set several months in advance and an outlook invite will be sent to all OB/GYN faculty and fellows.
• May – Present Research Study and Findings at Resident Research Day!
We encourage you to continue to participate in didactics and online tutorials on research methods and fully engage in discussions about research through journal club, grand rounds and with faculty.

**Fourth Year**

In this last year we hope you will work with your Research Mentor and any other members of your research team to develop a draft manuscript into a paper that could be submitted for publication as a review paper.

- **May:** At Research Day you will introduce one of the third-year residents. After her/his talk, please be prepared to give a very short (2-3 minute) summary of how this question contributes to patient care in a practical fashion; ask the opening question to the presenter, and moderate the question/answer section of the talk.

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
</table>
| **1** | **CITI test; IRB training**  
Identify mentor and working title of clinical Q by DEC  
Lit search and present to Research Project cmte – APR  
*Meet/email with RM Q3 months beginning in JAN*  
*Meet with RRA – OCT + MAY* |
| **2** | **Introduction and frame the clinical query by OCT**  
*Meet/email with RM Q3 months*  
*Meet with RRA – OCT + MAY* |
| **3** | **Meet with RRA – OCT**  
FEB 1: Draft of LitCrit to RM/RRA  
MAR 1: Final copy of LitCrit to RM/RRA  
APR 1: Submit PPT slides to RM/RRA  
~3 wks prior to Research Day: Present practice ‘run’  
MAY TBD: Present LitCrit at Research Day |

### III. Research Mentors

Research Mentors are faculty members (from inside and outside of the Department) who are active investigators in the resident’s clinical question of study. The Research Mentor will ideally also be someone with whom the resident has a positive working relationship. The Research Mentor and the resident should meet at least a few times a year, potentially more often if they are actively engaged on a mutual project. The department suggests that Research Mentors take on only one resident per year, given the time demands of the role. The primary responsibilities for the Research Mentor include:

1. Assistance with developing/defining the clinical question
2. Education and connection with resources pertaining to the topic of study
3. Discussion of specific topics including:
   a. Developing a research question to explore in the literature
   b. Analyzing the literature related to project
   c. Presenting research findings (in written, oral and PPT format)
4. Regular oversight regarding progress with project and assistance with any problems as they arise
IV. Guidelines for Grand Rounds and Journal Club Meetings (Dr. Broadwell)

The following topics will be covered as part of Journal Club primarily based on the book by Schulz and Grimes:

**Introduction**

1. An overview of clinical research: the lay of the land

**SUPPL:**
Design and analysis of clinical trials (definitions: levels of evidence; phase 1-4 studies, etc)
Epidemiologic research using administrative databases: Garbage in, garbage out. Grimes DA.

**Observational studies**

2. Descriptive studies: what they can and cannot do
3. Bias and causal associations in observational research

**SUPPL:**

4. Cohort studies: marching towards outcomes
5. Case-control studies: research in reverse
6. Compared to what? Finding controls for case-control studies

**Screening tests**

7. Uses and abuses of screening tests
8. Refining clinical diagnosis with likelihood ratios

**SUPPL:**

**Randomized controlled trials**

9. Sample size calculations in randomized trials: mandatory and mystical
10. Generation of allocation sequences in randomized trials: chance, not choice
11. Allocation concealment in randomized trials: defending against deciphering
12. Unequal group sizes in randomized trials: guarding against guessing
13. Sample size slippages in randomized trials: exclusions and the lost and wayward
15. Multiplicity in randomized trials I: endpoints and treatments
16. Multiplicity in randomized trials II: subgroup and interim analyses

**SUPPL:**
External validity of randomized controlled trials: “To whom do the results of this trial apply?” Rothwell PM. Lancet 365:2005.
Subgroup analysis in randomized controlled trials: importance, indications, and interpretation.
Format for LITERATURE CRITIQUE/SUMMARY – 2 page document

1) Introduction

2) Frame the clinical query

3) What approach did the papers take to test their hypotheses?

4) Were the study populations appropriate (including the control population) and how were they matched?

5) Were the statistical analyses suitable?
   a. Clinical vs. statistical significance, comment

6) What were the key findings and how might they be applied clinically?

7) What are the strengths and limitations of the current literature?

8) Wider implications of the findings

9) How might these findings be further explored?
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 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, 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>Laparoscopic hysterectomy</td>
<td>20</td>
</tr>
<tr>
<td>Incontinence and pelvic floor procedures (excluding cystoscopy)</td>
<td>25</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>A&amp;P</th>
<th>Repair anterior and posterior colporrhaphy</th>
<th>HRT</th>
<th>Hormone replacement therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB</td>
<td>Abortion</td>
<td>IUD</td>
<td>Intrauterine device</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
<td>kg</td>
<td>Kilogram</td>
</tr>
<tr>
<td>BSO</td>
<td>Bilateral salpingo-oophorectomy</td>
<td>LH</td>
<td>Luteinizing hormone</td>
</tr>
<tr>
<td>cm</td>
<td>Centimeter</td>
<td>P</td>
<td>Progesterone</td>
</tr>
<tr>
<td>D&amp;C</td>
<td>Dilation and curettage</td>
<td>PROM</td>
<td>Premature rupture of membranes</td>
</tr>
<tr>
<td>D&amp;E</td>
<td>Dilation and evacuation</td>
<td>PTL</td>
<td>Preterm labor</td>
</tr>
<tr>
<td>DHEAS</td>
<td>Dihydroepiandrosterone sulfate</td>
<td>SAB</td>
<td>Spontaneous abortion</td>
</tr>
<tr>
<td>E</td>
<td>Estrogen</td>
<td>SVD</td>
<td>Spontaneous vaginal delivery</td>
</tr>
<tr>
<td>E2</td>
<td>Estradiol</td>
<td>T</td>
<td>Testosterone</td>
</tr>
<tr>
<td>FSH</td>
<td>Follicle stimulating hormone</td>
<td>TAH</td>
<td>Total abdominal hysterectomy</td>
</tr>
<tr>
<td>gm</td>
<td>Grams</td>
<td>TSH</td>
<td>Thyroid stimulating hormone</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
<td>TVH</td>
<td>Total vaginal hysterectomy</td>
</tr>
<tr>
<td>HCG</td>
<td>Human chorionic gonadotropin</td>
<td>VBAC</td>
<td>Vaginal birth after cesarean</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papillomavirus</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

The 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, and your totals are tracked.

There is now an easy "Clock-in" feature on the iPad at the clinic checkout desk. Instructions are posted above each computer.
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

Chair: Jessica Bienstock, MD, MPH

Working Group
Karen E. Adams, MD
AnnaMarie Connolly, MD
Laura Edgar, EdD, CAE
Gary N. Frishman, MD
Alice R. Goepfert, MD
Robert V. Higgins, MD, FACOG, FACS
Lee A. Learman, MD, PhD
Rebecca McAlister, MD
Mary Joyce Turner, RHIA, MJ
George Wendel, MD
Christopher M. Zahn, MD

Advisory Group
Timothy P. Brigham, MDiv, PhD
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Larry C. Gilstrap III, MD
Hal C. Lawrence III, MD, FACOG
John R. Potts III, MD

*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: http://www.acgme-nas.org/assets/pdf/NASFAQs.pdf.
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” or
- 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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
</tr>
<tr>
<td>Understands the importance of respect for patient privacy and autonomy</td>
</tr>
<tr>
<td>Understands the ethical principles of appropriate patient physician relationships</td>
</tr>
<tr>
<td>Demonstrates understanding of ethical principles including boundary issues and consciously applies them in patient care</td>
</tr>
</tbody>
</table>

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).
## Obstetrics Milestones

### Antepartum Care and Complications of Pregnancy — Patient Care

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</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></td>
<td>Applies innovative approaches to complex and atypical antepartum conditions and implements treatment plans based on emerging evidence</td>
</tr>
<tr>
<td>Recognizes basic risk factors, symptoms, and signs of common obstetrical conditions (e.g., post-term gestation, abnormal placentation, third trimester bleeding)</td>
<td></td>
<td>Effectively supervises and educates lower level residents in antepartum care</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Collaborates and provides consultation to other members of the health care team in antepartum care</td>
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<td></td>
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</tbody>
</table>

**Comments:** Not yet rotated ☐
<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<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>
</tr>
<tr>
<td>Differentiates between normal and abnormal labor</td>
<td>Recognizes intrapartum complications (e.g., chorioamnionitis, shoulder dystocia)</td>
<td>Manages intrapartum complications (e.g., cord prolapse, placental abruption)</td>
<td>Identifies indications for consultation, referral, and/or transfer of care for patients with intrapartum complications</td>
<td>Effectively supervises and educates lower-level residents in intrapartum care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Collaborates and provides consultation to other members of the health care team in intrapartum care</td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
<td>Not yet rotated</td>
</tr>
</tbody>
</table>
## Care of Patients in the Postpartum Period — Patient Care

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates basic knowledge of normal postpartum care</td>
<td>Provides postpartum care for women with uncomplicated pregnancies, including lactation counseling</td>
<td>Manages common postpartum complications</td>
<td>Manages patients with complex complications of the postpartum period (e.g., septic pelvic thrombophlebitis, pulmonary embolism)</td>
<td>Applies innovative approaches to complex and atypical postpartum conditions and implements treatment plans based on emerging evidence</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>
<td>Determines the need for consultation, referral, or transfer for patients with complex complications in the postpartum period</td>
<td>Counsels patients about the risk of recurrence of antepartum, intrapartum, and postpartum complications (e.g., preeclampsia, pre-term delivery, shoulder dystocia, depression)</td>
<td>Effectively supervises and educates lower-level residents in postpartum care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Collaborates and provides consultation to other members of the health care team in postpartum care</td>
</tr>
</tbody>
</table>

**Comments:** Not yet rotated
<table>
<thead>
<tr>
<th>Obstetrical Technical Skills — Patient Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
</tr>
</tbody>
</table>
| Demonstrates basic surgical principles, including use of universal precautions and aseptic technique | Performs basic obstetrical skills, including:  
- assessment of cervical dilation  
- spontaneous vaginal delivery  
- ultrasound for assessment of fetal number, lie, presentation, viability, and placental location | Performs obstetrical procedures, including:  
- ultrasound to obtain fetal biometry  
- biophysical profile  
- repair of second degree perineal or vaginal lacerations  
- primary Cesarean section  
- uterine evacuation in the second trimester (e.g., induction, postpartum curettage) |Educates and supervises lower-level residents in performing obstetrical procedures  
Collaborates and provides consultation to other members of the health care team in performing obstetrical procedures | Applies innovative and complex approaches obstetrical care and implements treatment plans based on emerging evidence |
| Performs basic procedures, including speculum examination and cervical examination | | | | |
| Performed complex obstetrical procedures, including:  
- operative vaginal delivery  
- repair of 3rd- and 4th-degree perineal lacerations  
- repeat Cesarean section  
- cervical cerclage  
- breech vaginal delivery (including second twins)  
- cystotomy repair  
- surgical management of postpartum hemorrhage (e.g., Cesarean hysterectomy, peripartum hysterectomy) | | | | |
| Manages and repairs uterine rupture or perforation | | | | |
| Comments: | | | | Not yet rotated |
**Immediate Care of the Newborn — Patient Care**

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performs initial warming and drying of a non-depressed infant</td>
<td>Demonstrates the performance of Apgar testing</td>
<td>Performs initial resuscitation of a depressed infant</td>
<td>Capable of performing neonatal resuscitation that does not include administration of medications (may be demonstrated by satisfactory completion of the Neonatal Resuscitation Program [NRP] Provider Course [including hands-on skills stations and simulation] and receipt of a Provider Course Completion Card)</td>
<td>Manages both the resuscitation and the team in caring for infants who require resuscitation</td>
</tr>
</tbody>
</table>

**Comments:** Not yet rotated ☐
### Gynecology Technical Skills: Laparotomy (e.g., Hysterectomy, Myomectomy, Adnexectomy) — Patient Care

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<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 intra-operative decision making, including the ability to modify a surgical plan based on operative findings</td>
<td></td>
</tr>
<tr>
<td>Positions patient appropriately for surgery</td>
<td>Demonstrates basic surgical skills, including: knot tying, simple suturing, suture and staple removal</td>
<td>Performs uncomplicated gynecologic procedures</td>
<td>Demonstrates the ability to recognize and manage surgical complications, including the appropriate use of intra-operative consultation</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:** Not yet rotated
# Gynecology Technical Skills: Vaginal Surgery (e.g., Vaginal Hysterectomy, Colporrhaphy, Mid-urethral Sling) — Patient Care

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<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>Understand 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>
<td></td>
</tr>
<tr>
<td>Positions patient appropriately for surgery</td>
<td>Demonstrates basic surgical skills, including: • knot tying • simple suturing</td>
<td>Performs uncomplicated procedures</td>
<td>Recognizes and manages surgical complications, including the appropriate use of intra-operative consultation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recognizes surgical complications and formulates an initial management plan</td>
<td>Applies an evidence-based approach to the adoption of new technologies</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Effectively supervises and educates lower-level residents regarding vaginal surgery</td>
<td></td>
</tr>
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<td>Collaborates and provides consultation to other members of the health care team regarding vaginal surgery</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>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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<thead>
<tr>
<th>Peri-operative Care — Medical Knowledge</th>
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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  
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 | Applies innovative approaches to complex and atypical peri-operative care and implements treatment plans based on emerging evidence |

Comments: Not yet rotated
### Abdominal/Pelvic Pain (Acute and Chronic) — Medical Knowledge

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</thead>
</table>
| Demonstrates a basic understanding of patients presenting with abdominal/pelvic pain regarding:  
- risk factors  
- signs and symptoms | Demonstrates the ability to formulate a differential diagnosis  
Demonstrates an understanding of initial:  
- evaluation  
- treatment options | Demonstrates the ability to:  
- utilize focused diagnostic approaches  
- formulate comprehensive management plans | Demonstrates an in-depth knowledge regarding patients presenting with abdominal and pelvic pain relevant to:  
- varying patterns of presentation  
- treatment options  
- refractory pelvic pain  
Manages patients with complex and atypical chronic pelvic pain  
Demonstrates the ability to formulate comprehensive plans of management for patients with multiple and/or complex comorbidities | Leads a multidisciplinary team for care of patients with chronic pelvic pain  
Applies innovative approaches to complex and atypical abdominal/pelvic pain and implements treatment plans based on emerging evidence |

**Comments:** Not yet rotated
**Abnormal Uterine Bleeding (Acute and Chronic) — Medical Knowledge**

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<tbody>
<tr>
<td>Demonstrates basic knowledge about what constitutes normal and abnormal uterine bleeding</td>
<td>Demonstrates the ability to formulate a differential diagnosis</td>
<td>Demonstrates in-depth knowledge of the physiology of the normal menstrual cycle</td>
<td>Demonstrates an in-depth knowledge regarding patients presenting with abnormal uterine bleeding relevant to:</td>
<td>Applies innovative approaches to complex and atypical abnormal uterine bleeding and implements treatment plans based on emerging evidence</td>
</tr>
<tr>
<td>Verbalizes the phases of the normal menstrual cycle</td>
<td>Demonstrates an understanding of initial:</td>
<td>Demonstrates the ability to:</td>
<td>• varying patterns of presentation</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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| 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 | Applies innovative approaches to complex and atypical pelvic mass and implements treatment plans based on emerging evidence |

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<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>
<tr>
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<td>Demonstrates a basic understanding of patients presenting with pelvic floor disorders relevant to:</td>
<td>Demonstrates an understanding of patients presenting with pelvic floor disorders relevant to:</td>
<td>• utilizes focused diagnostic approaches</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• risk factors</td>
<td>• evaluation and interpretation of results</td>
<td>• uses non-surgical and surgical therapies</td>
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<td></td>
<td>• symptoms</td>
<td>• treatment options</td>
<td>• formulates comprehensive management plans for patients with comorbidities</td>
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<td>• physical exam findings</td>
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<td>• determines the need for consultation, referral, or transfer of patients</td>
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<td>Demonstrates the ability to formulate a differential diagnosis</td>
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# First Trimester Bleeding — Medical Knowledge

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<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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<tr>
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<td></td>
<td>Utilizes non-surgical and surgical methods to manage patients with:</td>
<td>Effectively supervises and educates lower-level residents regarding first trimester bleeding</td>
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<tr>
<td></td>
<td></td>
<td>• ectopic pregnancy</td>
<td>Collaborates and provides consultation to other members of the health care team regarding first trimester bleeding</td>
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<td>• abortion (spontaneous, induced)</td>
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<td>• other etiologies</td>
<td></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>
</tr>
<tr>
<td><strong>Demonstrates ability to perform basic first trimester uterine evacuation (medical and surgical)</strong></td>
<td><strong>Counsels on the effectiveness, benefits, and contraindications for male and female sterilization</strong></td>
<td><strong>Manages complications of contraceptive methods and pregnancy termination</strong></td>
<td><strong>Determines the need for consultation, referral, or transfer of patients with complex complications</strong></td>
<td><strong>Demonstrates ability to perform basic second trimester uterine evacuation (medical and surgical)</strong></td>
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## Ambulatory Gynecology — Patient Care

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<tbody>
<tr>
<td>Demonstrates basic knowledge about common ambulatory gynecologic problems</td>
<td>Performs the initial assessment, formulates a differential diagnosis, and initiates treatment for common ambulatory gynecologic problems (e.g., sexually transmitted infections, vaginitis)</td>
<td>Formulates management plans and initiates treatment for complex ambulatory gynecologic problems (e.g., cervical dysplasia, infertility, ovulatory disorders, breast disorders)</td>
<td>Effectively cares for patients with complex presentations (e.g., refractory to initial management, unusual presentations, complications)</td>
<td>Applies innovative approaches to complex and atypical ambulatory gynecology and implements treatment plans based on emerging evidence</td>
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<tr>
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<td>Performs colposcopy, basic gynecologic ultrasound, and other indicated office procedures</td>
<td>Uses a multi-disciplinary approach and makes appropriate referrals when caring for patients with complex ambulatory gynecologic problems (e.g., sexual dysfunction, menopausal symptoms, vulvovaginal syndromes and lesions)</td>
<td>Understands and applies principles of office management (e.g., billing)</td>
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### Care of the Patient with Non-Reproductive Medical Disorders — Patient Care

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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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<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>
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<td>Participates in “time-out”</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>
<td>Demonstrates knowledge of national patient safety standards, as well as their use/application in the institution</td>
<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>
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<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>Effectively communicates within his or her own hospital/clinic to advocate for patient needs</td>
<td>Effectively communicates within health care systems to advocate for the needs of patient populations</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><strong>Demonstrates an understanding of critical appraisal of the literature</strong></td>
<td><strong>Identifies resources (e.g., texts, search engines) to answer questions while providing patient care</strong></td>
<td><strong>Applies patient-appropriate use of evidence-based on review articles or guidelines on common topics in practice</strong></td>
<td><strong>Tailors evidence-based practice based on the values and preferences of each patient</strong></td>
<td><strong>Designs a hypothesis-driven or hypothesis-generating study</strong></td>
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<tr>
<td><strong>Demonstrates responsiveness to constructive feedback</strong></td>
<td><strong>Recognizes limits of knowledge, expertise, and technical skills</strong></td>
<td><strong>Critically reviews and interprets the literature with the ability to identify study aims, hypotheses, design, and biases</strong></td>
<td><strong>Reads and assesses strength of evidence in current literature and applies it to one’s own practice</strong></td>
<td><strong>Contributes to peer-reviewed medical literature</strong></td>
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<tr>
<td><strong>Describes commonly used study designs (e.g., randomized controlled trial [RCT], cohort; case-control, cross-sectional)</strong></td>
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<td><strong>Tailors evidence-based practice based on the values and preferences of each patient</strong></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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<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>
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<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>Understands level of evidence for patient care recommendations</td>
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<td>Organizes and leads effective institutional QI/patient safety projects</td>
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### Professionalism Milestones

**Compassion, Integrity, and Respect for Others — Professionalism**

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<td>Understands the importance of compassion, integrity, and respect for others</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>Demonstrates sensitivity and responsiveness to patients</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>
<td>Coaches others to improve compassion, integrity, and respect for patients</td>
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</tr>
<tr>
<td>Accepts constructive feedback to improve his or her ability to demonstrate compassion, integrity, and respect for others</td>
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### Accountability and Responsiveness to the Needs of Patients, Society, and the Profession — Professionalism

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<tr>
<td>Understands that physicians are accountable to patients, society, and the profession</td>
<td>Is consistently punctual for clinical assignments and responsive to requests for assistance; completes administrative duties (e.g., medical records, reports) on time and without reminders</td>
<td>Serves as an example for others in punctuality, responsiveness, and timely completion of duties</td>
<td>Coaches others to improve punctuality and responsiveness; offers assistance to ensure patient care duties are completed in a timely fashion</td>
<td>Participates in institutional or community peer counseling related to professionalism</td>
</tr>
<tr>
<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>Demonstrates self-awareness of fatigue and stress, and mitigates the effects</td>
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### Respect for Patient Privacy, Autonomy, Patient-Physician Relationship — Professionalism

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<tbody>
<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>
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<tr>
<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
<table>
<thead>
<tr>
<th>Communication with Patients and Families — Interpersonal and Communication Skills</th>
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<tbody>
<tr>
<td><strong>Level 1</strong></td>
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<tr>
<td>Demonstrates adequate listening skills</td>
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<tr>
<td>Communicates effectively in routine clinical situations</td>
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<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
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<th>Level 4</th>
<th>Level 5</th>
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</thead>
<tbody>
<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>
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<td>Demonstrates an understanding of transitions of care and team debriefing</td>
<td>Participates in effective transitions of care and team debriefing</td>
<td>Leads effective transitions of care and team debriefing</td>
<td>Provides effective consultation in complex and atypical patients</td>
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<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>
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Comments: Not yet achieved Level 1
### Informed Consent and Shared Decision Making — Interpersonal and Communication Skills

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<tr>
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<tbody>
<tr>
<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></td>
<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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#### Comments:

Not yet achieved Level 1