OB/GYN Standardized Letter of Evaluation (SLOE) Writing Guide

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I. Purpose of SLOE

The Standardized Letter of Evaluation (SLOE) is an evaluative instrument that provides an assessment of an applicant's candidacy for obstetrics and gynecology (OBGYN) residency training. The Coalition for Physician Accountability's Undergraduate Medical Education-Graduate Medical Education Review Committee (UGRC) recommends that structured evaluation letters replace all letters of recommendation as a universal tool in the residency program application process. By using Accreditation Council for Graduate Medical Education (ACGME) standards and competencies for residency and medical training, the letter is meant to provide a more holistic and efficient review of competencies and values that are essential in OBGYN training. The goal is to reduce bias by directing answers to standardized questions for all candidates applying to residency.

Another goal of the SLOE is to limit the variability and the lack of standardization found with traditional letters of recommendation. A standardized approach to structured evaluations in the residency application process ensures a more transparent, uniform, honest, and equitable process. This reduces the biases and subsequent disparities that result from the traditional letters of recommendation. The SLOE is intended to augment the Medical Student Performance Evaluation (MSPE) with an OBGYN-focused assessment.

For Doctor of Osteopathic (DO) medicine and International Medical Graduate (IMG) applicants, the SLOE can ensure that they are compared using the same criteria as students from US allopathic medical schools. The SLOE was designed and updated by a group that included both DO and IMG representatives. It is intended to work in various settings including for an applicant who is being evaluated while rotating with an OBGYN residency program in a large academic medical center or a small community hospital, or an applicant who is rotating in an outpatient setting with no residents. Any obstetrician-gynecologists who serves as a preceptor should be able to provide the observational information of the applicant's performance.

The SLOE for OBGYN applicants was piloted in the 2021-2022 residency application cycle when a SLOE was voluntary. For the 2022-23 application cycle, one SLOE was expected for each applicant. Feedback on the SLOE was solicited from applicants, program directors, and dean's offices after the 2022-23 application cycle. The SLOE was updated for the 2023-24 application cycle and was strongly recommended for an applicant to include one SLOE. In the 2024-25 application cycle, the SLOE was submitted directly into ResidencyCAS, the application service for OB/GYN residency applicants.

For the 2025-26 application cycle, the only change to the SLOE is clarifying the role of who is completing the SLOE. There are no changes to the content of the evaluation. **The submission of one SLOE is strongly recommended for each applicant for the 2025-26 application cycle.** While it is not universally mandatory, many programs may require a SLOE to apply to their program. Please read the specific application requirements for each program.

II. Who should write the SLOE?

The SLOE should be written by an individual or a group of people who know the applicant the best. Ideally, they will be able to speak to the applicant's clinical skills and can describe the unique attributes the applicant may bring to a residency program. It is critical that whoever completes the SLOE understands and appropriately answers the questions that are specifically addressed. The SLOE was created to be completed by someone within obstetrics and gynecology but may, in some unique circumstances, be completed by someone outside the specialty.

The SLOE asks each letter writer to "Please indicate in what capacity this letter is being written". The three choices are:

- A **Chair's letter** where the OB/GYN department chair provides an assessment of the applicant. This can be either from their personal interactions with the applicant or based on the feedback from other sources.
- **Composite group letter or committee assessment** can be either 1) a composite evaluation based on knowledge of their performance throughout medical school (e.g., input from other individuals or sources) from an advising team or undergraduate medical education committee or 2) a group who completes the SLOE based solely on their collective direct experiences and observations of the applicant as might occur with a clinical division or a physician group who worked closely with the applicant on a specific rotation.
- An **individual letter writing reflecting their own assessment** based solely on their direct observation of the applicant. An example would be a faculty member who worked with the applicant on a clinical rotation or a sub-internships/acting internship.

Accurate documentation aids the residency programs in understanding who has completed the SLOE, in what capacity the letter writer is serving, and what experiences the applicant had completed when the assessment of their skills was made. The "Indicate your present role" and "Please indicate ALL clerkship and elective experiences the student has already completed at the time of the completion of the SLOE" sections of the SLOE are critical to communicating this.

The section "In what context/capacity have you (individual author) or the composite group interacted with the applicant?" should be completed as follows:

> If the SLOE is written as the Chair's Letter, the chair should indicate the contexts and capacities that were considered in their evaluation of the applicant.
>
> If the SLOE is written as a committee assessment, the author should indicate all of the contexts and capacities that were considered in the evaluation of the applicant.

If the SLOE is completed as a composite group letter, the author should indicate the rotation(s)/experiences(s) the assessment is based on.

If the SLOE is completed by an individual letter writing reflecting their own assessment, the author should indicate the rotation(s)/experiences(s) the assessment is based on.

For osteopathic or international medical graduate applicants, the SLOE may be best completed by an individual letter writer rather than a composite of group letter from the College of Osteopathic Medicine (COM) or medical school. of the applicant.

III. When to complete the SLOE

The SLOE is ideally filled out after as many clinical rotations have been complete before the application deadline. This allows the most up-to-date assessment of the applicant's clinical skills. This may not be possible for all applicants if the SLOE is being completed based on a single clinical rotation or as a committee evaluation.

A SLOE written by an individual or group that is based solely on their direct observations (i.e., not a composite evaluation) should be completed as close to the time of clinical interaction with the applicant as possible. This approach provides the most accurate assessment and reduces recall bias. Because many osteopathic medical students change locations several times during their rotations, the applicant should provide the evaluator with sufficient information to recall their rotation performance at the time the letter is written.

When written as a composite evaluation by a committee, the SLOE should be completed following the most recent OBGYN clinical elective/sub-internship rotation preceding the interview season. This will allow for the most robust global assessment of the applicant.

IV. What information is needed to complete the SLOE

No additional information should be needed for a SLOE filled out by an individual or group based on their own direct observations.

For a composite SLOE, the following information should be available to writer(s):

- Core OBGYN clerkship performance
- Performance on OBGYN clinical electives, sub-internships/acting internships
- Other experiences that have guided the applicant's decision to become an OBGYN

Osteopathic or international medical applicants who elect to have an individual complete the SLOE as a composite evaluation should ensure that the evaluator has access to all information including assessments of clinical performance to aid in completing the SLOE.

The feedback the SLOE design team has received from program directors is that a truthful assessment of the applicant is paramount. The SLOE is a criteria-based evaluation that is one element of the overall residency application. The desire to paint the applicant in the best light should be balanced by an accurate, honest assessment.

V. SLOE Components

The SLOE has been intentionally created to provide information to assist both the author and the reader to ascertain the attributes of the applicant. Understanding the sections of the SLOE will aid in the success of the process.

- Competency Assessment Rubric – these competencies align with the ACGME competency domains that are assessed in OBGYN residency. The anchors for these descriptors are in a table located on the last page of the SLOE form. That table is also at the end of this guide document under Section VII.

  The brief descriptions are written to reflect the expected behaviors of a medical student who is about to graduate. For each competency, please select the box that best aligns with the applicant's level of functioning: Early clerkship student, Immediate end-of-OBGYN clerkship student, Acting intern or 4th year student, Intern (at the third month of training), Not observed sufficiently.

  - Rate the applicant based on your direct observation or available aggregated information
  - Most applicants are expected to fall under the "Immediate end-of-OBGYN clerkship student" or "Acting intern or 4th year student" category
  - Since most applicants are expected to have relative strengths and areas for growth, the SLOE is most useful when the ratings reflect this variation (e.g., rating the applicant at "Intern" level for each category is difficult to interpret and should be avoided unless this accurately represents the applicant)
  - Specific comments or examples are strongly recommended, especially if Early clerkship student or Intern levels (lowest and highest) are chosen; comments should be brief

- Most Outstanding Feature
  - 5 words or less
  - What most impresses you about the applicant?
  - What are the applicant's greatest strengths?
  - What makes the applicant unique and distinguishable from others?

- Areas of Focus – "If a program plans to provide focused coaching or development opportunity for the interns in the first year of residency, indicate up to 3 areas of focus for this individual applicant:"
  - The assumption is that every applicant will have areas for growth
  - Choose up to three areas you would tell the applicant to focus on to become a better intern/doctor
  - Listing no areas for growth is not recommended; all applicants have areas where they can develop or grow

    - Include brief specific comments or examples when applicable

- Narrative
    - In 250 words or less, please comment on 1-2 unique characteristics or strengths of the applicant
    - Do not attempt to summarize the applicant's CV
    - This is not intended to be a shorter version of a typical letter of recommendation, but rather an emphasis of the unique strengths a candidate would bring to a program

VI. Changes for the 2025-26 Application Cycle

For the 2025-26 application cycle, the only change to the SLOE is clarifying the role of who is completing the SLOE. There are no changes to the content of the evaluation.

The SLOE will be directly entered into ResidencyCAS as it was in the 2024-25 application cycle.

VII. Competency Rubric Table

	Intern	Acting intern or 4th year student	Immediate end-of-OBGYN clerkship	Early clerkship student
Interpersonal and Communication Skills	**Performed or demonstrated CONSISTENTLY (> 75% of time)**	**Performed or demonstrated MOST OF THE TIME (50 – 75% of time)**	**Performed or demonstrated MOST OFTEN (~ 50% of time)**	**Performed or demonstrated INFREQUENTLY or INCONSISTENLY (< 50% of time)**
	• Demonstrates respect and establishes rapport with patients and patients' families (e.g., situational awareness of language, disability, health literacy level, cultural differences) • Communicates with patients and their families in an understandable and respectful manner • Understands and respects the role and function of interprofessional team members • Accurately records information in the patient record			
Patient Care	**Performed or demonstrated CONSISTENTLY (> 75% of time)**	**Performed or demonstrated MOST OF THE TIME (50 – 75% of time)**	**Performed or demonstrated MOST OFTEN (~ 50% of time)**	**Performed or demonstrated INFREQUENTLY or INCONSISTENLY (< 50% of time)**
	• Takes a focused patient HX and performs appropriate PE for common ambulatory OBGYN problems • Provides postpartum and interconception care for patients with uncomplicated pregnancies • Provides routine postoperative care for patients undergoing uncomplicated procedures (e.g., hysterectomy, laparoscopy)			
	• Formulates **COMPREHENSIVE** DDX based on symptoms and Hx for common conditions (e.g., 1st-trimester bleeding, pelvic pain, adnexal mass/cyst, AUB) • Recognizes **MOST** risk factors leading to critical illness in an OB or GYN patient, including OB emergencies and GYN complications		• Formulates **SHORT** DDX based on symptoms and Hx for common conditions (e.g., 1st-trimester bleeding, pelvic pain, adnexal mass/cyst, AUB) • Recognizes **SOME** risk factors leading to critical illness in an OB or GYN patient, including OB emergencies and GYN complications	
Procedural Skills	**Performed with MINIMAL or REACTIVE / ON-DEMAND supervision**	**Performed AT TIMES with MINIMAL or REACTIVE / ON-DEMAND supervision, or with LESS DIRECT supervision,**	**Performed with DIRECT or PROACTIVE / FULL supervision**	**Performed with SIGNIFICANT DIRECT or PROACTIVE / FULL supervision as co-activity, or NOT ALLOWED to perform**
	• Performs basic obstetric skills (e.g., identification of fetal lie, interpretation of fetal heart rate monitoring, and tocodynamometry) • Demonstrates basic surgical principles, including use of universal precautions and aseptic technique • Demonstrates basic OR and surgical skills (e.g., positioning, knot tying, suturing, draping)			
Medical Knowledge	**Performed or demonstrated CONSISTENTLY (> 75% of time)**	**Performed or demonstrated MOST OF THE TIME (50 – 75% of time)**	**Performed or demonstrated MOST OFTEN (~ 50% of time)**	**Performed or demonstrated INFREQUENTLY or INCONSISTENLY (< 50% of time)**
	• Demonstrates basic knowledge of normal OB care and common medical complications seen in pregnancy, and routine/uncomplicated intrapartum OB care including conduct of normal labor • Demonstrates basic knowledge of routine GYN care including screening, common GYN conditions, and routine/uncomplicated peri-operative care • Identifies normal anatomy relevant to physical examination, imaging, and surgery • Demonstrates knowledge of physiology of reproduction			
Professionalism	**Performed or demonstrated CONSISTENTLY (> 75% of time)**	**Performed or demonstrated MOST OF THE TIME (50 – 75% of time)**	**Performed or demonstrated MOST OFTEN (~ 50% of time)**	**Performed or demonstrated INFREQUENTLY or INCONSISTENLY (< 50% of time)**
	• Demonstrates knowledge of ethical principles • Identifies and describes potential triggers for professionalism lapses and how to appropriately report professionalism lapses • Takes responsibility for failure to complete tasks and responsibilities, identifies potential contributing factors, and describes strategies for ensuring timely task completion in the future • Responds promptly to requests or reminders to complete tasks and responsibilities			
Practice-Based Learning and Improvement	**Performed or demonstrated CONSISTENTLY (> 75% of time)**	**Performed or demonstrated MOST OF THE TIME (50 – 75% of time)**	**Performed or demonstrated MOST OFTEN (~ 50% of time)**	**Performed or demonstrated INFREQUENTLY or INCONSISTENLY (< 50% of time)**
	• Demonstrates how to access and use available evidence and incorporate patient preferences and values to the care of a routine patient • Identifies gap(s) between expectations and actual performance • Establishes goals for personal and professional development		• Demonstrates how to access available evidence for the care of a routine patient • Identifies gap(s) between expectations and actual performance	
Systems Based Practice	**Performed or demonstrated CONSISTENTLY (> 75% of time)**	**Performed or demonstrated MOST OF THE TIME (50 – 75% of time)**	**Performed or demonstrated MOST OFTEN (~ 50% of time)**	**Performed or demonstrated INFREQUENTLY or INCONSISTENLY (< 50% of time)**
	• Demonstrates knowledge of common patient safety events • Demonstrates knowledge of care coordination • Identifies key elements for safe and effective transitions of care and hand-offs • Demonstrates knowledge of community and population health needs and inequities			
	• Demonstrates knowledge of how to report common patient safety events • Demonstrates knowledge of basic QI methodologies and metrics • Identifies key components of the complex health care system (e.g., hospital, SNF finance, personnel, tech)			