DEPARTMENT OF
OBSTETRICS AND GYNECOLOGY
University of Wisconsin
School of Medicine and Public Health

Resident Learning Objectives

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Residency Rotation Guidelines & Objectives
Overall Program Goals

The University of Wisconsin Ob-Gyn Residency Program trains competent Ob-Gyn physicians who, at the conclusion of residency, possess the knowledge base, skill set and professional attributes to enter practice independently, and who will contribute to the specialty through patient care, education or research. Certain professional attributes and skills are essential for all competent physicians, and are not limited to any rotation or level of training.

MEDICAL KNOWLEDGE (MK)

This is evidenced by a command of established and evolving knowledge in the biomedical, clinical and social sciences, 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 life long commitment to daily learning.

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 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.

These overall goals represent the core of our residency program's educational efforts. Our mission is to train physicians who will provide the highest quality care for their patients and who will make meaningful contributions to Women's Health throughout their careers.

Last Revision: 6/2/2009

Residency Rotation Guidelines & Objectives
Service: Family Planning Services **Level:** PGY-1

OVERVIEW

Goals

To develop clinical skills in family planning and abortion services and to develop awareness of the larger role that access to these services plays in the lives of our patients. Participation in performing abortion procedures is optional, and should be discussed with Dr. Dutton and the program director on an individual basis.

Duty Hours & Locations

Two blocks of consecutive four week rotations with days alternated between Planned Parenthood and UHS. This rotation takes place at Planned Parenthood of Wisconsin's Comprehensive Reproductive Health Center (CRHC).

The schedule is:

8:00 am – 5:00 pm, Monday: Family planning
8:00 am – 5:00 pm, Tuesday: Pre-op/counseling visits and first trimester abortion procedures

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: Participate in the UWHC home call schedule.
Vacation: One vacation week may be taken during this rotation.

Supervision

This rotation has been established under the Kenneth J. Ryan Residency Training Program in Abortion and Family Planning with Dr. Caryn Dutton serving as the director. Dr. Dutton and the PPWI staff provide direct supervision for the resident.

LEARNING OBJECTIVES

- Counsel patient about all alternatives available to them for unplanned pregnancy including induced abortion. *PC, ICS, PBLI, P*
- Understand and comply with state laws requiring 24-hour waiting period prior to abortion. *MK, SBP*
- Understand pre-operative evaluation and elicit pertinent history from patients requesting induced abortion. *MK, PC*
- Perform bimanual pelvic exam and transvaginal and/or abdominal ultrasound to date early pregnancies. *PC*

- Describe techniques and appropriate timing for pregnancy termination methods including suction curettage, dilation and evacuation, and medical abortion. Residents opting to perform abortions will demonstrate initial procedural skill with manual vacuum aspiration, electric suction aspiration (D&C), and evaluation of POCs. *MK*
- Describe and understand treatment of potential complications of pregnancy termination. *MK*
- Explore social, political, economic, cultural, and personal issues surrounding abortion care and access to reproductive health care. *PBLI, SBP*

EDUCATION PROGRAM

Clinical Scope

This clinic offers a full range of reproductive health care including well-woman exams, contraception and family planning, sexually transmitted infection testing for men and women, medical and surgical abortion services, colposcopy, and community education programs.

PGY1 residents will participate in a full day of family planning clinic, and one day of pre-op counseling and abortion procedures each week on rotation.

Residents opting out of performing abortions will be present in clinic and may participate in all other aspects of patient care including pre-op exams, follow-up exams, and recovery care. Participation in performing abortion procedures is optional and should be discussed with Dr. Dutton on an individual basis.

Other Educational Activities

A written or oral presentation (in conjunction with UHS project) will be presented to PPWI staff.

LEARNING MATERIALS

- ACOG Practice Bulletin #73, Use of Hormonal Contraception for Women with Coexisting Medical Conditions, June 2006, Reaffirmed 2008.
- ACOG Practice Bulletin #67, Medical Management of Abortion, October 2005. Reaffirmed 2009.
- ACOG Practice Bulletin #59, Intrauterine Device, January 2005, Reaffirmed 2009.
- Stubblefield et al. "Methods for Induced Abortion," Obstetrics and Gynecology 2004. 104:174-185.
- NAF textbook: Paul et al., A Clinician's Guide to Medical and Surgical Abortion. 2009.
- Hatcher et al., Contraceptive Technology. 2008.
- Values Clarification Workbook, NAF.
- PPFA Ultrasound Training CD-ROM.
- Ryan Program Online Curriculum.

EVALUATION

Global assessment by Dr. Dutton with feedback from PPWI staff.

Last Revision: 6/2/2009

DEPARTMENT OF
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Residency Rotation Guidelines & Objectives
Service: Meriter Hospital Low Risk Obstetrics **Level:** PGY-1

OVERVIEW

Goals

Develop the knowledge and skills required to provide competent antepartum, intrapartum and postpartum care for uncomplicated obstetrical patients of the generalist and FM faculty and the RCC. The resident will develop an understanding of the labor process and become proficient at determining the correct timing of delivery, performance of spontaneous vaginal deliveries and providing assistance during abdominal deliveries. The resident will gain experience with operative vaginal deliveries and become familiar with principles of obstetric anesthesia. The resident will provide assessment and develop management plans for patients presenting to obstetric triage. The resident is expected to actively involve and instruct medical students in patient care.

Duty Hours & Locations

24 weeks in 4 to 8 week continuous blocks (including two 4 continuous week blocks of night float).
Daytime:

The PGY1 is expected to be available in the birthing center from 0600 to 1700 or 1900 at the discretion of the PGY4.

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: Participate in the Meriter OB call pool.
Vacation: May be assigned a vacation during this block.

Night float:

The PGY1 is expected to be available in the birthing center from 1900 to 0730 Sun through Thurs.

RCC: Continuity Clinic every other Friday morning.
Other: Attend Thursday morning 7:00 a.m. conference per department schedule.
Call: None.
Vacation: Permitted.

Supervision

The PGY4 is responsible for the clinical and educational activities of the daytime team. The night float PGY3 is responsible for the clinical and educational activities of the night float PGY1. Performance of deliveries is under the direction of the attending staff.

LEARNING OBJECTIVES

- Elicit an accurate history, perform a focused exam and develop a treatment plan for term patients presenting with labor concerns, ROM, vaginal bleeding and decreased fetal movement,

including determination of fetal position, clinical pelvimetry, clinical estimation of fetal weight. *PC*

- Perform and interpret the following methods of fetal monitoring: intermittent auscultation, electronic monitoring, fetal scalp stimulation, vibroacoustic stimulation, non stress test and biophysical profile. *PC*
- Describe the possible causes for and clinical significance of bradycardia, tachycardia, increased variability, decreased/absent variability, decelerations (early, variable, and late) and the sinusoidal waveform. *MK*
- Describe appropriate indications for and complications of cervical ripening agents and labor inducing agents. *MK*
- Describe the normal course of labor, risk factors for abnormal labor and identify abnormalities of labor including failed induction, prolonged latent phase, protracted active phase, arrest of dilatation, protracted descent and arrest of descent. *MK*
- Describe the appropriate role for and complications of the following interventions for abnormal labor: analgesia, amniotomy, augmentation of labor, uterine contraction monitoring, episiotomy, operative vaginal and abdominal delivery. *MK*
- Counsel patients about risks, benefits, appropriateness and contraindications to VBAC, including criteria for anesthesia and hospital policies. Recognize complications including hemorrhage, uterus scar dehiscence and fetal compromise. *MK, PC, ICS, PBLI, SBP, P*
- Perform spontaneous vaginal delivery and episiotomy under the supervision of attending staff and/or senior resident. *PC*
- Assist in cesarean deliveries. Describe the procedure and surgical instruments used. *MK, PC*
- Assist external cephalic version procedure. Describe contraindications, procedure risks and factors increasing or decreasing potential success. *MK, PC*
- Counsel patients regarding the types, benefits, risks and contraindications of anesthesia appropriate for control of pain during labor and delivery including epidural, spinal, pudendal, local infiltration, general and intravenous sedation. *MK, ICS, P*
- Be able to evaluate and provide immediate care for the newborn, including neonatal resuscitation, APGAR score assignment and cord blood gas analysis. Maintain neonatal resuscitation certification. *MK, PC*
- Describe the causes and management of post partum hemorrhage. *MK*
- Identify and treat the most common maternal complications that occur in the puerperium: delayed hemorrhage, fever, infection and bladder instability. *MK, PC*
- Under the guidance of the senior resident, evaluate, perform focused exam and perform/interpret appropriate tests for patients who present to triage for third trimester bleeding, pre-term labor, PPROM and general medical concerns. *PC*

EDUCATION PROGRAM

Clinical Scope

Learning will be facilitated via direct patient care activities of uncomplicated obstetrical patients presenting to triage and labor and delivery.

Conferences

- Mon – Fri: 7:00 - 7:30 a.m. Sign Out Rounds
- Monday: 7:30 - 8:30 a.m. Resident OB Didactics
- Tuesday: 7:30 - 8:30 a.m. Perinatal Conference
- Wednesday: 7:30 – 8:30 a.m. MFM Didactics
- Thursday: M&M, Grand Rounds, resident didactics and simulation lab per department schedule.
- Fridays 7:30 – 8:30 a.m. L&D Conference

During these times a single resident will be available by pager to respond to clinical emergencies.

Other Educational Activities

Complete the ACOG **Episiotomy: Procedure and Repair Techniques** Monograph.

LEARNING MATERIALS

- Normal and Problem Preganancies, Stephen Gabbe, latest edition.
- Williams Obstetrics, latest edition.
- ACOG Practice Bulletin #76, Postpartum Hemorrhage, October 2006, Reaffirmed 2008.
- ACOG Practice Bulletin #70 Intrapartum Fetal Heart Rate Monitoring, December 2005, Reaffirmed 2007.
- ACOG Practice Bulletin #49 Dystocia and Augmentation of Labor, December 2003, Reaffirmed 2009.
- ACOG Practice Bulletin #36 Obstetric Analgesia and Anesthesia, July 2002, Reaffirmed 2008.
- ACOG Practice Bulletin #40 Shoulder Dystocia, November 2002, Reaffirmed 2008.
- ACOG Practice Bulletin #10 Induction of Labor, November 1999, Reaffirmed 2006.
- ACOG Practice Bulletin #9 Antepartum Fetal Surveillance, October 1999, Reaffirmed 2009.
- ACOG Practice Bulletin #13 External Cephalic Version, February 2000, Reaffirmed 2008.
- ACOG Practice Bulletin #17 Operative Vaginal Delivery, June 2000, Reaffirmed 2008.

EVALUATION

- Global assessment by attendings on the service.
- Formative surgical skills assessment by attendings on the service.
- Medical student evaluation of teaching efforts.

Last Revision: 6/2/2009

Residency Rotation Guidelines & Objectives
Service: Ultrasound/Genetics **Level:** PGY-1

OVERVIEW

Goals

Develop knowledge and skills of obstetric ultrasound including competence to confirm fetal viability, number of fetuses, position of fetus, placenta location, and perform AFI, BPP, endovaginal cervical evaluation and basic fetal biometry resulting in attainment of "Ultrasound Certification". In addition, develop skills to correctly counsel patients regarding testing for and diagnosis of genetic conditions and common fetal anomalies.

Duty Hours & Locations

Four consecutive weeks in the OB ultrasound unit which is located in the Perinatal Clinic at Meriter hospital. Attends all clinic office hours, generally 7:45 a.m. to 5:00 p.m. daily.

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: Participate in the St. Mary's call pool.
Vacation: Permitted

Supervision

The MFM attending physicians direct education activities. The unit's senior sonographer signs off on the "Ultrasound Certification". Daily activities are under the direction of the RDMS sonographers and MFM attending of the day.

LEARNING OBJECTIVES

- Describe the basic physics of ultrasound resulting in correct and safe system settings, transducer selection, focus, depth correction, TGC curve, gain settings etc. *MK*
- Describe the clinical significance of karyotype abnormalities including trisomy, monosomy, deletions and inversions; describe the clinical significance of heritable diseases, such as cystic fibrosis, Tay-Sachs disease and hemophilia. *MK*
- Describe the available screening and diagnostic tests including limitations, accuracy and risks for detecting fetal anomalies. *MK*
- Identify optimal timing for the various types of ultrasound exams. *MK*
- Verbalize the ultrasound dating criteria that are used in each trimester of pregnancy. *MK*
- Demonstrate ability to perform a complete first trimester evaluation, including M-mode and ovaries. *MK, PC*
- Demonstrate correct sonographic attainment of fetal biometry measurements. *MK, PC*
- Obtain correct views for Perform a basic obstetrical ultrasound exam, including fetal lie, amniotic fluid volume, cardiac activity, placental position and fetal number. *MK, PC*
- Perform a biophysical profile and AFI. *MK, PC*
- Perform an endovaginal evaluation of placental position and cervical length. *MK, PC*

EDUCATION PROGRAM

Clinical Scope

Learning is facilitated by observation of patient sessions with genetic counselors, RDMS sonographers and MFM attendings, one on one discussion of exam protocols, imaging parameters and system settings, guided hands-on scanning and one on one evaluation of scanning technique and critique of images obtained. *The resident will act as an observer for at least 4 patient sessions addressing patient problems: advanced maternal age, abnormal 1st or 2nd trimester serum screening, fetal anomaly and medication or toxin exposure.* Hands on performance of skills expected for the Ultrasound Certification is under the direct supervision of the RMDS senior sonographers and MFM staff.

Other Educational Activities

- Attend weekly Perinatal Conference Tuesdays 7:30 a.m.
- Attend MFM division didactics Wednesdays at 7:30 a.m.
- Attend M&M, Grand Rounds, resident third hour didactics and sim lab sessions per department schedule.

LEARNING MATERIALS

Required Reading

- Smith & Smith: Obstetric and Gynecological Ultrasound Made Easy 2nd (2006)
- ACOG Practice Bulletins #101 Ultrasonography in Pregnancy (February 2009)
- ACOG Practice Bulletins #88 Invasive Prenatal Testing for Aneuploidy (December 2007)
- ACOG Committee Opinion #410 Ethical Issues in Genetic Testing (June 2008)
- ACOG Committee Opinion #409 Direct-to-Consumer Marketing of Genetic Testing (June 2008)
- ACOG Committee Opinion #393 Newborn Screening (December 2007), (Replaces No. 287, October 2003)

Recommended References

- Kremkau: Diagnostic Ultrasound: Principles and Instruments; 7th
- Callen: Ultrasonography in Obstetrics and Gynecology; 5th
- Goldberg: Atlas of Ultrasound Measurements; 2nd
- Sanders: Structural Fetal Anomalies - The Total Picture; 2nd
- Benacerraf: Ultrasound of Fetal Systems 2nd

EVALUATION

- Global assessment by MFM staff.
- Focused assessment of ultrasound competency by Senior RDMS.
- Attainment of ultrasound certification.

Last Revision: 6/2/2009

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Residency Rotation Guidelines & Objectives
Service: University Student Health **Level:** PGY-1

OVERVIEW

Goals

Become a more experienced primary care gynecologic clinician of reproductive age women by improved history taking, physical exam skills including breast and pelvic exams, wellness and preventative care, contraceptive counseling, patient education and experience working with an integrated care team.

Duty Hours & Locations

Two consecutive four week rotations with days alternated between Planned Parenthood and UHS. You may be assigned a vacation week during this rotation.

UHS Daily Schedule:

8:30 am – 5:00 pm, Wednesday
10:30 am – 5:00 pm, Thursday
8:30 am – 5:00 pm, Friday

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: Participate in the UWHC home call schedule.
Vacation:

Supervision

The resident works under the direct supervision of Dr. Mary Landry. The resident can expect staff support from the professional and support staff of the UHS clinic.

LEARNING OBJECTIVES

- Elicit an appropriate history, perform a well woman exam and recommend screening adhering to the primary preventative care standards established by the RRC and ACOG.
- Interpret and establish treatment plan for abnormal Pap smear and/or colposcopy results in accordance with 2006 ASCCP guidelines.
- Perform and interpret the results of colposcopy exam for follow up evaluation of abnormal Pap Smear.
- Elicit a pertinent history, perform a focused physical examination, select and interpret diagnostic tests and establish initial treatment plan for the following conditions: sexually transmitted infections, vaginitis, amenorrhea, pelvic pain, breast mass, galactorrhea, abnormal uterine bleeding and pelvic pain.
- Describe advantages, disadvantages, failure rates and complications associated with hormonal, intrauterine, barrier and permanent contraceptive methods.
- Describe appropriate methods for post coital contraception.

- Demonstrate ability to identify candidates for intra-uterine contraception. Be able to appropriate counseling and demonstrate competency of insertion
- Perform and interpret the results of tests to confirm the diagnosis of vaginal infections including: vaginal pH, saline and potassium hydroxide microscopy, bacterial and viral culture.
- Describe the most common STDs, including causes, symptoms, risk of transmission and appropriate test modality and testing limitations.
- Describe long-term follow up for patients with a STD including assessment for the patient's sexual partner, discussion of preventative measures and review of serious sequelae.
- Be able to evaluate and diagnose PCOS and make appropriate management recommendations.
- Develop a research question on a topic of residents choosing and conduct a thorough literature search. Prepare and present a 40 minute power-point presentation of the topic.
- Demonstrate skill at performing pelvic ultrasound for the identification of reproductive organ pathology.

EDUCATION PROGRAM

Clinical Scope

Learning is facilitated by direct patient care activities in the clinic. The resident will have his/her own schedule of patients each day and will be expected to provide care for them including routine annual examinations, contraception and other family planning services, sexually transmitted disease evaluations and treatment, amenorrhea, dysmenorrhea, galactorrhea, breast masses, vaginitis, abnormal vaginal bleeding, lower abdominal pain, ovarian cysts, abnormal Pap smears, colposcopic examinations, IUD placement, office Gyn surgery, ultrasound, and other women's health issues.

Other Educational Activities

- Friday Didactics with Dr. Landry:
  - Week 1: Cervical dysplasia – screening, diagnosis, and management
  - Week 2: Non-contraceptive benefits of hormonal contraception.
  - Week 3: Hormonal contraception and coexisting medical conditions
  - Week 4, 5 & 6: Colposcopy
  - Week 7: Resident choice: eating disorders, sexual abuse exam, abdominal pain made easy, abnormal bleeding-definitions, evaluations and/or ultrasound cases
  - Week 8: Resident to present "most interesting case", with literature review (topic selected at the end of week 4)
- Complete ASCCP CD ROM
- UHS Lecture Series:
  - STDs, Craig Roberts
  - Hormonal contraception and IUDs, Amy Miller
  - Managing side effects of hormonal contraception, Sharon Woodford
  - Headache I and II, Allan Rifkin
  - Sexual history taking, Paul Grossberg
  - Eating disorders, Sara Van Orman

LEARNING MATERIALS

- ACOG Practice Bulletin #73, Use of Hormonal Contraception in Women with Coexisting Medical Conditions, June 2006, Reaffirmed 2008.
- ACOG Practice Bulletin #15, Premenstrual Syndrome, April 2000, Reaffirmed 2008.
- ACOG Practice Bulletin #14, Management of Anovulatory Bleeding, March 2000, Reaffirmed 2008.
- ACOG Practice Bulletin #11, Medical Management of Endometriosis, December 1999. Reaffirmed 2007.
- ACOG Practice Bulletin #41, Polycystic Ovary Syndrome, December 2002, Reaffirmed 2006.

- ACOG Practice Bulletin #83, Management of Adnexal Masses, July 2007.
- ACOG Practice Bulletin #99, Human Papilloma Virus, April 2005.
- ACOG Practice Bulletin #69, Emergency Contraception, March 2001, Reaffirmed 2007.
- ACOG patient education pamphlet "Human Papilloma Virus Vaccine", 2007.
- 2006 Consensus Guidelines for the management of Women with Cervical cytological and Histological Abnormalities, 2006. www.asccp.org. Including the review articles published in AJOG 10/07, algorithms and the CD ROM "Colposcopy" in the Image Library.
- Managing Contraceptive Pill Patients, Richard P Dickey

EVALUATION

Global assessment by Dr. Landry.

Last Revision: 5/19/2009

Residency Rotation Guidelines & Objectives
Service: Gynecologic Oncology **Level:** PGY-1

OVERVIEW

Goals

General knowledge of gynecologic cancers and pre-invasive neoplasias (surgical management, medical management, co-morbidities and risk factors, chemotherapy concepts). Surgical Training (introduction to operating room, learning of general principles, post-operative care, perioperative complications). Integration of data (consultations, lab testing, radiologic studies, pathology). Participate in supervision and teaching of medical students. Interaction with consultants and services that request gynecologic oncology consultation.

Duty Hours & Locations

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: Participate in the UWHC home call schedule.
Vacation: Permitted.

Supervision

- Work under supervision of senior residents and fellows
- Take direction from attending physician in clinic, operating room and inpatient wards

LEARNING OBJECTIVES

- Assessment of outpatients including chief complaint, history, comprehensive or targeted physical exam, testing (laboratory, radiologic, physiologic, procedural, etc.), treatment planning - New patient workups, Return visits, Post-treatment surveillance, Pre-operative evaluations, Chemotherapy initiation and maintenance, Postoperative assessment, Documentation, Coordination of follow-up care. ***PC, MK, ICS, SBP, P, PBLI***
- Evaluation and workup of inpatients - New admissions, Consultations from other services and the emergency department, Pre- and post-operative patients, Patients with complications of gynecologic malignancies, Recipients of chemotherapy and radiologic therapy, Palliative and supportive care. ***PC, MK, ICS, SBP, P, PBLI***
- Procedure-related knowledge - Indications, Contraindications, Risks, Benefits, Alternatives, Complications. ***PC, MK***
- Charting and rounding - Competency in use of HealthLink, Documentation (history and physical exam, daily notes, consultation notes, discharge summaries), Orders (pre-operative, post-operative, supportive care), Coordination of care (consulting services, primary care needs, community resources). ***PC, ICS, SBP, PBLI***
- Technical competency - Outpatient procedures (preparation, procedure, post-procedure care), Inpatient and Ambulatory Care operations (time-out, positioning patient in the operating room, demonstrate understanding anatomy and physiology, operative field exposure, tissue handling, sequence of procedural steps, management of altered anatomy, hemostasis, dealing with

intraoperative complications, closure of surgical site, post-procedure [cleanup, repositioning, transition to PACU]). *PC, MK, ICS*

- Teamwork and individual accomplishments - Presentation of patients to upper level residents, fellow, attendings, Effective and efficient signouts and hand-offs, Understand limits of knowledge and ability, Feedback (receptivity to instruction and suggestions, implementation of proposed changes, behavior modification, provide constructive advice and comments to others), Teaching (learning from senior team members, instruction of junior team members, self-teaching using recommended resources, interactive participation in conferences and rounds), Information exchange (professional and sensitive interactions [patients, families, students, nurses, mid-level providers, ancillary and support staff, colleagues, supervisors], thorough and detailed documentation [HealthLink, dictations, correspondence, medicolegal adequacy, billing support]). *PC, MK, PBLI, ICS, P, SBP*

Cognitive

Basic Science and Mechanisms of Disease

- Genetics
    - Describe the inheritance patterns for malignancies of the pelvic organs and breast
    - Describe the cell replication cycle and identify the phases of the cycle most sensitive to radiation and chemotherapy
- Physiology
    - Describe the ability of vital organ systems to tolerate cancer therapy
    - Describe the metabolic changes that occur in patients with a malignancy of the pelvic organs or breast
- Embryology and Developmental Biology (Pre-requisite Objectives)
    - Describe the embryology of gonadal migration and its role in the pathogenesis of epithelial cell tumors
    - Describe the pathogenesis of gonadal tumors in patients with gonadal dysgenesis
    - Describe the embryologic precursors of ovarian germ cell tumors
- Anatomy (Pre-requisite Objectives)
    - Describe the gross and histologic anatomy of the pelvic organs and breast
    - Describe the vascular, lymphatic, and nerve supply to each of the pelvic organs
    - Describe the anatomic relationship between the reproductive organs and other viscera such as bladder, ureters, and bowel
- Pharmacology (Pre-requisite Objectives)
    - List the major chemotherapeutic agents used for treatment of malignancies of the reproductive organs and breast
- Pathology and Neoplasia
    - Describe the pathogenesis of malignancies of the pelvic organs and breast
- Microbiology and Immunology

Carcinoma of the Breast

- Diagnosis of Invasive Carcinoma of the Breast
    - Perform a focused history and physical examination on women with signs or symptoms of breast cancer, accurately assessing risk factors, symptoms, and physical findings
- Management of Invasive Breast Cancer
    - Describe FIGO staging of breast cancer and the prognostic significance of histologic type, regional lymph node metastasis, distant metastasis, and receptor status

Vulvar and Vaginal Malignancies

- Preinvasive Vulvar Lesions
    - Describe the epidemiology and pathogenesis of preinvasive vulvar lesions
    - Describe the typical clinical manifestations of preinvasive vulvar lesions
    - List the differential diagnosis of pigmented and nonpigmented vulvar lesions
- Invasive Vulvar Carcinoma

- Describe the epidemiology and pathogenesis of invasive vulvar lesions (i.e., melanoma, squamous cell cancer, basal cell carcinoma, Paget's disease, sarcoma, verrucous carcinoma, and Bartholin's gland carcinoma)
    - Describe the clinical manifestations of invasive vulvar malignancies
- Preinvasive Vaginal Neoplasia (Vaginal Intraepithelial Neoplasia [VAIN])
    - Describe the epidemiology and pathogenesis of VAIN
    - Describe the typical clinical manifestations of VAIN
- Invasive Carcinoma of the Vagina
    - Describe the epidemiology and pathogenesis of invasive vaginal cancer
    - Describe the typical clinical manifestations of invasive vaginal cancer

Cervical Disorders
- Preinvasive Cervical Disease
    - Describe the epidemiology and pathogenesis of cervical dysplasia
    - Elicit a pertinent history in a woman with an abnormal Pap test
    - Interpret Pap test reports using the Bethesda classification system
- Invasive Cervical Cancer
    - Describe the epidemiology and pathogenesis of invasive cervical cancer
    - Describe the typical clinical manifestations of invasive cervical cancer

Uterine Cancer
- Endometrial Hyperplasia
    - Obtain an appropriate targeted history in patients who have abnormal bleeding, including an assessment of risk factors such as obesity, anovulation, polycystic ovarian syndrome, glucose intolerance, estrogen or anti-estrogen exposure, and family history
    - Perform an appropriate focused physical examination on women who have abnormal bleeding and risk factors for endometrial hyperplasia
- Carcinoma of the Endometrium
    - Describe the epidemiology and pathogenesis of invasive endometrial cancer
    - Describe the typical clinical manifestations of invasive endometrial cancer

Ovarian and Tubal Carcinoma
- Carcinoma of the Ovary
    - Describe the epidemiology and pathogenesis of ovarian cancer
    - Describe the inherited syndromes that increase a woman's likelihood of developing ovarian cancer
    - Describe the screening protocols that may identify patients who have an inherited form of ovarian cancer
    - Describe the clinical manifestations of ovarian cancer
- Carcinoma of the Fallopian Tube
    - Describe the epidemiology and pathogenesis of fallopian tube cancer
    - Describe the typical clinical manifestations of fallopian tube cancer

Gestational Trophoblastic Disease
- Hydatidiform Mole
    - Describe the epidemiology and pathogenesis of hydatidiform mole
    - Describe the typical clinical manifestations of GTD
- Malignant Gestational Trophoblastic Disease

Therapy
- Radiation therapy
- Chemotherapy
- Terminal care

Behavioral

Work-up of new patients and consultations, Care of patients perioperatively, Identification of surgical and therapeutic complications, Integration of data, Formulation of assessments and treatment plans.

Technical

Understand principles and uses

- Vulva and vagina (punch biopsy, excisional biopsy, colposcopy)
- Cervix (pap test, colposcopy and directed biopsies, endocervical curettage, LEEP, cold knife conization, cryoablation, laser ablation)
- Uterus (endometrial sampling, sonohysterogram, dilation and curettage, suction evacuation of molar pregnancy, endometrial ablation)
- Ovary and fallopian tube (diagnostic ultrasound, paracentesis)

EDUCATION PROGRAM

Clinical Scope

Clinical - Outpatient clinics with attendings, Chemotherapy clinics, Inpatient management (morning and afternoon rounds [senior residents, fellows, faculty]), Surgical assistance (ambulatory surgery center, operating room), Consultations (inpatient, emergency department).

Other Educational Activities

- Structured teaching and didactic conferences
    - Attending rounds (3 times/week)
    - Tumor Board (weekly)
    - Didactic lectures (weekly)
    - Pre-operative conference (weekly)
    - Gynecologic Oncology journal club (monthly)
    - Departmental conferences:
      Morbidity and Mortality
      Simulation lab
      Grand Rounds
      Obstetrics and Gynecology Journal Club

LEARNING MATERIALS

- Practical Gynecologic Oncology. Berek and Hacker. 2004.
- TeLinde's Operative Gynecology. Rock and Jones. 2008.

EVALUATION

- Feedback - Residents, Fellows, Students, Mid-level providers, Nurses, Ancillary staff, Patients and their families.
- Joint global assessments by Gynecologic Oncology Attendings.
- Individual evaluation in the operating room.
- Meetings with Gynecologic Oncology division director.

Under Revision

Residency Rotation Guidelines & Objectives
Service: Meriter Hospital Benign Gynecology **Level:** PGY-2

OVERVIEW

Goals

Develop ability to manage gynecologic patients who present for surgery including post operative care/complications, management of gynecologic medical patients, inpatient assessment of acute gynecologic issues (consultations) and assessment of acute gynecologic complaints to the emergency department. Participation in major and minor gynecologic surgeries. Perform as first assist on simple surgical cases.

Duty Hours & Locations

Eight continuous weeks at Meriter Hospital. Schedule and responsibilities:
Available by pager from 7 am to 5 or 7 pm per rotation schedule for emergency room and inpatient gynecologic consults.

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: Participate in the St. Mary's OB call pool.
Vacation: Permitted.

Supervision

The PGY4 guides educational activities, resident participation in surgical cases and patient care. Dr. Diem assigns the didactic teaching schedule. Surgical procedures are performed under the direct supervision of the attending physician.

LEARNING OBJECTIVES

- Perform a pertinent history, focused physical examination, selection and interpretation of diagnostic tests and initial treatment plan for the common presenting patient complaints including: abdominal pain, vaginal bleeding (early pregnancy and non-pregnancy related), pelvic mass, urologic/gynecologic infections and vulvar/vaginal symptoms. *PC*
- Evaluate patients and develop initial treatment plans for common post-operative signs/symptoms including fever, bleeding, pain control, bowel dysfunction, cardiovascular symptoms, mental status changes, renal/fluid balance issues, respiratory symptoms and thromboembolism. *PC*
- Describe pre-operative indication, potential intra- and post-operative complications and perform as first assistant: dilatation and sharp/suction curettage, diagnostic and simple operative hysteroscopy, diagnostic and simple operative laparoscopy, excision of vulvar lesions and sterilization procedures. *MK*
- Meet in person and review history and physical on each surgical patient prior to surgery. *PC, P*

- Provide comprehensive postoperative care including fluid and electrolyte management and appropriate pain control (advancement of diet, ambulation, voiding trials, VTE prophylaxis, wound care) based on the surgical procedure and co-existing morbidities. *MK, PC, ICS, SBP*
- Describe the anatomy of the anterior abdominal wall, pros and cons of surgical incisions, use of pre and post incision anesthesia. *MK*
- Identify and describe use of common laparoscopic instruments including those used to enter the peritoneal cavity. *MK*
- Describe the anatomy of the pelvis including the arterial blood supply, venous and lymphatic drainage, neurologic innervation and anatomic relationship between the reproductive organs and the nongynecologic abdominal viscera. *MK*
- Describe indications and methods for mechanical bowel preparation, antibiotic use and thromboembolism prophylaxis. *MK*

EDUCATION PROGRAM

Clinical Scope

- Learning will be facilitated via direct patient care activities in the emergency department, operating room and inpatient gynecology unit.
- The PGY2 is first call for emergency department and inpatient gynecology consults and first call for urgent assessment of all post-operative patients on the gynecology service.
- Daily rounding on inpatients.

Conferences

Gynecologic service teaching rounds from 7 – 7:30 am

- Mon, Tues, Wed,: assigned topic per gynecology attending schedule
- Thurs: M&M, Grand Rounds, Resident Didactics and simulation lab per department schedule.
- Fri: Dr. Diem, pathology, radiology or topic conference.

Other Educational Activities

- View ACOG Office and Operative Hysteroscopy DVD.
- View Essure instructional video.
- View GyneCare Thermachoice instructional video.
- Complete CD-ROM instructional video for endometrial ablation.

LEARNING MATERIALS

- TeLinde's Operative Gynecology. John A. Rock.
- Atlas of Pelvic Anatomy and Gynecologic Surgery. Baggish & Karram.
- ACOG Practice Bulletin #81, Endometrial Ablation, May 2007.
- ACOG Practice Bulletin #46, Benefits and Risks of Sterilization, September 2003, Reaffirmed 2008.
- ACOG Committee Opinion #371, Sterilization of Women, Including Those With Mental Disabilities, July 2007.
- ACOG Practice Bulletin #94, Medical Management of Ectopic Pregnancy, June 2008,
- ACOG Practice Bulletin #84, Prevention of Deep Vein Thrombosis and Pulmonary Embolism, August 2007.
- ACOG Practice Bulletin #74, Antibiotic Prophylaxis for Gynecologic Procedures, May 2009.
- ACOG Committee Opinion #421 Antibiotic Prophylaxis for Infective Endocarditis, November 2008.

EVALUATION

- Global assessment by attendings on the service.

- Formative surgical skills assessment by attendings on the service.
- Junior resident assessment of leadership.
- Medical student evaluation of teaching efforts.

Last Revision: 6/2/2009

Residency Rotation Guidelines & Objectives
Service: Reproductive Endocrinology & Infertility **Level:** PGY-2

OVERVIEW

Goals
To develop knowledge and skills in reproductive endocrinology and infertility and pelvic ultrasound.

Duty Hours & Locations
Eight consecutive weeks at UWHC.
- Perform daily rounds on any inpatients
- Attend all clinics and participate in all scheduled procedures.

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: Participate in the UWHC home call schedule.
Vacation: Permitted.

Supervision
The division director guides educational activities, patient care and conducts all formal evaluations.

LEARNING OBJECTIVES

- Discuss the basic causes, pathophysiology, evaluation and treatment of primary or secondary infertility. *MK*
- Discuss the basic causes, pathophysiology, evaluation and treatment of Polycystic Ovary Syndrome (PCOS). *MK*
- Discuss the basic causes, pathophysiology, evaluation and treatment of galactorrhea/hyperprolactinemia. *MK*
- Discuss the basic causes, pathophysiology, evaluation and treatment of endometriosis. *MK*
- Discuss the basic causes, pathophysiology, evaluation and treatment of primary and secondary amenorrhea. *MK*
- Discuss the basic causes, pathophysiology, evaluation and treatment of primary ovarian insufficiency (POI). *MK*
- Describe the detection of and treatment options for mullerian anomalies. *MK*
- Perform and describe the indications for saline infusion sonography for tubal patency and flexible office hysteroscopy. *MK, PC*
- Perform transvaginal ultrasonography and be able to detect endometrial growth and follicular development during the menstrual cycle and infertility treatment. *MK, PC*
- Describe the indications, risks, success rates of ovulation induction with oral agents (Clomiphene citrate, aromatase inhibitors) as well as injection meds and IVF. *MK*

EDUCATION PROGRAM

Clinical Scope

Learning will be facilitated via direct patient care activities in clinic and the operating room. The resident will see patients presenting for care in the clinic and present findings, assessment and plan to the clinic attending staff. The resident will perform office pelvic ultrasounds and sonohysterograms under the direct supervision of attending staff. The resident will first assist on level-appropriate surgical cases and second assist on more complex cases.

Conferences

- The resident will present a weekly pre-approved topic to the REI staff.
- Attend M&M per department schedule. Present REI cases selected for discussion.
- Attend Thursday Grand Rounds and resident third hour didactic session per schedule.

LEARNING MATERIALS

- ACOG Practice Bulletin #24, Management of Recurrent Early Pregnancy Loss, February 2001.
- ACOG Practice Bulletin #34, Management of Infertility Caused by Ovulatory Dysfunction, February 2002, reaffirmed 2008.
- ACOG Committee Opinion #412, Aromatase Inhibitors in Gynecologic Practice, August 2008.
- Casper RF, Mitwally MF. Review: aromatase inhibitors for ovulation induction. J Clin Endocrinol Metab. 91(3):760-71, 2006.
- Guzick et al. Efficacy of superovulation and intrauterine insemination in the treatment of infertility. NEJM. 3 40:177-83, 1999.
- Norman RJ, Dewailly D, Legro RS, Hickey TE. Polycystic ovary syndrome. Lancet. 370: 685–97, 2007.
- Rai R, Regan L. Recurrent miscarriage. Lancet. 368:601-11, 2006.
- Reproductive Endocrinology and Infertility: Handbook for Clinicians. 425 pp., 1e. Scrub Hill Press, Inc., Arlington, VA. Lebovic DI, Gordon JD and Taylor RN eds., June 2005.

EVALUATION

- Global assessment by REI attending staff.
- Formative surgical skills assessment by REI attending staff.

Last Revision: 6/2/2009

DEPARTMENT OF
OBSTETRICS AND GYNECOLOGY
University of Wisconsin
School of Medicine and Public Health

Residency Rotation Guidelines & Objectives
Service: St. Mary's Hospital High Risk Obstetrics Night Float **Level:** PGY-2

OVERVIEW

Goals

To gain experience in the clinical care of the high risk obstetrical patients on the St. Mary's Obstetric Service including labor and delivery and antepartum units. Gain experience in the supervision of Family Practice residents on the St. Mary's low risk obstetrical service.

Duty Hours & Locations

Four consecutive weeks at St. Mary's Hospital, Labor & Delivery. Except when off duty or scheduled to be elsewhere (didactics, continuity clinic), the resident is expected to be available in the Birthing Center between the hours of 7:00 p.m. and 7:30 a.m. The resident must carry a pager.

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: None.
Vacation: Not permitted.

Supervision

Surgical procedures and clinical care performed under the direct supervision of the attending physician. Dr. Gary Waters assigns educational activities.

LEARNING OBJECTIVES

- Provide primary ante- and intrapartum clinical care for complicated OB patients, including: ***MK, PC***
  - Multiple gestations
  - Diabetics
  - Preterm ROM < 36 weeks' gestation
  - Preterm labor
  - Preeclampsia and severe chronic hypertension
  - Preterm fetal demise
  - Placenta previa
  - Abruption
  - Severe postpartum hemorrhage
  - Other diagnoses at the discretion of the attending obstetrician
- Interpretation of antenatal fetal testing. Develop and communicate plan for continued patient care based on antenatal test results with OB attendings. ***MK, PC, ICS***
- Perform as primary assistant on all cesarean sections. ***PC***
- Provide post operative care for C-section patients. ***MK, PC, ICS***
- Performance of operative vaginal deliveries (forceps and vacuums). ***PC***

- Provide post partum care to post partum patients on the obstetrical service including patients following operative vaginal or cesarean delivery; complicated labor including any of the conditions listed above. *MK, PC, ICS*
- Provide consultative care and recommendation under the direct supervision of the attending obstetrician for prolonged labor, fetal malpresentations (breech, face, brow, compound) and/or FHT abnormalities. *PC, ICS*
- Evaluation of ER gynecologic patients and assistance with "add-on" Gyn surgical cases as a second priority to birth room duties while on call. *PC*

EDUCATION PROGRAM

Clinical Scope

- Rounds on and manages the day to day care of antepartum and postpartum patients on the obstetric service.
- Work with FP attendings when OB consultation has been requested.
- Provide obstetrical education to the on-call FP residents.

Other Educational Activities

Wednesday morning OB conferences at 7:00 am

LEARNING MATERIALS

- Normal and Problem Pregnancies, Stephen Gabbe, latest edition
- Maternal-fetal Medicine, Creasy Resnik, latest edition
- Williams Obstetrics, latest edition
- ACOG Practice Bulletin #102 Management of Stillbirth, March 2009 (Replaces Committee Opinion Number 383, October 2007
- ACOG Practice Bulletin #80 Premature Rupture of Membranes, April 2007
- ACOG Practice Bulletin #33 Diagnosis and Management of Preeclampsia and Eclampsia, Reaffirmed 2008
- ACOG Practice Bulletin #17 Operative Vaginal Delivery, Reaffirmed 2008
- ACOG Practice Bulletin #31 Assessment of Risk Factors for Preterm Birth, Reaffirmed 2008

EVALUATION

- Global assessment by attendings on the service.
- Formative surgical skills assessment by attendings on the service.

Last Revision: 6/2/2009

Residency Rotation Guidelines & Objectives
Service: Gynecologic Oncology **Level:** PGY-2

OVERVIEW

Goals

General knowledge of gynecologic cancers and pre-invasive neoplasias (surgical management, medical management, co-morbidities and risk factors, chemotherapy concepts). Surgical Training (introduction to operating room, learning of general principles, post-operative care, perioperative complications). Integration of data (consultations, lab testing, radiologic studies, pathology). Participate in supervision and teaching of medical students. Interaction with consultants and services that request gynecologic oncology consultation. Teamwork:

- Work under supervision of senior residents and fellows.
- Take direction from attending physician in clinic, operating room and inpatient wards.
- Participate in supervision and teaching of medical students and junior residents.
- Interaction with consultants and services that request gynecologic oncology consultation.

Duty Hours & Locations

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: Participate in the UWHC home call schedule.
Vacation: Permitted.

Supervision

- Work under supervision of senior residents and fellows
- Take direction from attending physician in clinic, operating room and inpatient wards

LEARNING OBJECTIVES

- Assessment of outpatients including chief complaint, history, comprehensive or targeted physical exam, testing (laboratory, radiologic, physiologic, procedural, etc.), treatment planning - New patient workups, Return visits, Post-treatment surveillance, Pre-operative evaluations, Chemotherapy initiation and maintenance, Postoperative assessment, Documentation, Coordination of follow-up care. ***PC, MK, ICS, SBP, P, PBLI***
- Evaluation and workup of inpatients - New admissions, Consultations from other services and the emergency department, Pre- and post-operative patients, Patients with complications of gynecologic malignancies, Recipients of chemotherapy and radiologic therapy, Palliative and supportive care. ***PC, MK, ICS, SBP, P, PBLI***
- Procedure-related knowledge - Indications, Contraindications, Risks, Benefits, Alternatives, Complications. ***PC, MK***
- Charting and rounding - Competency in use of HealthLink, Documentation (history and physical exam, daily notes, consultation notes, discharge summaries), Orders (pre-operative, post-operative, supportive care), Coordination of care (consulting services, primary care needs, community resources). ***PC, ICS, SBP, PBLI***

- Technical competency - Outpatient procedures (preparation, procedure, post-procedure care), Inpatient and Ambulatory Care operations (time-out, positioning patient in the operating room, demonstrate understanding anatomy and physiology, operative field exposure, tissue handling, sequence of procedural steps, management of altered anatomy, hemostasis, dealing with intraoperative complications, closure of surgical site, post-procedure [cleanup, repositioning, transition to PACU]). ***PC, MK, ICS***
- Teamwork and individual accomplishments - Presentation of patients to upper level residents, fellow, attendings, Effective and efficient signouts and hand-offs, Understand limits of knowledge and ability, Feedback (receptivity to instruction and suggestions, implementation of proposed changes, behavior modification, provide constructive advice and comments to others), Teaching (learning from senior team members, instruction of junior team members, self-teaching using recommended resources, interactive participation in conferences and rounds), Information exchange (professional and sensitive interactions [patients, families, students, nurses, mid-level providers, ancillary and support staff, colleagues, supervisors], thorough and detailed documentation [HealthLink, dictations, correspondence, medicolegal adequacy, billing support]). ***PC, MK, PBLI, ICS, P, SBP***

Cognitive

Basic Science and Mechanisms of Disease

- Genetics
  - Describe the clinical relevance of oncogenes
  - Describe the role of aneuploidy in the pathogenesis of neoplasia
  - Describe the genetic basis for tumor immunotherapy
- Physiology
  - Describe the changes in cellular physiology that result from injury due to radiation and chemotherapy
- Anatomy
  - Describe the likely changes in the anatomic relationships of the pelvic and abdominal viscera created by surgical or radiation treatment for malignancy
- Pharmacology
  - Describe the principal adverse effects of major chemotherapeutic agents
  - Describe the medications of most value in treatment of complications resulting from chemotherapy and irradiation (e.g., marrow suppression, nausea and vomiting, hemorrhagic cystitis, peripheral neuropathy)
- Pathology and Neoplasia
  - Describe the histology of malignancies of the pelvic organs and breast
  - Describe the prognosis for the major malignancies of the reproductive organs and breast using the staging system adopted by FIGO
- Microbiology and Immunology
  - Describe the alterations in host immune mechanisms that occur as a result of malignancies of the reproductive tract and breast
  - Describe the immune changes that occur as a result of treatment of malignancies of the reproductive tract and breast
  - Describe the immune aberrations that result from malnutrition and cachexia
  - List the consequences of immunosuppression (e.g., increased susceptibility to infection and poor wound healing)

Carcinoma of the Breast

- Breast cancer Survivorship
  - Describe the psychosocial impact of breast cancer on family dynamics, sexuality, and stress management and make appropriate referral to support groups and health care professionals
  - Manage the adverse effects of antiestrogen medications such as tamoxifen

Vulvar and Vaginal Malignancies

- Preinvasive Vulvar Lesions
  - Treat preinvasive vulvar lesions with the appropriate modality
  - Implement appropriate follow-up after treatment
- Invasive Vulvar Carcinoma
  - Describe FIGO staging of invasive vulvar cancers
  - Describe the differential diagnosis of vulvar cancer
  - Describe the treatments for invasive vulvar malignancies
  - Describe the prognosis for invasive vulvar malignancies
- Preinvasive Vaginal Neoplasia (Vaginal Intraepithelial Neoplasia [VAIN])
  - Diagnose VAIN based on cytologic, colposcopic, and histologic findings
  - Describe the structural and histologic changes in the vagina characteristic of in utero exposure to diethylstilbestrol (DES)
- Invasive Carcinoma of the Vagina
  - Describe FIGO staging of invasive vaginal cancer
  - Describe the differential diagnosis of invasive vaginal cancer
  - Describe the treatments for invasive vaginal cancer
  - Describe the prognosis for invasive vaginal cancer

Cervical Disorders

- Preinvasive Cervical Disease
  - Interpret the results of cervical biopsy and plan definitive therapy
  - Describe appropriate follow-up for a woman who has been treated for cervical dysplasia
  - Describe the structural changes in the, cervix that are characteristic of intrauterine DES exposure
- Invasive Cervical Cancer
  - Describe FIGO staging of invasive cervical cancer
  - Describe the differential diagnosis of invasive cervical cancer
  - Describe the treatments for invasive cervical cancer
  - Describe the prognosis for invasive cervical cancer

Carcinoma of the Uterus

- Endometrial Hyperplasia
  - Describe the classification of endometrial hyperplasia: simple, complex, and atypical
  - Describe the factors that influence treatment such as classification and histology, age of patient, reproduction goals, risk of malignancy
- Carcinoma of the Endometrium
  - Describe FIGO staging of invasive endometrial cancer
  - Describe the differential diagnosis of invasion endometrial cancer
  - Describe the treatments for invasive endometrial cancer
  - Describe the prognosis for invasive endometrial cancer

Ovarian and Tubal Carcinoma

- Carcinoma of the Ovary
  - Describe the histology, staging, and prognosis for epithelia tumors, germ cell tumors, stromal tumors, sarcomas, metastatic tumors, and tumors of low malignant potential
  - Interpret the following tests to diagnose ovarian cancer: ultrasound, serum tumor markers, and cytology from paracentesis
  - Describe the treatment of ovarian cancer based on type, grade, stage, and patient characteristics
- Carcinoma of the Fallopian Tube
  - Describe the histology, FIGO staging, and prognosis of fallopian tube tumors
  - Perform appropriate tests to diagnose cancer of the fallopian tube
  - Describe the treatment for fallopian tube cancer based on type, grade, stage, and patient

characteristics

Gestational Trophoblastic Disease (GTD)
- Hydatidiform Mole
  - Diagnose GTD and its complications using tests such as: ultrasound, quantitative beta-HCG, chest x-ray, computed tomography of brain, liver and chest, thyroid function tests
  - Distinguish between a complete and partial hydatidiform using histology and cytogenetic findings
  - Describe the appropriate follow-up for a patient who has had suction evacuation of a molar pregnancy
- Malignant Gestational Trophoblastic Disease
  - Describe the conditions that may precede malignant GTD
  - Describe the histologic appearance of invasive mole vs. choriocarcinoma vs. placental site trophoblastic tumor

Therapy
- Radiation Therapy
  - Describe the general principles of radiation therapy
- Chemotherapy
  - Describe the general principles and mechanism of action of chemotherapy
- Terminal Care
  - Describe the basic principles of palliative care
  - Describe medical, radiation and operative modalities for palliation of symptoms in terminally ill patients

Behavioral
Work-up of new patients and consultations, Care of patients perioperatively, Identification of surgical and therapeutic complications, Integration of data, Formulation of assessments and treatment plans.

Technical
Understand principles and uses
- Vulva and vagina ("simple" vulvectomy, topical therapy, laser vaporization).
- Cervix (laser ablation, vaginal hysterectomy, abdominal hysterectomy, laparoscopic hysterectomy).
- Uterus (Vaginal hysterectomy, extrafascial hysterectomy +/- adnexectomy).
- Ovary and fallopian tube (diagnostic ultrasound, paracentesis adnexal removal [any technique], appendectomy, omentectomy, enterotomy repair, abdominal exploration).

Able to perform independently
- Vulva and vagina (punch biopsy, excisional biopsy, colposcopy).
- Cervix (pap test, colposcopy and directed biopsies, endocervical curettage, LEEP, cold knife conization, cryoablation).
- Uterus (endometrial sampling, sonohysterogram, dilation and curettage, suction evacuation of molar pregnancy, endometrial ablation.
- Ovary and fallopian tube (collection of peritoneal cytology).

EDUCATION PROGRAM

Clinical Scope
Clinical - Outpatient clinics with attendings, Chemotherapy clinics, Inpatient management (morning and afternoon rounds [senior residents, fellows, faculty]), Surgical assistance (ambulatory surgery center, operating room), Consultations (inpatient, emergency department).

Other Educational Activities

- Structured teaching and didactic conferences
  - Attending rounds (3 times/week)
  - Tumor Board (weekly)
  - Didactic lectures (weekly)
  - Pre-operative conference (weekly)
  - Gynecologic Oncology journal club (monthly)
  - Departmental conferences:
    - Morbidity and Mortality
    - Simulation lab
    - Grand Rounds
    - Obstetrics and Gynecology Journal Club

LEARNING MATERIALS

- Practical Gynecologic Oncology. Berek and Hacker. 2004.
- TeLinde's Operative Gynecology. Rock and Jones. 2008.

EVALUATION

- Feedback - Residents, Fellows, Students, Mid-level providers, Nurses, Ancillary staff, Patients and their families.
- Joint global assessments by Gynecologic Oncology Attendings.
- Individual evaluation in the operating room.
- Meetings with Gynecologic Oncology division director.

Under Revision

Residency Rotation Guidelines & Objectives
Service: Meriter Hospital Benign Gynecology **Level:** PGY-3

OVERVIEW

Goals

Expand ability to manage gynecologic patients who present for surgery including post operative care/complications, management of gynecologic medical patients, inpatient assessment of acute gynecologic issues (consultations) and assessment of acute gynecologic complaints to the emergency department. Participates in major and minor gynecologic surgeries. Performs as first assist on major surgical cases. Responsible for medical student teaching.

Duty Hours & Locations

Eight continuous weeks at Meriter Hospital. Schedule and responsibilities:

- Available by pager from 7 am to 5 or 7 pm per rotation schedule for emergency room and inpatient gynecologic consults.

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: Participate in the Meriter OB call pool.
Vacation: Permitted.

Supervision

The PGY4 guides educational activities, resident participation in surgical cases and patient care. Dr. Diem assigns the didactic teaching schedule. Surgical procedures are performed under the direct supervision of the attending physician.

LEARNING OBJECTIVES

- Perform a pertinent history, focused physical examination, selection and interpretation of diagnostic tests and initial treatment plan for the common presenting patient complaints including: abdominal pain, vaginal bleeding (early pregnancy and non-pregnancy related), pelvic mass, urologic/gynecologic infections and vulvar/vaginal symptoms. *PC*
- Evaluate patients and develop initial treatment plans for common post-operative signs/symptoms including fever, bleeding, pain control, bowel dysfunction, cardiovascular symptoms, mental status changes, renal/fluid balance issues, respiratory symptoms and thromboembolism. *PC*
- Describe pre-operative indication, potential intra- and post-operative complications and perform as first assistant on more advanced gynecologic surgical procedures: operative hysteroscopy, operative laparoscopy, simple supracervical and total laparoscopic hysterectomy, vaginal hysterectomy and procedures for correction of prolapse and urinary and rectal incontinence. *MK*

- Exhibit level of surgical skill that allows teaching guidance for junior residents through simple surgical cases: sterilization procedures, diagnostic hysteroscopy, dilatation and sharp/suction curettage, diagnostic laparoscopy, excision of vulvar lesions. *MK, PC, ICS*
- Meet in person and review history and physical on each surgical patient prior to surgery. *PC, P*
- Provide comprehensive postoperative care including fluid and electrolyte management and appropriate pain control based on the surgical procedure and the degree of patient discomfort and co-existing morbidities. *MK, PC, ICS, SBP*
- Describe intra-operative surgical complications and management. *MK*
- Identify and describe use of laparoscopic instruments including those used to enter the peritoneal cavity. *MK*
- Describe the types, risks and benefits of energy sources in gynecologic surgery. *MK*
- Describe permanent sterilization techniques, including vasectomy, appropriate patient selection, post operative counseling. *MK, PC*
- Describe the anatomy of the pelvis including the arterial blood supply, venous and lymphatic drainage, neurologic innervation and anatomic relationship between the reproductive organs and the nongynecologic abdominal viscera. *MK*
- Describe indications and methods for mechanical bowel preparation, antibiotic use and thromboembolism prophylaxis. *MK*
- Describe surgical treatment options for endometriosis. *MK*

EDUCATION PROGRAM

Clinical Scope

Learning will be facilitated via direct patient care activities in the emergency department, operating room and inpatient gynecology unit.

- Daily rounding on inpatients.

Conferences

Gynecologic service teaching rounds from 7 – 7:30 am

- Mon, Tues, Wed,: assigned topic per gynecology attending schedule
- Thurs: M&M, Grand Rounds, Resident Didactics and simulation lab per department schedule.
- Fri: Dr. Diem, pathology, radiology or topic conference.

Other Educational Activities

- View total laparoscopic hysterectomy DVD (McCarus).
- View Outpatient Total/Supracervical Laparoscopic Hysterectomy DVD

LEARNING MATERIALS

- TeLinde's Operative Gynecology. John A. Rock.
- Atlas of Pelvic Anatomy and Gynecologic Surgery. Baggish & Karram.
- ACOG Practice Bulletin #96, Alternatives to Hysterectomy in the Management of Leiomyomas, August 2008.
- ACOG Committee Opinion #426, The Role of Transvaginal Ultrasonography in the Evaluation of Postmenopausal Bleeding, February 2009.
- ACOG Committee Opinion #388, Supracervical Hysterectomy, November 2007.
- ACOG Committee Opinion #310, Endometriosis in Adolescents, April 2005.

EVALUATION

- Global assessment by attendings on the service.
- Formative surgical skills assessment by attendings on the service.

- Junior resident assessment of leadership.
- Medical student evaluation of teaching efforts.

Residency Rotation Guidelines & Objectives
Service: Meriter Hospital High Risk Obstetrics **Level:** PGY-3

OVERVIEW

Goals

Develop the knowledge base, clinical skills and leadership qualities to counsel and care for complicated obstetric patients during and throughout pregnancy. Be able to counsel patients pre-conceptually regarding the risks of pregnancy on maternal medical conditions and risks of the maternal medical condition on pregnancy. The PGY-3 is responsible for the supervision of third and fourth year medical students who may attend the clinic.

Duty Hours & Locations

Eight continuous weeks at Meriter Hospital, Maternal Fetal Medicine Clinic. Member of Obstetric Labor & Delivery Team. Except when off duty or scheduled to be elsewhere (didactics, continuity clinic), the resident is expected to be available in the Birthing Center between the hours of 6:00 a.m. and 5:00 pm on "short" and 7:00 p.m. on "long" days. The resident should plan to be available to the Perinatal Clinic between 8:00 a.m. and 4:30 p.m.. The resident should carry a pager. On days when the PGY-4 attends his/her own continuity clinic or is otherwise unavailable, the Perinatal Clinic residents functions as the senior resident on the Obstetric service. On days when a PGY-1 attends his/her resident clinic, the Perinatal Clinic resident may cover that intern's duties on Labor and Delivery (usually triage and scheduled procedures).

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: Participate in the Meriter OB call pool.
Vacation: Permitted.

Supervision

Dr. Shah is responsible for the programmatic and educational curriculum. The resident functions under the direction of the Maternal-Fetal Medicine faculty or fellows assigned to the Perinatal Clinic. The clinic resident reports to the OB chief resident.

LEARNING OBJECTIVES

- Manage the day-to day operations of the perinatal outpatient clinic. In addition to clinical care, this includes intake history and physical exams, review of patient charts prior to scheduled clinic visits, updates of the perinatal problem list, daily review and disposition of laboratory reports, and review of NSTs. *ICS, PBLI, P*
- Describe the major physiologic changes in each organ system during pregnancy, evaluate symptoms and physical findings in a pregnant patient to distinguish physiologic from pathologic findings and be able to interpret common diagnostic tests in the context of the normal physiologic changes of pregnancy. *MK, PC, SBP*
- Describe the factors that influence transplacental drug transfer, such as molecular size, lipid solubility, degree of ionization at physiologic pH and protein binding. *MK*

- Describe the possible teratogenic effects of prescription and nonprescription drugs in pregnancy particularly those used for psychiatric conditions, seizure disorders, hypertension and drugs of abuse (alcohol, heroin, cocaine and tobacco). *MK*
- Identify and utilize electronic teratogenic databases *MK SBP*
- Counsel patients regarding fetal and maternal risks and future reproductive implications; obtain appropriate history and physical, identify and interpret common diagnostic tests and be able to recommend care plans for: *MK, PC, ICS, P*
  - Diabetes Mellitus
  - Hypertension
  - Diseases of the urinary system
  - Thyroid disease
  - Cardiopulmonary Disease
  - Gastrointestinal Disease
  - Infectious Diseases
  - Neurologic diseases,
  - Collagen vascular disorders
  - Psychiatric disorders
  - Substance abuse in pregnancy
  - Asthma
- Classify diabetes mellitus in pregnancy; monitor and control blood sugar in the pregnant patient with diabetes mellitus; assess, recognize, and manage fetal and maternal complications such as fetal malformations, disturbances in fetal growth and diabetic ketoacidosis. *MK, PC, ICS*
- Describe the major antigen–antibody reactions that result in red cell isoimmunization or thrombocytopenia, interpret serologic assays that quantify antibody titers, describe the appropriate indications for determination of paternal antigen status and the major fetal complications of isoimmunization and alloimmune thrombocytopenia. *MK, PC*
- Evaluate possible causes of anemia, thrombocytopenia, deep vein thrombosis, and coagulopathy in pregnancy; recommend appropriate acute and chronic management plans for these conditions, including prophylaxis to minimize recurrence risk; counsel patients about the fetal and maternal impact of hematologic disorders in pregnancy. *PC, ICS, SBP*
- Describe the factors that predispose to multiple gestation and the medical rationale for selective fetal reduction in higher order multiple gestation. *MK*
- Describe, diagnose, and manage the maternal and fetal complications associated with multiple gestation; perform tests to assess the general well-being of the fetuses of a multiple gestation; counsel patients as to the antenatal testing and delivery plans for multiple gestations. *ICS, P, PC*
- Describe the factors that predispose to fetal growth restriction; monitor a fetus with suspected growth restriction (e.g., with antepartum heart rate tests, ultrasonography, and Doppler velocimetry) to determine the appropriate time and method of delivery; counsel patients about the recurrence risk for intrauterine growth restriction. *MK, PC, ICS, P*

EDUCATION PROGRAM

Clinical Scope

Learning will be facilitated via direct patient care activities of high risk obstetrical patients presenting to Perinatal Clinic, triage and labor and delivery.

- Responsible for patients receiving antenatal care in the Meriter High Risk Clinic.
- Provide ante- and intrapartum care of patients on the University's Perinatal Service in conjunction with the PGY-4.
- In addition to clinical duties on the OB Service, on-call responsibilities include cross-coverage for Meriter gynecology patients (including emergency surgery), and the rendering of supervision and assistance to the on-call first year resident.
- Attend Maternal-Fetal Medicine consultations. Review of the patient's intake chart prior to the consultation is expected.

- Working in conjunction with the OB Chief, attend scheduled deliveries and other operative cases on High risk clinic patients.
- Complete dictation of discharge summaries on maternal transport patients, high risk and continuity clinic patients with a referring physician, high risk antepartum patients, and any patient with a complicated hospital course. Dictation of the discharge summary by the resident most familiar with a patient's case (this includes the PGY-4) is specifically encouraged.

Conferences

- Mon – Fri: 7:00 - 7:30 a.m. Sign Out Rounds
- Monday: 7:30 - 8:30 a.m. Resident OB Didactics
- Tuesday: 7:30 - 8:30 a.m. Perinatal Conference
- Wednesday: 7:30 – 8:30 a.m. MFM Didactics
- Thursday: M&M, Grand Rounds, resident didactics and simulation lab per department schedule.
- Friday: 7:30 – 8:30 a.m. L&D Conference

During these times a single resident will be available by pager to respond to clinical emergencies.

Other Educational Activities

Present a case at Tuesday's Perinatal Conference.

LEARNING MATERIALS

- Normal and Problem Preganancies, Stephen Gabbe, latest edition
- Maternal-Fetal Medicine, Creasy Resnik, latest edition
- Operative Obstetric, Hankins, latest edition
- ACOG Committee Opinion #435 Postpartum Screening for Abnormal Glucose Tolerance in Women Who Had Gestational Diabetes, June 2009
- ACOG Committee Opinion #419 Use of Progesterone to Reduce Preterm Birth, October 2008
- ACOG Committee Opinion #369 Multifetal Pregnancy Reduction, June 2007
- ACOG Practice Bulletin #95 Anemia in Pregnancy, July 2008
- ACOG Practice Bulletin #97 Fetal Lung Maturity, September 2008
- ACOG Practice Bulletin #92 Use of Psychiatric Medications During Pregnancy and Lactation, April 2008 (Replaces #87, November 2007)
- ACOG Practice Bulletin #90 Asthma in Pregnancy, February 2008
- ACOG Practice Bulletin #75 Management of Alloimmunization During Pregnancy, Reaffirmed 2008
- ACOG Practice Bulletin #60 Pregestational Diabetes Mellitus, 2007
- ACOG Practice Bulletin #86 Viral Hepatitis in Pregnancy, Reaffirmed 2009
- ACOG Practice Bulletin #56 Multiple Gestation: Complicated Twin, Triplet, and High-Order Multifetal Pregnancy, Reaffirmed 2009

EVALUATION

- Global assessment by attendings on the service.
- Focused surgical skills assessments.
- Junior resident assessment of leadership.
- Medical student evaluation of teaching efforts.

Last Revision: 6/2/2009

Residency Rotation Guidelines & Objectives
Service: Meriter Hospital Senior Obstetric Night Float **Level:** PGY-3

OVERVIEW

Goals

Comprehensive responsibility for the clinical and educational operations of the entire Meriter Obstetric Service at night. S/he directs the activities of the junior night float resident, and the on-call medical students. L&D acuity permitting, the senior night float resident also has comprehensive responsibilities to the Meriter Gynecology service. In addition to clinical duties on the obstetric service, s/he responds to questions or problems on the Gyn floor, is available to assist with emergency gynecologic surgeries, and may be asked to evaluate patients presenting to Meriter ER with Gyn complaints. IF the UW night float resident is unavailable, the Meriter senior night float resident is *expected* to evaluate all resident clinic patients (OB- or Continuity Clinic) patients presenting in the Emergency Department.

Duty Hours & Locations

Four continuous weeks at Meriter Hospital Labor & Delivery. Except when off duty or scheduled to be elsewhere (didactics, continuity clinic), the resident is expected to be available in the Birthing Center between the hours of 7:00 p.m. and 7:30 a.m. The resident must carry a pager.

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: None.
Vacation: Not permitted.

Supervision

Surgical procedures and patient care are under the direct supervision of the attending physician. Dr. Shah is responsible for the programmatic and educational curriculum.

LEARNING OBJECTIVES

- Management of the entire obstetrical service, assuring there is an integrated and teamwork-oriented approach to patient care. While the junior OB night float residents may function in direct consultation with the attending faculty, the senior night float resident remains available to assist and to provide advice and guidance whenever necessary. ***PC, ICS, P***
- For resident OB clinic patients, the Senior night float resident is to be thought of as the patient's primary staff (with the attending acting as a backup) and *must* be notified *whenever* any resident clinic patient presents for admission, or is seen in the ER or L&D triage. ***PC, ICS, SBP, P***
- Responsible for all complications arising in patients on the obstetric service. Major deviations from normal (e.g., prolonged labor, multiple gestations, malpresentations, preeclampsia, infections, labor suppression) are to be presented to the senior resident. The senior night float may choose to take over the management of a particularly complicated patient or s/he may delegate this responsibility to the junior resident. ***PC, ICS, SBP, P***

- Facilitates communications with the nursing staff, and is the primary resource when there are questions about resident coverage and response times or disputes about the appropriateness of clinical care. (See Birthing Center Chain of Command). ***PC, ICS, SBP, PBLI, P***
- May be asked to provided consultative services and assist with the care of CNM or Family Practice patients under the guidance of an attending obstetric physician. The senior resident is not available to act as an independent consultant. ***PC, ICS, SBP, P***
- Is responsible for the care and management of the following intrapartum obstetric conditions including describing possible etiologies, obtaining an appropriate history, performing a focused physical exam, ordering and interpreting appropriate tests (additional specific expectations listed): ***MK, PC, ICS, P***
  - **Preterm labor:** Assess cervical effacement and dilatation; recognize the indications for, and complications of interventions including antibiotics, tocolytics, corticosteroids, amniocentesis, cerclage and/or bed rest; describe the expected frequency and severity of neonatal complications resulting from preterm delivery; appropriately counsel patients about management options for the extremely premature fetus
  - **Bleeding in late pregnancy:** Perform abdominal ultrasonography to localize the placenta; determine the appropriate timing and method of delivery in patients with bleeding in late pregnancy and manage serious complications such as hypovolemic shock and coagulopathy.
  - **Preterm Premature rupture of membranes:** Describe the indications for, and complications of, expectant management in preterm PROM; describe the indications for, and complications of, induction of labor and possible complications of interventions including tocolytics, corticosteroids, antibiotics and amniocentesis.
  - **Fetal death:** Confirm the diagnosis by ultrasound examination; interpret results of diagnostic tests to determine the etiology of fetal death; select and perform the most appropriate procedure for uterine evacuation based on gestational age and maternal history; describe and treat the principal complications of a retained dead fetus; describe and treat the major complications of surgical and medical uterine evacuation; describe the grieving process associated with pregnancy loss and refer patients for counseling as appropriate.
  - **Hypertension in pregnancy:** Describe the clinical manifestations of chronic hypertension, gestational hypertension, and preeclampsia; perform tests to differentiate and assess severity of chronic hypertension, gestational hypertension, and preeclampsia including assessment of fetal well-being in patients; treat hypertensive disorders of pregnancy intrapartum; recognize and treat possible maternal complications of hypertension in pregnancy, such as cerebrovascular accident, seizure, renal failure, pulmonary edema, HELLP (hemolysis, elevated liver enzymes, and low platelet count) syndrome and abruptio placentae

EDUCATION PROGRAM

Clinical Scope

Learning will be facilitated via direct patient care activities of high risk and uncomplicated obstetrical patients presenting to triage and labor and delivery.

Conferences

- Mon – Fri: 7:00 - 7:30 a.m. Sign Out Rounds
- Monday: 7:30 - 8:30 a.m. Resident OB Didactics
- Tuesday: 7:30 - 8:30 a.m. Perinatal Conference
- Wednesday: 7:30 – 8:30 a.m. MFM Didactics
- Thursday: M&M, Grand Rounds, Resident Didactics and simulation lab per department schedule.
- Friday: 7:30 – 8:30 a.m. L&D Conference

During these times a single resident will be available by pager to respond to clinical emergencies.

LEARNING MATERIALS

- Normal and Problem Preganancies, Stephen Gabbe, latest edition
- Maternal-Fetal Medicine, Creasy Resnik, latest edition
- Williams Obstetrics, latest edition
- ACOG Practice Bulletin #102 Management of Stillbirth, March 2009
- ACOG Practice Bulletin #80 Premature Rupture of Membranes, April 2007
- ACOG Practice Bulletin #33 Diagnosis and Management of Preeclampsia and Eclampsia, Reaffirmed 2008
- ACOG Practice Bulletin #17 Operative Vaginal Delivery, Reaffirmed 2008
- ACOG Practice Bulletin #31 Assessment of Risk Factors for Preterm Birth, Reaffirmed 2008

EVALUATION

Global assessment by attendings on the service.
Formative surgical skills assessments by attendings on the service.
Junior resident assessment of leadership.
Medical student evaluation of teaching efforts.

Last Revision: 6/2/2009

Residency Rotation Guidelines & Objectives
Service: St. Mary's Hospital High Risk Obstetrics **Level:** PGY-3

OVERVIEW

Goals

To gain experience in the clinical care of the high risk obstetrical patients on the St. Mary's Obstetric Service including labor and delivery and antepartum units. Gain experience in the supervision of Family Practice residents on the St. Mary's low risk obstetrical service.

Duty Hours & Locations

Four consecutive weeks at St. Mary's Hospital Labor & Delivery. Except when off duty or scheduled to be elsewhere (didactics, continuity clinic), the resident is expected to be available in the Birthing Center between the hours of 6:00 a.m. and 7:00p.m. The resident must carry a pager.

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: Participate in the St. Mary's OB call pool
Vacation: Permitted.

Supervision

Surgical procedures and clinical care performed under the direct supervision of the attending physician. Dr. Gary Waters assigns educational activities.

LEARNING OBJECTIVES

- Provide primary ante- and intrapartum clinical care for complicated OB patients, including: ***MK, PC***
  - Multiple gestations
  - Diabetics
  - Preterm ROM < 36 weeks' gestation
  - Preterm labor
  - Preeclampsia and severe chronic hypertension
  - Preterm fetal demise
  - Placenta previa
  - Abruption
  - Severe postpartum hemorrhage
  - Other diagnoses at the discretion of the attending obstetrician
- Interpretation of antenatal fetal testing. Develop and communicate plan for continued patient care based on antenatal test results with OB attendings. ***MK, PC, ICS***
- Perform as primary assistant on all cesarean sections. ***PC***
- Provide post operative care for C-section patients. ***MK, PC, ICS***
- Performance of operative vaginal deliveries (forceps and vacuums). ***PC***

- Provide post partum care to post partum patients on the obstetrical service including patients following operative vaginal or cesarean delivery; complicated labor including any of the conditions listed above. ***MK, PC, ICS***
- Provide consultative care and recommendation under the direct supervision of the attending obstetrician for prolonged labor, fetal malpresentations (breech, face, brow, compound) and/or FHT abnormalities. ***PC, ICS***

EDUCATION PROGRAM

Clinical Scope

- Rounds on and manages the day to day care of antepartum and postpartum patients on the obstetric service.
- Work with FP attendings when OB consultation has been requested.
- Provide obstetrical education to the on-call FP residents.
- Weekend call duty includes evaluation of ER gynecologic patients and assistance with "add-on" Gyn surgical cases as a second priority to birth room duties while on call.

Other Educational Activities

Schedules and prepares for Wednesday morning OB conferences at 7:00 am

LEARNING MATERIALS

- Normal and Problem Pregnancies, Stephen Gabbe, latest edition
- Maternal-fetal Medicine, Creasy Resnik, latest edition
- Williams Obstetrics, latest edition
- ACOG Practice Bulletin #102 Management of Stillbirth, March 2009 (Replaces Committee Opinion Number 383, October 2007
- ACOG Practice Bulletin #80 Premature Rupture of Membranes, April 2007
- ACOG Practice Bulletin #33 Diagnosis and Management of Preeclampsia and Eclampsia, Reaffirmed 2008
- ACOG Practice Bulletin #17 Operative Vaginal Delivery, Reaffirmed 2008
- ACOG Practice Bulletin #31 Assessment of Risk Factors for Preterm Birth, Reaffirmed 2008

EVALUATION

- Global assessment by attendings on the service.
- Formative surgical skills assessment by attendings on the service.

Last Revision: 6/2/2009

Residency Rotation Guidelines & Objectives
Service: Meriter Hospital Benign Gynecology **Level:** PGY-4

OVERVIEW

Goals

Continue to expand ability to manage gynecologic patients who present for surgery including post operative care/complications, management of gynecologic medical patients, inpatient assessment of acute gynecologic issues (consultations) and assessment of acute gynecologic complaints to the emergency department. Develop more advanced technical skills to be able to perform a wide range of gynecologic procedures. Responsible for the management of the resident gynecologic service.

Duty Hours & Locations

Eight continuous weeks at Meriter Hospital. Schedule and responsibilities:
- Available by pager from 7 am to 5 or 7 pm per rotation schedule for emergency room and inpatient gynecologic consults.

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: No call.
Vacation: Permitted.

Supervision

The PGY4 guides educational activities, resident participation in surgical cases and patient care. Dr. Diem assigns the didactic teaching schedule. Surgical procedures are performed under the direct supervision of the attending physician.

LEARNING OBJECTIVES

- Perform a pertinent history, focused physical examination, selection and interpretation of diagnostic tests and initial treatment plan for the common presenting patient complaints including: abdominal pain, vaginal bleeding (early pregnancy and non-pregnancy related), pelvic mass, urologic/gynecologic infections and vulvar/vaginal symptoms. *PC*
- Evaluate patients and develop treatment plans for post-operative complications including fever, bleeding, pain control, gastrointestinal ileus/obstruction, nausea, wound complications, infection, cardiovascular symptoms, mental status changes, renal/fluid balance issues, respiratory symptoms and thromboembolism. *PC*
- Describe pre-operative indication, potential intra- and post-operative complications and function as the primary assistant on more complicated gynecologic surgical procedures: operative hysteroscopy, operative laparoscopy, supracervical and total laparoscopic hysterectomy, vaginal hysterectomy, and procedures for correction of prolapse and urinary and rectal incontinence. *MK*
- Exhibit level of surgical skill that allows teaching guidance for junior residents through simple surgical cases: sterilization procedures, diagnostic hysteroscopy, dilatation and sharp/suction

curettage, diagnostic and operative laparoscopy, surgical management of ectopic pregnancy, abdominal hysterectomy and BSO. ***MK, PC, P***

- Meet in person and review history and physical on each surgical patient prior to surgery. ***PC, P***
- Provide comprehensive postoperative care including fluid and electrolyte management and appropriate pain control based on the surgical procedure and the degree of patient discomfort and co-existing morbidities. ***MK, PC, ICS, SBP***
- Describe intra-operative surgical complications and management. ***MK***
- Identify and describe use of all laparoscopic instruments. ***MK***
- Describe the types, risks and benefits of energy sources in gynecologic surgery. ***MK***
- Describe surgical and medical treatment options for endometriosis in adolescents and adults. ***MK***
- The PGY4 is considered the "Chief Resident" of the benign gynecology service and is responsible for the education, supervision and evaluation of the medical students and junior residents on the team and for ensuring resident participation in surgical cases. ***ICS, PBLI, SBP, P***

EDUCATION PROGRAM

Clinical Scope

- Learning will be facilitated via direct patient care activities in the emergency department, operating room and inpatient gynecology unit.
- Daily rounding on inpatients.
- Responsible for the education, supervision and evaluation of the medical students and junior residents on the team and for ensuring resident participation in surgical cases.

Conferences

Gynecologic service teaching rounds from 7 – 7:30 am

- Mon, Tues, Wed,: assigned topic per gynecology attending schedule
- Fri: Dr. Diem, pathology, radiology or topic conference.

Other Educational Activities

Total laparoscopic hysterectomy DVD

LEARNING MATERIALS

- TeLinde's Operative Gynecology. John A. Rock.
- Atlas of Pelvic Anatomy and Gynecologic Surgery. Baggish & Karram
- ACOG Practice Bulletin #89, Elective and Risk-Reducing Salpingo-oophorectomy, January 2008.
- ACOG Committee Opinion #380, Disclosure and Discussion of Adverse Events, October 2007.
- ACOG Committee Opinion #372, The Role of Cystourethroscopy in the Generalist Obstetrician-Gynecologist, July 2007.
- ACOG Committee Opinion #367, Communication Strategies for Patient Handoffs, June 2007.
- ACOG Committee Opinion #365, Seeking and Giving Consultation, May 2007.
- ACOG Committee Opinion #323, Elective Coincidental Appendectomy, November 2005, Reaffirmed 2007.

EVALUATION

- Global assessment by attendings on the service.
- Formative surgical skills assessment by attendings on the service.
- Medical student evaluation of teaching efforts.
- Professional associates' evaluation of professionalism.

DEPARTMENT OF
OBSTETRICS AND GYNECOLOGY
University of Wisconsin
School of Medicine and Public Health

Residency Rotation Guidelines & Objectives
Service: Meriter Hospital High Risk Obstetrics **Level:** PGY-4

OVERVIEW

Goals
Integration of the knowledge base, clinical skills and leadership qualities acquired during the preceding three years. Development of the judgment and skills needed to practice obstetrics independently and safely without supervision. Mastery of obstetric procedures and operative deliveries.

Duty Hours & Locations
Eight consecutive weeks at Meriter

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: Participate in the Meriter OB call pool.
Vacation: Permitted.

Supervision
Surgical procedures and patient care are under the direct supervision of the attending physician. Dr. Shah is responsible for the programmatic and educational curriculum.

LEARNING OBJECTIVES

- management of major medical conditions complicating pregnancy including diabetes, hypetension, cardiopulmonary disease, diseases of the urinary system, thyroid disease, gastrointestinal disease, infectious diseases, neurologic diseases, collagen vascular disorders, psychiatric disorders, substance abuse in pregnancy, high risk thrombophilias, and iso and alloimmunization diseases *MK, PC*
- management of pregnancies complicated by fetal anomalies *MK, PC, ICS, SBP*
- management of second trimester medical abortion, after fetal injection *ICS, SBP*
- management of complicated postpartum hemorrhage, including uterine compression sutures and cesarean hysterectomy *MK, PC, ICS, SBP*
- performance of operative vaginal delivery *PC*
- performance of complex cesarean section/cesarean hysterectomy *PC*
- Describe indications for and perform cervical cerclage *MK, PC*
- direction and coordination of Ob team *SBP, ICS, P*
- coordination of Ob didactic series *MK, P, PBLI*
- development, review and improvement of patient care processes and procedures as needed to insure safe, effective patient care *PBLI, SBP, PC*

EDUCATION PROGRAM

Clinical Scope
- coordination of the resident team's management of routine and high-risk obstetrical patients during the antepartum, intrapartum and postpartum periods

- personal medical management of the highest risk patients when service acuity and workload demand
- coordination of morning OB Board sign out / PBL&I conference
- participation in appropriate surgical procedures
- attendance of all resident clinic deliveries and cesarean sections
- assurance of efficient, safe patient care through development/improvement of processes and procedures when appropriate
- presentation of data and cases at M&M
- assistance with medical student orientation

Other Educational Activities/Conferences
Mon – Fri: 7:00 - 7:30 a.m. Sign Out Rounds
Monday: 7:30 - 8:30 a.m. Resident OB Didactics
Tuesday: 7:30 - 8:30 a.m. Perinatal Conference
Wednesday: 7:30 – 8:30 a.m. MFM Didactics
Thursday: M&M, Grand Rounds, Resident Didactics and simulation lab per department schedule.
Fridays 7:30 – 8:30 a.m. L&D Conference
During these times a single resident will be available by pager to respond to clinical emergencies.

LEARNING MATERIALS

- Obstetrics, Normal and Problem Pregnancies, Gabbe, latest edition
- Maternal-Fetal Medicine, Creasy Resnik, latest edition
- Operative Obstetric, Hankins, latest edition
- Ultrasonography in Obstetrics & Gynecology, Callen, latest edition

EVALUATION

- Global assessment by attendings on the service
- Focused surgical skills assessments
- Junior resident assessment of leadership
- Medical student evaluation of teaching efforts

Last Revision: 6/2/2009

Residency Rotation Guidelines & Objectives
Service: St. Mary's Hospital Benign Gynecology **Level:** PGY-4

OVERVIEW

Goals

Expand ability to manage gynecologic patients who present for surgery including post operative care/complications, management of gynecologic medical patients, inpatient assessment of acute gynecologic issues (consultations) and emergency room evaluation of gynecological patients. Develop more advanced technical skills to be able to perform a wide range of gynecologic procedures.

Duty Hours & Locations

Eight continuous weeks at St. Mary's Hospital. Schedule and responsibilities:

- Daily rounding on inpatients to be completed by 7:30 a.m.
- Available for patient care until 1900 daily.
- Assist with all "add-on" Gyn surgical cases as a second priority to birth room duties while on call.

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: Participate in the St. Mary's call pool.
Vacation: Permitted.

Supervision

Dr. Gary Waters ensures coverage of surgical cases and assignment of educational activities. Surgical procedures are performed under the direct supervision of the attending physician.

LEARNING OBJECTIVES

- Evaluate patients and develop treatment plans for post-operative complications including fever, bleeding, pain control, gastrointestinal ileus/obstruction, nausea, wound complications, infection, cardiovascular symptoms, mental status changes, renal/fluid balance issues, respiratory symptoms and thromboembolism. *PC*
- Describe pre-operative indication, potential intra- and post-operative complications and function as the primary assistant on all scheduled gynecologic surgical procedures: operative hysteroscopy, operative laparoscopy, supracervical and total laparoscopic hysterectomy, abdominal hysterectomy, vaginal hysterectomy, procedures for the correction of prolapse and urinary and fecal incontinence and robotic procedures. *MK, PC*
- Meets in person and reviews history and physical on each surgical patient prior to surgery. *PC, P*
- Provide comprehensive postoperative care including fluid and electrolyte management and appropriate pain control based on the surgical procedure and the degree of patient discomfort and co-existing morbidities. Makes daily rounds on gynecology patients. *MK, PC, ICS, SBP*

- May see a patient in the E.R. prior to an emergent surgery as requested by the attending physician. In general, residents are not responsible for seeing patients or assisting with D&C's in the ER. *PC*
- Performs post operative care duties including operative report dictation, care orders and post operative evaluation. *SBP*

EDUCATION PROGRAM

Clinical Scope

Learning will be facilitated via direct patient care activities in the operating room and inpatient gynecology unit. The resident is first call for urgent assessment of all post-operative patients on the gynecology service.

Conferences

- Gynecologic service teaching conference Tuesday mornings at 7 - 7:30 am.

LEARNING MATERIALS

- TeLinde's Operative Gynecology. John A. Rock.
- Atlas of Pelvic Anatomy and Gynecologic Surgery. Baggish & Karram

EVALUATION

- Global assessment by attendings on the service.
- Formative surgical skills assessment by attendings on the service.

Last Revision: 6/2/2009

Residency Rotation Guidelines & Objectives
Service: Gynecologic Oncology **Level:** PGY-4

OVERVIEW

Goals

General knowledge of gynecologic cancers and pre-invasive neoplasias (surgical management, medical management, co-morbidities and risk factors, chemotherapy concepts). Surgical Training (introduction to operating room, learning of general principles, post-operative care, perioperative complications). Integration of data (consultations, lab testing, radiologic studies, pathology). Participate in supervision and teaching of medical students. Interaction with consultants and services that request gynecologic oncology consultation. Teamwork:

- Work under supervision of fellows.
- Take direction from attending physician in clinic, operating room and inpatient wards.
- Participate in supervision and teaching of medical students and junior residents.
- Interaction with consultants and services that request gynecologic oncology consultation.

Duty Hours & Locations

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: Participate in the UWHC home call schedule.
Vacation: Permitted.

Supervision

- Work under supervision of senior residents and fellows
- Take direction from attending physician in clinic, operating room and inpatient wards

LEARNING OBJECTIVES

- Assessment of outpatients including chief complaint, history, comprehensive or targeted physical exam, testing (laboratory, radiologic, physiologic, procedural, etc.), treatment planning - New patient workups, Return visits, Post-treatment surveillance, Pre-operative evaluations, Chemotherapy initiation and maintenance, Postoperative assessment, Documentation, Coordination of follow-up care. ***PC, MK, ICS, SBP, P, PBLI***
- Evaluation and workup of inpatients - New admissions, Consultations from other services and the emergency department, Pre- and post-operative patients, Patients with complications of gynecologic malignancies, Recipients of chemotherapy and radiologic therapy, Palliative and supportive care. ***PC, MK, ICS, SBP, P, PBLI***
- Procedure-related knowledge - Indications, Contraindications, Risks, Benefits, Alternatives, Complications. ***PC, MK***
- Charting and rounding - Competency in use of HealthLink, Documentation (history and physical exam, daily notes, consultation notes, discharge summaries), Orders (pre-operative, post-operative, supportive care), Coordination of care (consulting services, primary care needs, community resources). ***PC, ICS, SBP, PBLI***

- Technical competency - Outpatient procedures (preparation, procedure, post-procedure care), Inpatient and Ambulatory Care operations (time-out, positioning patient in the operating room, demonstrate understanding anatomy and physiology, operative field exposure, tissue handling, sequence of procedural steps, management of altered anatomy, hemostasis, dealing with intraoperative complications, closure of surgical site, post-procedure [cleanup, repositioning, transition to PACU]). ***PC, MK, ICS***
- Teamwork and individual accomplishments - Presentation of patients to upper level residents, fellow, attendings, Effective and efficient signouts and hand-offs, Understand limits of knowledge and ability, Feedback (receptivity to instruction and suggestions, implementation of proposed changes, behavior modification, provide constructive advice and comments to others), Teaching (learning from senior team members, instruction of junior team members, self-teaching using recommended resources, interactive participation in conferences and rounds), Information exchange (professional and sensitive interactions [patients, families, students, nurses, mid-level providers, ancillary and support staff, colleagues, supervisors], thorough and detailed documentation [HealthLink, dictations, correspondence, medicolegal adequacy, billing support]), Demeanor (professional attitude and attire, prompt response to pages and consultation requests, ethical principles and cultural sensitivity). ***PC, MK, PBLI, ICS, P, SBP***

Cognitive

Basic Science and Mechanisms of Disease

- Genetics
- Physiology
- Embryology and developmental biology
- Anatomy
- Pharmacology
- Pathology and Neoplasia
- Microbiology and Immunology

Carcinoma of the Breast

- Epidemiology and Risk Assessment of Breast Cancer
  - Explain to patients and their families the pathophysiology and epidemiology of breast cancer
  - Evaluate a patient's personal or family history of breast cancer including inherited risk of BRCA 1 or BRCA 2 and counsel patients regarding screening, testing, and prevention strategies
  - Evaluate other epidemiologic factors such as patient age, parity, ethnicity, lactation, hormone replacement, alcohol consumption, and lack of estrogen use in assessing a woman's risk for developing breast cancer
- Diagnosis of Invasive Carcinoma of the Breast
  - Explain to the patient the appropriate diagnostic tests for evaluating a suspicious breast lesion
  - Describe the indications for needle aspiration of a breast cyst and fine needle biopsy of a solid lesion
  - Describe the indications for, and interpret the results of, other diagnostic studies such as mammography, ultrasonography, core needle biopsy, and excisional biopsy
- Management of Invasive Breast Cancer
  - Describe the conservative and radical surgical interventions for breast cancer and the factors influencing treatment selection
  - Describe the indications for adjuvant therapy with hormonal treatment, chemotherapy, or radiotherapy
  - Describe the impact of pregnancy on the treatment and prognosis of breast cancer

Vulvar and Vaginal Malignancies

- Invasive Vulvar Carcinoma

- Refer patients to a subspecialist for definitive treatment of an invasive vulvar malignancy
- Manage, in consultation with a subspecialist, the common complications of surgical and radiation treatment for invasive vulvar cancer
- Describe the impact of treatment of vulvar cancer on sexual function and appropriately refer the patient for specialized treatment if sexual dysfunction develops

▪ Preinvasive Vaginal Neoplasia (Vaginal Intraepithelial Neoplasia [VAIN])
  - Treat patients with VAIN using the appropriate modalities
▪ Invasive Carcinoma of the Vagina
  - Refer patients to a subspecialist for definitive treatment
  - Manage, in combination with a subspecialist, the common complications of surgical and radiation treatment for vaginal cancer

Cervical Disorders
▪ Preinvasive Cervical Disease
  - Treat cervical dysplasia appropriately
  - Manage the complications resulting from treatment of cervical dysplasia
▪ Invasive Cervical Cancer
  - Refer patients to a subspecialist for definitive treatment
  - Manage, in combination with a subspecialist, the common complications of surgical and radiation treatment for cervical cancer
  - Address the psychosocial concerns of patients who have invasive cervical cancer and refer to a consultant when indicated

Carcinoma of the Uterus
▪ Endometrial Hyperplasia
  - Select and perform appropriate management options for endometrial hyperplasia
    Medical therapy (progestins, oral contraceptives, ovulation-induction agents, gonadotropin-releasing hormone analogs, danazol)
    Surgery (endometrial curettage, endometrial ablation, hysterectomy)
  - Describe and manage the potential complications of these interventions
  - Describe appropriate follow-up for these patients after treatment
▪ Carcinoma of the Endometrium
  - Refer patients to a subspecialist for definitive treatment
  - Manage, in combination with a subspecialist, the common complications of surgical and radiation treatment for endometrial cancer

Ovarian and Tubal Carcinoma
▪ Carcinoma of the Ovary
  - Perform procedures to treat women with ovarian cancer, III consultation with subspecialists when indicated
  - Describe the indications for secondary cytoreductive surgery
  - Manage, in consultation with a subspecialist, the common complications resulting from treatment of ovarian cancer
  - Provide psychosocial support and appropriate palliative therapy for women dying of ovarian cancer
▪ Carcinoma of the Fallopian Tube
  - Perform procedures to treat women with fallopian tube cancer in consultation with subspecialists when indicated
  - Manage, in consultation with a subspecialist, the common complications resulting from treatment of fallopian tube cancer
  - Provide psychosocial support and appropriately palliate women dying of fallopian tube cancer

Gestational Trophoblastic Disease (GTD)
▪ Hydatidiform Mole

- Describe the indications for, and complications of, chemotherapy after surgical evacuation of a molar pregnancy
  - Describe when to refer the patient to the appropriate subspecialist for chemotherapy
  - Counsel the patient regarding recurrence risk for GTD
- Malignant Gestational Trophoblastic Disease
  - Diagnose malignant GTD using a combination of physical examination, beta-HCG, chest x-ray, CT scan, and ultrasound
  - Classify GTD into good prognosis (low risk) vs. poor prognosis (high risk)
  - Describe the medical and surgical management of malignant GTD
  - Provide, in consultation with a subspecialist, medical and surgical treatment for a patient with malignant GTD
  - Provide appropriate follow-up at the completion of treatment
  - Counsel patients regarding risk of recurrence and prognosis for future pregnancies

Therapy

- Radiation Therapy
  - Identify when radiation therapy is indicated, either as primary treatment or as adjunctive treatment, for gynecologic neoplasms
  - Describe the basic mechanism of action of these interventions: Intracavity irradiation, External-beam irradiation, Interstitial irradiation, Radioisotopes, Palliative radiation therapy
  - Describe the factors that influence decisions regarding intervention such as: Classification and FIGO staging of disease and histology, Age of patient, Underlying medical conditions, Implications for future fertility, Concomitant therapy with radio sensitizers or chemotherapy, Previous abdominal procedures, Maximal dose tolerance of selected organ systems
  - Describe the potential complications of radiation therapy
  - In consultation with a subspecialist, manage the complications of radiation therapy
- Chemotherapy
  - Identify when chemotherapy is indicated, either as primary treatment or as adjunctive treatment, for gynecologic neoplasms
  - Describe the likelihood of response of each common gynecologic malignancy to chemotherapeutic agents
  - Describe the mechanisms of action and antineoplastic activity of various chemotherapeutic agents: Biologic agents, Alkylating agents, Antimetabolites, Vinca alkaloids, Antibiotics, Hormones, Heavy metals, Immunotherapy
  - Describe and manage the potential complications of chemotherapy
  - Describe the long-term effects of chemotherapy on fertility
- Terminal Care
  - Describe the appropriate indications for a "Do Not Resuscitate" order
  - Describe the medical, ethical, and legal indications of such an order
  - Describe the concept of therapeutic index when considering medical or operative intervention to improve patients' quality of life
  - Describe the basic principles of pain management

Behavioral

Work-up of new patients and consultations, Care of patients perioperatively, Identification of surgical and therapeutic complications, Integration of data, Formulation of assessments and treatment plans.

Technical

Understand principles and uses

- Vulva and vagina (radical vulvectomy, inguinal lymphadenectomies, vaginal reconstruction, martius flap, gracilis flap, TRAM flap, skin graft).

- Cervix (radical hysterectomy with lymphadenectomy, pelvic exenteration +/- reconstruction, brachytherapy for cervical cancer).
- Uterus (pelvic and aortic lymph node dissection, pelvic radiation, vaginal cuff brachytherapy).
- Ovary and fallopian tube (staging biopsies of the peritoneal cavity, pelvic and aoric lymph node dissection, resection of rectosigmoid colon, right hemicolectomy, intraperitoneal port placement, small bowel resection and anastomosis, repair of enterotomy, colostomy).

Able to perform independently

- Vulva and vagina (punch biopsy, excisional biopsy, colposcopy, "simple" vulvectomy, topical therapy).
- Cervix (pap test, colposcopy and directed biopsies, endocervical curettage, LEEP, cold knife conization, cryoablation, vaginal hysterectomy, abdominal hysterectomy, laparascopic hysterectomy).
- Uterus (endometrial sampling, sonohysterogram, dilation and curettage, suction evacuation of molar pregnancy, endometrial ablation, vaginal hysterectomy, extrafascial hysterectomy +/- adnexectomy).
- Ovary and fallopian tube (collection of peritoneal cytology, adnexal removal [any technique], appendectomy, omentectomy [infracolic], abdominal exploration).

EDUCATION PROGRAM

Clinical Scope

Clinical - Outpatient clinics with attendings, Chemotherapy clinics, Inpatient management (morning and afternoon rounds [senior residents, fellows, faculty]), Surgical assistance (ambulatory surgery center, operating room), Consultations (inpatient, emergency department).

Other Educational Activities

- Structured teaching and didactic conferences
    - Attending rounds (3 times/week)
    - Tumor Board (weekly)
    - Didactic lectures (weekly)
    - Pre-operative conference (weekly)
    - Gynecologic Oncology journal club (monthly)
    - Departmental conferences:

      Morbidity and Mortality
      Simulation lab
      Grand Rounds
      Obstetrics and Gynecology Journal Club

LEARNING MATERIALS

- Practical Gynecologic Oncology. Berek and Hacker. 2004.
- TeLinde's Operative Gynecology. Rock and Jones. 2008.

EVALUATION

- Feedback - Residents, Fellows, Students, Mid-level providers, Nurses, Ancillary staff, Patients and their families.
- Joint global assessments by Gynecologic Oncology Attendings.
- Individual evaluation in the operating room.
- Meetings with Gynecologic Oncology division director.

Residency Rotation Guidelines & Objectives
Service: Gynecology and Pelvic Reconstructive Surgery **Level:** PGY-4

OVERVIEW

Goals

To manage patients with urogenital prolapse and incontinence, vulvar dermatoses, inpatient gynecologic consultations and assessment and management of gynecologic emergencies. The responsibilities of the service include daytime coverage of inpatient consults, gynecologic emergency room, gynecology clinic, assistant for surgical cases, and supervision of medical students. The resident is responsible for management of pre-operative and post-operative problems with surgical patients.

Duty Hours & Locations

Eight continuous weeks at the University Hospital and Clinics.
The schedule is:

- The resident on service should be available by pager from 7 am to 5 pm every day.
- Clinic all day Thursday and Friday, Tuesday afternoons, and Monday mornings.
- Surgery Tuesday morning for ambulatory cases and all day Wednesday for hospitalized patients.
- Daily rounding on inpatients.

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M, grand rounds, resident didactics and simulation lab per department schedule.
Call: Participate in the UWHC home call schedule.
Vacation: Permitted

Supervision

Dr. Thomas Julian provides supervision for the service.

LEARNING OBJECTIVES

- Elicit a complete history and perform a physical exam that appropriately assesses the patient complaint (pelvic organ prolapse, incontinence, sexual dysfunction, pelvic pain, vulvar disorder). Formulate a plan based on the examination. *MK, PC*
- Demonstrate knowledge of the anatomy and function of the bladder, rectum, and pelvic floor. Describe common normal variation and those seen in pathologic conditions. *MK*
- Perform and interpret the results of office testing including urinalysis and culture, post-void residual, stress test and voiding diary. *PC*
- Differentiate stress, urge and mixed urinary incontinence using history and physical exam and adjunct testing. State appropriate indications for referral of a patient for multichannel urodynamic studies. *MK*
- Describe the treatment modalities, including success, costs and contraindications, for different types of urinary incontinence including surgery, pharmacologic management , pelvic floor exercise/behavior modification. *MK, SBP*

- Recognize candidates for the use of vagina pessaries and appropriately fit and care for complications of pessaries. *PC*
- Describe the major causes of pelvic masses, including nongynecologic sources and those arising from the female genital tract. Elicit pertinent history, focused physical exam, perform and interpret test in order to formulate an appropriate plan. *PC*
- Describe the principal types of vulvar dystrophies and dermatoses such as lichen sclerosus, lichen planus, lichen simplex chronicus, atrophic dermatitis and VIN. *PC*
- Elicit a pertinent history, perform a focused physical exam and perform and/or interpret the results of selected diagnostic tests to confirm the diagnosis of vulvar disorders. *PC*
- Perform and interpret the results of colposcopy exam of the cervix, vagina and/or vulva utilizing ASCCP cytology guidelines. *MK, PC*
- Provide comprehensive postoperative care including fluid and electrolyte management and appropriate pain control based on the surgical procedure and the degree of patient discomfort and co-existing morbidities. Makes daily rounds on gynecology patients. *PC, ICS, SBP*

EDUCATION PROGRAM

Clinical Scope

Learning will be facilitated via direct patient care activities in the clinic, operating room, emergency department and inpatient gynecology unit. The resident is first call for emergency department and inpatient gynecology consults and first call for urgent assessment of all post-operative patients on the gynecology service.

LEARNING MATERIALS

- Ostergard's Urogyencology and Pelvic Floor Dysfunction. Bent and Cundiff. Sixth Edition. 2007.
- TeLinde's Operative Gynecology. John A. Rock. Tenth Edition. 2008.
- Advances in Reconstructive Vaginal Surgery. Kovac & Zimmerman. Third Edition. 2007.
- Obstetric and Gynecologic Dermatology. Black M, et al. Third Edition. 2008.
- Colposcopy: Principles and Practice. Apgar. Second Edition. 2008
- Comprehensive Gynecology. Stenchever. Fourth Edition. 2001

EVALUATION

Global assessment by Dr. Julian; formative surgical skills assessment by Dr. Julian

Last Revision: 6/2/2009

Residency Rotation Guidelines & Objectives
Service: Resident Continuity Clinic **Level:** PGY-1 - PGY-4

OVERVIEW

Goals
Provide primary preventative care, high and low risk obstetric care and consultative services specific to obstetrics and gynecology care for women of all ages with responsibilities similar to a private practice, including billing & coding for service provided and the maintenance of patient records.

Duty Hours & Locations
Meriter Hospital 2-C. ½ day per week.

Supervision
During clinic hours supervision provided by senior residents and the resident continuity attending staff of the day.

LEARNING OBJECTIVES

Primary Care
- Elicit medical history, perform well woman exam and recommend screening tests for selected diseases in accordance with the primary preventative care guidelines of the RRC and ACOG. ***MK, PC***
- Perform preconception care assessment and recommendations for all reproductive age women including evaluation of immunization history as part of well woman care. ***MK, PC, ICS, P***
- Elicit history, perform focused exam, order laboratory tests, imaging studies, consultations and develop treatment plan (which may include referral) for respiratory tract infection, otitis media, allergic rhinitis, thyroid disease, hypertension, diabetes, dyslipidemias, urinary tract disorders, depression, common GI disease, headaches, PMS and PMDD, skin disorders, musculoskeletal diseases and asthma. ***MK, PC, ICS, SBP, P***

Obstetric Care
- Elicit a thorough history, identify maternal conditions that impact on pregnancy and/or that pregnancy may influence; Order and interpret routine lab tests and those required because of risk factors during pregnancy; schedule and perform appropriate antepartum follow-up visits for routine and high-risk obstetric care. ***PC, SBP***
- Counsel patients regarding appropriate lifestyle modifications conducive to favorable pregnancy outcome; pregnancy associated risks and conditions including advanced age, hypertension, diabetes and/or prior anomalous fetus/newborn or other pregnancy complication. ***PC, ICS, P***
- Describe and counsel patients regarding limitations, risks and benefits of antenatal screening and diagnostic tests. ***PC, ICS, SBP, P***
- Describe indications, contraindications, advantages and disadvantages of antepartum fetal well being tests such NST, BPP and/or Doppler velocimetry. ***MK***

- Describe common symptoms, clinical manifestations and management of the following obstetric complications: second-trimester loss, preterm labor, third trimester bleeding, hypertension, GDM, multiple gestation, IUGR, isoimmunization, post-term pregnancy, and fetal death. *MK*
- Postpartum care: Perform a focused post partum exam, counsel patients regarding contraception including permanent sterilization, future pregnancies and breast feeding; identify and treat the most common maternal complications including mastitis, perineal discomfort, wound infection, post partum depression. *MK, PC, ICS*

Gynecologic Care

- First trimester pregnancy loss: Describe the differential diagnosis, usual symptoms, perform and/or interpret results of selected test used for diagnosis and management, be able to counsel patients regarding treatment options including risks and benefits of expectant, medical and surgical management. *MK, PC, ICS*
- Ectopic pregnancy: Describe risk factors that predispose to ectopic pregnancy, elicit a pertinent history, describe differential diagnosis, perform and interpret results of tests to confirm the diagnosis including ultrasound, BHCG, progesterone, CBC, D&C and laparoscopy. Describe the indications, contraindications and complications of surgical and medical management. Describe follow up for a patient treated for ectopic pregnancy including prognosis for normal intrauterine pregnancy. *MK, PC, ICS, SBP*
- STDs: Elicit pertinent history, perform focused exam, perform and interpret specific tests for patients suspected of STD. Treat STDs and recommend long-term follow up. *PC, ICS, P*
- Abnormal Pap Smears: Interpret and establish treatment plan for abnormal Pap smear and/or colposcopy results in accordance with 2006 ASCCP guidelines. *PC*
- Abnormal Uterine Bleeding: Describe the principal causes of abnormal uterine bleeding, be able to distinguish from dysfunctional uterine bleeding, elicit a pertinent history, perform and interpret selected tests such as endometrial biopsy, pelvic ultrasound and laboratory results, and describe treatment options. *MK, PC*
- Surgical care: Describe indications and alternatives for patients undergoing gynecologic surgery; conduct a preoperative assessment with consideration of special patient groups (cardiovascular disease, coagulopathy); compose appropriate preoperative plans for patients undergoing gynecologic surgery including mechanical bowel preparation, antibiotic use and VTE prophylaxis; provide counseling regarding surgical risks, obtain informed consent and provide post operative care. *MK, PC, ICS, SBP, P*
- Sexual function: Describe stages of normal sexual response; principal disorders of sexual function, elicit complete sexual history, perform focused exam and describe interventions for sexual disorders. *MK, PC*
- PGY4 residents are responsible for teaching junior residents, supervising medical students and conducting audits of junior resident charts to evaluate compliance with the primary preventative care guidelines. *ICS, SBP, P*

Practice Responsibilities

- PGY4 residents are responsible for teaching junior residents, supervising medical students and conducting audits of junior resident charts to evaluate compliance with the primary preventative care guidelines. *MK, ICS, SBP, PBLI, P*
- Demonstrate skill communicating with patients, office staff, colleagues and referring providers. *ICS, SBP, P*
- Demonstrate basic knowledge of office coding and billing procedures. *MK*
- Complete written and electronic records in a thorough and timely manner. *SBP*

Procedures: Perform common office procedures including

- Vulvar/skin biopsy/excision under local anesthesia.

- Endometrial biopsy.
- Placement of contraceptive devices, Mirena and ParaGard IUDs, Implanon.
- Colposcopy and LEEP.
- Ultrasound: pregnancy viability and dating, fetal position, AFI, location of IUD.
- Saline infusion sonograms.

Resident Patient Scheduling

Patients will be scheduled in an effort to reflect progressive level of responsibility and complexity of patient care. All levels of resident will assume well woman care, although post-menopausal patients will be assigned to senior residents.

- PGY1: low risk obstetric patients, STD screening, vaginitis
- PGY2: low and high risk obstetric patients, STD screening, vaginitis, consults for abnormal Pap smears, first trimester pregnancy loss
- PGY3: high risk obstetric patients, consults for abnormal Pap smears, pelvic pain, endometriosis, infertility, amenorrhea, abnormal uterine bleeding, pelvic mass, second trimester fetal loss
- PGY4: no new obstetric patients, consults for abnormal Pap smears, pelvic pain, endometriosis, infertility, amenorrhea, abnormal uterine bleeding, pelvic mass, second trimester fetal loss, supervisory responsibilities

EDUCATION PROGRAM

Clinical Scope

Learning is facilitated via direct patient care activities in the clinic and the operating room. The resident will see patients presenting for care in the clinic and present findings, assessment and plan to the senior resident or clinic attending staff. The resident will perform office procedures under the direct supervision of attending staff. The resident will be the primary surgeon on all clinic surgical cases. Depending on the complexity of the case another resident will be second assist, both under the direction of a clinic attending staff.

Other Educational Activities

- PGY1s: complete the APGO on-line monographs and case studies for "Nausea & Vomiting of Pregnancy" and CD-ROMs for "Immunizations" and Vaginitis" and the Mirena instructional video
- PGY2s: complete the APGO on-line monographs and case studies for "Cervical Disease" and "Perimenopause".
- PGY3s: complete the APGO on-line monograph and case studies for "Pelvic Pain" and "Abnormal Uterine Bleeding".
- PGY4s: complete the APGO on-line monograph and case studies for "Osteoporosis" and "Urinary Incontinence".

LEARNING MATERIALS

- Clinical Updates in Women's Health Care. http://www.clinicalupdates.org.
- ACOG Committee Opinion #357, Primary and Preventive Care: Periodic Assessments, December 2006.
- ACOG Committee Opinion #384 Colonoscopy and Colorectal Cancer Screening and Prevention, November 2007.
- ACOG Practice Bulletin #99 Management of Abnormal Cervical Cytology and Histology, December 2008.
- ACOG Practice Bulletin #28 Use of Botanicals for Management of Menopausal Symptoms, June 2001, Reaffirmed 2008.
- ACOG Committee Opinion #329 Tracking and Reminder Systems, March 2006.

- ACOG Practice Bulletin #72 Vaginitis, May 2006, Reaffirmed 2008.
- ACOG Practice Bulletin #102 Management of Stillbirth, March 2009.
- ACOG Practice Bulletin #92 Use of Psychiatric Medications during Pregnancy and Lactation, April 2008.
- ACOG Practice Bulletin #55 Management of Post term Pregnancy, September 2004, Reaffirmed 2007.
- ACOG Practice Bulletin #54 Vaginal Birth After Previous Cesarean Delivery, July 2004, Reaffirmed 2007.

EVALUATION

- Global assessment by clinic attending staff.
- Formative surgical skills assessment.
- Patient evaluation of care.

Last Revision: 6/2/2009

DEPARTMENT OF
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Resident Research Program

This new time line is built on a framework of quarterly meetings for each residency class. This gives 12 months to define the project and prepare for it, about 16 months to do the project and 5-6 months to analyze it.

PGY-1

- SEMINAR - "How to select a research topic and mentor."
- Including initial review of project "menu" At this meeting we will set the goal for next meeting—Identify 2-3 projects of interest and meet at least once with the primary mentor involved.
- SEMINAR - Part A: Statistical presentation; Part B: budget and regulatory/IRB issues.
- Present 1-3 tentative research topics to discuss with committee and finalize choice of project to move forward with. GOAL: meet with mentor over next quarter to better define project needs for Funding and regulatory approvals.
- Present progress and finalize budget or IRB if needed.

PGY-2

- Progress reports to discuss any barriers and plans to remedy them.
- March - presentation to faculty at Grand Rounds.

PGY-3

- October: another update.
- January: data bases should be locked and data to Statistician if appropriate.
- February: data back from Stats.
- March: submit report to Rick to verify no statistical issues/problems.
- Seminar on oral research presentation, i.e. how to prepare/structure presentation (from outline).
- Electronic submission of presentation to the research committee by noon on Monday, week of presentation.

PGY-4

- Seminar on manuscript preparation and peer review process. Discussion of possible presentation venues and timeline for abstract submissions.
- Updates on progress.
- Submission of manuscript and or presentation of review critics and discussion of responses.
- Updates and final sign off on completion of project.

Under Revision

PGY-1 UNIVERSITY HEALTH SERVICE & FAMILY PLANNING

UHS Daily Schedule:

8:30 am – 5:00 pm Wednesday

10:30 am – 5:00 pm Thursday

8:30 am – 5:00 pm Friday

The goal of this PGY-1 rotation is to become a more experienced primary care gynecologic clinician. This will be accomplished by working with the entire staff in the Women's Clinic at University Health Services. The women patients at UHS are students at UW-Madison or spouses/domestic partners of students. Most are of reproductive age and many are seeking family planning services. The PGY-1 can expect to develop skills in caring for these patients including diagnosis and treatment of illness, but also significant depth in prevention of health problems, maintaining wellness and providing patient education in areas relevant to patients seeking care from an OB-GYN provider.

The PGY-1 resident will have a schedule of patients each day and will be expected to provide care for patients coming to UHS for a variety of primary gynecological concerns. The reasons for visits will include routine annual examinations, prescription of contraceptive methods and other family planning services, sexually transmitted disease evaluations, amenorrhea, dysmenorrhea, galactorrhea, breast masses, vaginitis, abnormal vaginal bleeding, lower abdominal pain, ovarian cysts, abnormal Pap smears, colposcopic examinations, IUD placement, office Gyn surgery, ultrasound, and other women's health issues. The resident can expect staff support from the professional and support staff of the Women's Clinic, and the attending gynecologist. The rotation is under the administrative direction of Dr. Mary Landry.

There will also be opportunities to attend weekly lectures for trainees by UHS clinical medicine staff (see below for required lectures) and to work with the UHS dermatologist, Dr. Athena Daniolos, in a mole clinic. There will also be, as appropriate, collegial work with and referrals to other health care providers within and outside of UHS.

Friday Didactics (Dr. Landry)

Week 1: Cervical dysplasia – screening, diagnosis, and management

Week 2: Noncontraceptive benefits of hormonal contraception: dysmenorrheal, oligo and amenorrhea, menorrhagia, menometrorrhagia, Ovarian cysts, acne, hirsutism, menstrual migraines, PMS etc.

Week 3: Hormonal contraception and coexisting medical conditions (PCOS, migraines, hypertension, dyslipidemias, smoking, diabetes, epilepsy, family history of breast/ovarian cancer, clotting disorders etc.

Week 4: Colposcopy

Week 5 & 6: Colposcopy

Week 7: Resident choice (any of the above) or eating disorders, sexual abuse exam/SANE evidence collection kit, abdominal pain made easy, abnormal bleeding-definitions, evaluations and cases

Week 8: Resident to present "most interesting case" (with literature review)

UHS Lecture Series – Required Attendance

STDs	Craig Roberts
Hormonal contraception and IUDs	Amy Miller
Managing side effects of hormonal contraception	Sharon Woodford
Headache I and II	Allan Rifkin
Sexual history taking	Paul Grossberg
Eating disorders	Sara Van Orman

At the end of the first 4-week rotation, residents select a topic of interest for an in-depth literature review to be presented to UHS clinical providers at the end of the second 4-week rotation. They develop a research question, work with Heidi Marleau from Ebling Library one-on-one to conduct a computer-aided literature search, advancing their individual skills, and present a 40-minute power-point talk on their topic.

At the end of the rotation at University Health Services, the resident will ably perform gynecological examinations, will be adept in interacting with patients and meeting their needs, will be working collegially as a team member with UHS clinic staff, and will have understanding of and experience with the management of the primary care issues facing the gynecologist in outpatient practice, especially with women of reproductive age.

Planned Parenthood's Comprehensive Reproductive Health Center (CRHC) schedule:

8:00 am – noon – Monday: Family planning

1:00 pm – Meriter Gyn Service (PG-1 should contact PG-4 on Meriter Gyn)

8:00 am – 5:00 pm – Tuesday: Abortions & counseling OR family planning & counseling

This rotation will take place at Planned Parenthood of Wisconsin's new Comprehensive Reproductive Health Center (CRHC) at 3706 Orin Road (off N. Stoughton Rd. across from MATC). This clinic offers a full range of reproductive health care including well-woman exams, contraception and family planning, sexually transmitted infection testing for men and women, medical and surgical abortion services, colposcopy, and community education programs. This rotation has been established under the Kenneth J. Ryan Residency Training Program in Abortion and Family Planning, with Dr. Caryn Dutton serving as the director. The goal of this training is not only to develop clinical skills in family planning and abortion services, but also to develop awareness of the larger role that access to these services plays in the lives of our patients. Participation in performing abortion procedures is optional, and should be discussed with Dr. Dutton on an individual basis.

Call on this rotation is in the "junior" resident night call schedule at UWHC.

Rotation eliminated for 2009-2010

PGY-2 CLINICS ROTATION

During the four week Clinics rotation, the resident will gain exposure to many aspects of the ambulatory healthcare of women.

The resident provides cross-coverage on L&D at St. Mary's Hospital one day/week, and has one unscheduled afternoon for research related activities.

Experience may be gained in abortions and counseling at Planned Parenthood's Comprehensive Reproductive Health Center, although this clinic is optional. The resident should inform the program coordinator at least one month in advance whether s/he is planning to attend. Individuals who elect not to participate in this clinic are required to submit a proposal to Dr. Droste for an alternate primary care experience.

The resident on the clinics rotation is expected to attend all scheduled clinics, unless signed out on vacation, or indisposed due to illness. Clinics are to be notified of any anticipated or unanticipated absences.

During the Clinics rotation, the resident is in the call schedule at St. Mary's and provides Labor and Delivery coverage.

See "Ambulatory Clinics Schedule" for specifics.

Rotation under revision for 2009-2010

DEPARTMENT OF
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PGY-2 TLC

I. Introduction

The Trauma and Life Support Center (TLC) is the adult multi-disciplinary ICU for University Hospital located in the B module on the third floor strategically situated near the Emergency and Operating Rooms and across from the Diagnostic Radiology Module. This geographic orientation facilitates the provision of critical care services because physicians and ancillary personnel remain within close proximity of the critically ill. The TLC serves as the tertiary referral ICU for the south central area of Wisconsin as well as the primary ICU for the following services:

Medicine	ENT
General Surgery	Plastic Surgery
Trauma Surgery	Gynecologic Surgery
Transplant Surgery	Urology
Peripheral Vascular Surgery	

Neuroscience, Cardiology, Cardiothoracic, Burn and Pediatric patients are admitted to their respective ICUs.

The TLC consists of 24 beds arranged in two identical twelve bed modules. Keeping with the character of a multidisciplinary ICU, there is no segregation of patients by service, location or nursing. Patients in the TLC are of a high acuity but occasionally intermediate care unit (IMC) patients will be admitted given bed constraints in other modules. Each module (North 1-12 and South 13-24) has its own respiratory therapy station, pharmacy and unit coordinator, with all support facilities located in the immediate area.

A. Admitting Teams

All patients admitted to the TLC will have a clearly identified Primary Team that has overall responsibility for the care of the patient including; admission and daily progress notes, daily rounds by the primary attending/residents, determination of the direction of care and family discussion/updates. Admission and subsequent orders are the exclusive responsibility of the primary team. All contacts regarding patient care from nursing, respiratory care or pharmacy should be directed towards the primary team on a 7/24 basis. Consultants should not write orders unless discussed with and approved by the primary team or when emergent situations arise and the primary team is not available. Specific Primary Team's are defined below:

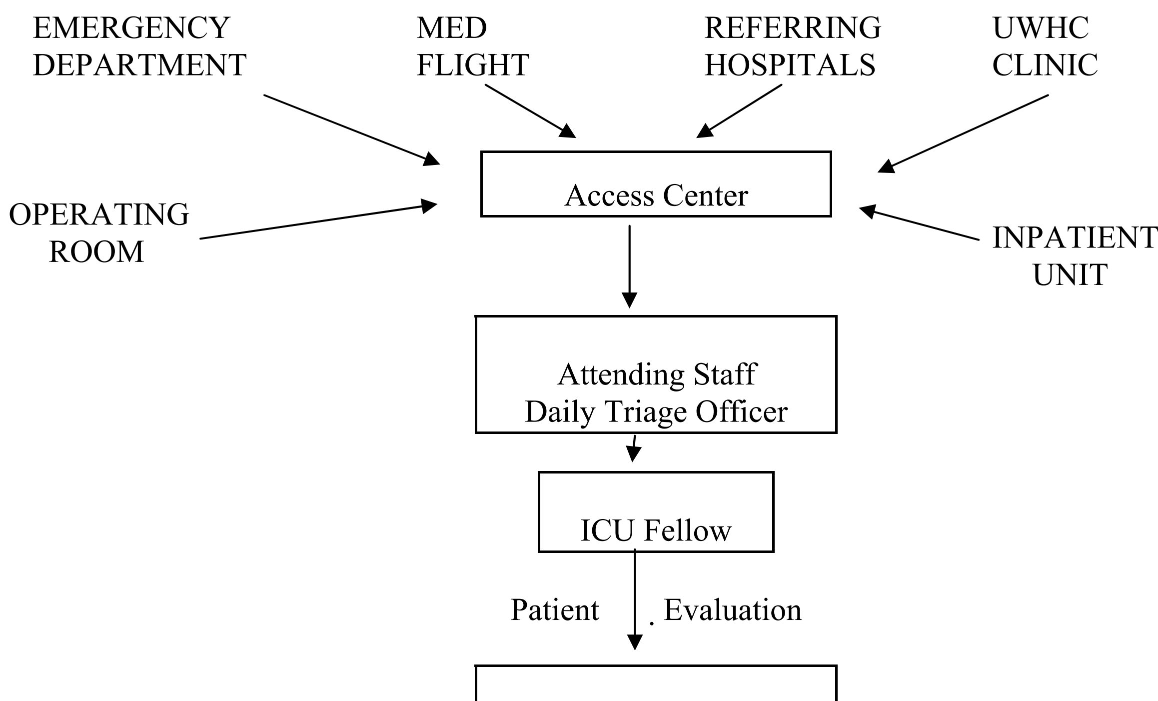
- Critical Care Service (CCS)
    - All Department of Medicine patients on ICU or IMC status in TLC or Burn Unit
    - Bone marrow transplant

- CCS will function as the primary team for critical care issues for the following services
    - Plastic surgery
    - ENT
    - Orthopaedics
    - Interventional Radiology
    - Orthopaedic Spine Surgery
    - Neurology (non-stroke)
- Vascular Surgery
- Transplant Surgery
- General Surgery
- Trauma Surgery

The CCS will consultatively participate in the care of all patients in the TLC except for the Trauma Surgery Service. In times of capacity constraint, patients from Cardiology, Cardiac Surgery, Congestive Heart Failure Service, Thoracic Surgery or Neurosurgery, may board in the TLC. The CCS will participate in the care of these patients by specific request only.

B. Admissions

Admission to the TLC is based upon medical necessity and ranges from the critically ill patients, which constitute most admissions to intermediate care unit patients accommodated in times of bed shortages. Admission status should be clarified upon arrival as ICU or IMC status. This will significantly impact upon nursing assignments and patient charges. A simplified algorithmic schema for admissions is presented below:



ICU Resident

Every effort will be made to admit critically ill patients to the TLC. However, on occasion, the TLC census may dictate admission to other geographic units such as Burn, Neurosciences, or Cardiac/Cardiothoracic ICU. The preceding Primary Team concept will be similarly applied in these instances.

C. Teams

The CCS is staffed by two rounding teams, each of which consists of:

(1) Staff Attending
- Pulmonary/Critical Care
- Anesthesia/Critical Care
- Infectious Disease/Critical Care

(1) Fellow
- Pulmonary/Critical Care
- Anesthesia/Critical Care

(2-3) Residents
- Internal Medicine
- Anesthesiology
- Surgery

(1-2) Interns
- Anesthesiology
- Urology
- Internal Medicine
- OB/GYN
- Orthopaedics
- ENT
- Plastics
- Neurosurgery

(1-2) 4th Year Students

Teams alternate admission call days beginning at 0800. Teams should be evenly balanced amongst housestaff and patients and if disparity occurs the teams can negotiate the housestaff-patients numbers.

D. Daily Schedule

0630 - Student-Intern-Resident work rounds

0800 - Sign-in rounds/X-ray conference (TLC Conference Room B6/355)

Newly admitted patients and issues concerning cross-covered patients are discussed during the review of the AM films. The conference is also attended by the TLC north and south nursing care team leaders, respiratory therapy, and case management. In addition to briefly reviewing newly admitted patients and issues

concerning cross coverage, patient care status (ICU, IMC, general care) triage and transfer status are reviewed.

0830 - Team teaching rounds

Multidisciplinary teaching rounds are held each day. In addition to the TLC team, they are regularly attended by and should involve the patients nurse, pharmacist, respiratory therapist and clinical nutritionist. These rounds are distinct from resident work rounds in that all patients should have been previously evaluated, pertinent data gathered for presentation and a housestaff management plan formulated. Teaching rounds focus upon discussions regarding patient management issues and bedside teaching.

0900 - Medical Residents Morning Report

1100 - Critical Care Curriculum Tuesday, Wednesday, Thursday (B6/355)

1200 - Medical Residents Noon Lecture

1630 - Formal sign-out rounds with admitting team.

With the exception of post- call housestaff, who are excused when their work is done or by 1:00 PM at the latest, housestaff should be present to briefly address issues regarding their patients for the cross covering team.

II. Medical Responsibility and Patient Management

The unique multidisciplinary nature and severity of illness in the TLC provides a diverse and challenging experience to housestaff from several disciplines. This situation requires excellent lines of communication within the TLC team, between TLC teams, and between the TLC team and primary service.

To facilitate the optimal delivery of care in such a complex environment, a system of graded responsibility and management has been utilized. Although not rigid in character, the following designations allow for the system to function most efficiently.

A. Students

One to two senior medical students typically rotate with each team. Each student is assigned to a resident and essentially will shadow that supervising resident regarding patient assignments and on-call responsibilities. Students should be limited to two patients in most instances. For students, emphasis is placed on understanding and integrating pathophysiologic disease processes. Students work in concert with the team and should not independently write orders or perform any procedure without direct bedside supervision. Students are expected to write admission notes and daily progress notes on their patients. These notes should be reviewed and co-signed by the supervising resident who is primarily responsible for that patient. It is fully expected that all patients will be seen on resident work rounds and presented during attending teaching rounds.

B. Interns

For most PGY-1 residents this rotation constitutes the first exposure to critical care in a position of patient responsibility. Accordingly, interns are assigned to a supervising resident with whom patient management issues are addressed in conjunction with the TLC team. Interns are expected to integrate pathophysiologic processes and during the course of the rotation develop patient management skills applicable to the critically ill. Admission notes and daily progress notes are required on all patients, with the emphasis on integration and management. All procedures need to be supervised. Patient responsibility throughout the rotation will be delegated based upon competence. It is expected that all patients will be seen on resident work rounds and presented on teaching rounds.

C. Residents

Supervising residents are responsible for the interns and students patients as well as their own patients. The supervising resident is expected to be directly involved in the care of each patient and provide instruction and teaching aimed at the interns and students. All patients should be seen or reviewed with the intern/student on resident work rounds prior to teaching rounds. The resident should insure that the appropriate information is available for teaching rounds and have a coordinated management plan to present. A resident admit note is required on all admissions to TLC. A resident daily progress note is required on all patients being followed. The resident should also review student/intern progress notes and edit and/or amend before co-signing. Supervision of all student/intern procedures is required. If a resident does not have significant procedural expertise to supervise or is not certified, then the fellow or staff will supervise the resident.

D. Fellows

Fellows training in critical care are expected to be knowledgeable of all patients on the service, acquire an in-depth understanding of pathophysiologic processes and fully define patient management issues. Fellows serve as a resource for housestaff and ancillary services regarding education and teaching, patient management issues and for procedural supervision. Fellows are available continuously for any problems and will admit all patients with the housestaff. Fellow's notes should reflect an integrative analysis of patient problems and focus upon major pertinent management issues.

The above should not be taken to mean a rigid hierarchically driven system is present but such descriptions are necessary to define rotational expectations. In the end, the balance between housestaff autonomy and staff supervision is individually determined as increasing responsibility is directed toward housestaff who demonstrate their knowledge, competency and management skills on rounds.

III. Note Writing

Effective note writing constitutes an integral part of medical care. Notes reflect one's thinking committed to paper. They are the basis for communicating patient care information to multiple services and function as the legal record of the patient's stay. The character and the quality of these notes reflects upon one's knowledge of the case and management skills and is one of the measures used by staff to assess trainee competence. Given the number of services and consultants in the TLC, legible, comprehensive, organized, and well written notes are a necessity. All notes must be dated, including year, timed and signed legibly (name and beeper number).

The following format is used in the TLC on preprinted order forms:

A. Admission Orders

TLC Admit Orders

1. Diagnosis____
2. Condition____
3. Isolation _____ YES _____NO
   TYPE _____ Airborne
   _____ Droplet
   _____ Contact
   _____ Protective (Hepafilter)
4. Primary service
   Attending ______________________________
   Resident________________________________
5. Resuscitation status (enclosed and requires completion upon admission)
6. Consent form (enclosed and requires completion upon admission)
7. Advanced directive (enclosed and requires completion within 48 hours)
8. Nursing
   a. VS will be done every 1-2 hours & PRN
      - Includes HR, BP, RR
      - Q hour will be done if patient on vasoactive infusion being titrated
      - Cardiac monitor with continuous pulse oximetry
   b. Daily weights
   c. Intake & output
   d. Line & site care
   e. Activity as tolerated
   f. HOB elevated 30 degrees for all intubated patients unless contraindicated.
9. Respiratory care per TLC protocol
   - Initiation of mechanical ventilation (UW Policy 8.14)
   - Weaning
     Respiratory protocols, check appropriate indication below:
     ☐ Asthma, COPD, Wheezing

☐ Atelectasis associated with $FiO_2 \geq 40\%$
☐ Mucus Plugging/Secretion retention

10. Pharmacy TLC Protocols
    - Paralytics
    - Sedation
    - Analgesia
    - Stress ulcer prophylaxis
    - Albumin
    - DVT prophylaxis

    (Specify exceptions and list rationale below)
11. Diagnostic/laboratory studies (no standing orders for radiologic or laboratory testing is permitted beyond any 24 hour period.)
12. Medications

B. <u>Resuscitation Status Orders</u>

These orders should be used by physicians to more clearly specify decisions that have been made with the patient and/or family/decision maker regarding code status. IT IS PRESUMED THAT A PATIENT IS A FULL CODE UNLESS OTHERWISE SPECIFIED. PLEASE PLACE AN "X" NEXT TO THE STATEMENT(S) THAT APPLY.

In the event of a cardiopulmonary arrest, the patients CODE STATUS shall be designated as:

☐ No cardiopulmonary resuscitation – ALL treatments directed at restoring cardiopulmonary function should be WITHHELD

☐ Limited resuscitation – indicate what should be done with regard to the following measures in the event of a cardiopulmonary arrest

	YES	NO
Intubation/mechanical ventilation		
Chest Compressions		
Defibrillation/Countershock		
Antiarrhythmic Drugs		
Vasoactive Drugs		
Other		
Other		

For the patient NOT to receive a full code No cardiopulmonary resuscitation or limited resuscitation), the rationale for the order is:

☐ The patient has the decision-making capacity and states that he/she does not want full resuscitation to take place.

☐ The patient lacks decision-making capacity and the decision NOT to undertake a full resuscitation is based upon one or more of the following:

☐ Guardian

☐ Health care agent as specified by the power of attorney for health care document Authorized representative (next of kin, per UW Policy _____)

☐ Living will

☐ DNR bracelet (confirmed)

Signature of resident/fellow ________________________________ Date ___________
Signature of attending ______________________________________Date____________

C. THE UNIVERSITY OF WISCONSIN HOSPITAL AND CLINICS
TRAUMA AND LIFE SUPPORT CENTER
CONSENT FOR PROCEDURES

I have been admitted to the Trauma and Life Support Center at the University of Wisconsin. The Trauma and Life Support Center is an Intensive Care Unit where the most seriously ill patients are admitted and cared for by specialty-trained physicians, nurses and therapists who work together as a team to provide the best possible care. Critically ill patients commonly need to undergo procedures to assist in the diagnostic evaluation and/or treatment of their disease. Frequently, there is the need to perform these procedures emergently or when critical illness renders a patient incapable of consent and an authorized patient representative is not available.

I, hereby, give consent to and authorize the giving of treatments and performance of the following procedures, which in the judgment of the ICU physicians may be considered necessary or advisable for my diagnosis or treatment. I understand that some of these procedures may be performed more than once during my admission. I understand that I may refuse to consent for any procedure and that I may, at any time withdraw my consent. These procedures and their use in my diagnosis and treatment have been explained to me and I have had the opportunity to ask questions about the commonly performed procedures and the complications generally associated with them.

These procedures and the most common complications associated with them are briefly described on the attached sheet. Additional written information about each procedure is available in the family waiting area.

I give consent for the following procedures:

Intubation
Mechanical Ventilation
Central Line Insertion
Pulmonary Artery Catheter Insertion
Arterial Line Insertion
Peripherally inserted Central Line

Lumbar Puncture
Paracentesis
Thoracentesis
Chest Tube Insertion
Bronchoscopy

I have read and understand this form.

Signature of Patient: ____________________________Date:___________Time:____________

Signature of person
Authorized to consent
For the patient: ____

Relationship to patient: ____

Witness to signature: ____

Signature of Licensed
Physician explaining
And obtaining consent: ____Pager#___________

COMMONLY PERFORMED PROCEDURES AND THE MORE COMMON POSSIBLE ASSOCIATED COMPLICATONS

Patients in the Trauma and Life Support Center may have many procedures done to assist in the monitoring and management of their care. Below are some of the more commonly performed procedures and their more commonly associated complications:

INTUBATION: An endotracheal tube (ETT) is placed into the patient's mouth and down into the trachea (windpipe) to allow the delivery of oxygen directly into the lungs. It is a plastic tube that curves to fit the windpipe. Once placed, the tube is connected to a ventilator (breathing machine).

Complications: bleeding, injury to the vocal cords, extubation (the tube comes out for some reason such as slipping out or pulled out by accident), disturbances in the heart beat while the doctors are trying to place the tube in the throat, tube put in the wrong place, infection, patient's oxygen level may go down while the doctors placing the tube in the throat

MECHANICAL VENTILATION: The patient is connected to a breathing machine called a mechanical ventilator (respirator) to help the patient breathe and keep the lungs open.

Complications: pneumothorax (air leaks into the chest cavity), pneumomediastinum (air leaks into the space in the chest cavity between the lungs).

CENTRAL VENOUS CATHETER INSERTION: A small plastic tube is placed in one of the patient's major veins. This special IV allows the medical team to give nourishment and medicine to the patient and also monitor the pressure in the patient's vein. Sometimes this procedure may need to be repeated during a hospitalization, particularly if the patient remains in the ICU for an extended period of time, or if the patient develops a fever.

Complications: bleeding, infection, accidental puncture of an artery, tube not put in the

correct place, needle used to place catheter accidentally going through the lining of the lung and allowing air to leak out of the lung, pain while placing catheter

PULMONARY ARTERY CATHETER INSERTION: A thinner tube is placed through an existing central vein tube to measure the pressure in the heart.

Complications: damage to the valves of the heart, damage to the blood vessels of the lung, irregular rhythms of the heart, information obtained from the tube might not be understood correctly and might lead to mistakes in managing the patient

ARTERIAL LINE: A tube is placed in one of the patient's arteries. This catheter allows the medical team to monitor the patient's blood pressure, oxygen and carbon dioxide precisely. This catheter also allows the medical team to draw the patient's blood often without sticking the patient each time. This procedure may need to be repeated if the patient remains in the ICU for an extended period of time, or if the patient develops a fever.

Complications: bleeding, infection, reduced blood flow to the limb that has the tube, pain while placing catheter, inability to complete the procedure

PERIPHERALLY INSERTED CENTRAL CATHETER: This is a more long term I.V. It is a long thin tube or catheter placed, usually, in the arm and goes into one of the major veins. It is usually placed to give medications that can only be given through the veins. It is an I.V. that can be safely maintained for several weeks.

Complications: bleeding, infection, displacement of the tube into the heart, blood clot formation

LUMBAR PUNCTURE (spinal tap): A small needle is placed between two of the bones in the lower back. The needle goes through the sac that contains the spinal cord but not at a level where the nerves are present. Spinal fluid is removed and tests are performed that may help explain the patient's illness. The procedure may also be done to relieve increased fluid pressure in the brain.

Complications: infection, headache, feeling of burning or tingling, pain during procedure

PARACENTESIS: A tube is placed in the patient's abdomen to remove fluid. The fluid that is removed can assist in the diagnosis or treatment and/or to help in deciding the patient's diagnosis
Complications: infection, bleeding, rapid decrease in blood pressure, accidental puncture of the bowel

THORACENTESIS: A tube is placed between two ribs into the chest to allow the removal of fluid from the chest cavity. The fluid can be sent for tests to aid in the patient's diagnosis or to make the patients more comfortable, by relieving some of the pressure on the lungs.

Complications: pain during placement, bleeding, accidental puncture of the lung causing collapse

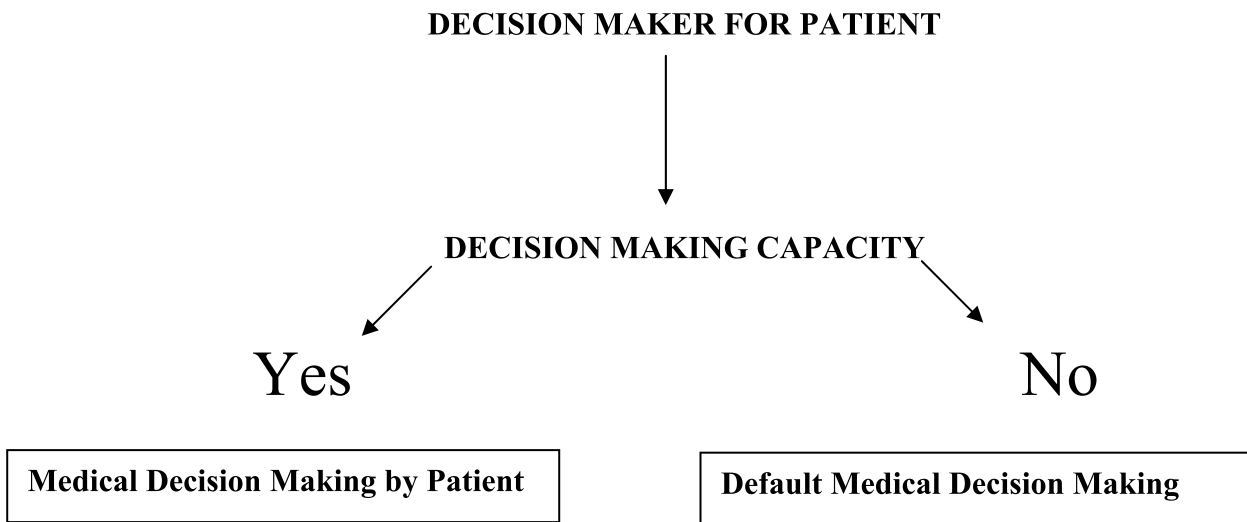
CHEST TUBE INSERTION: A tube is placed between the ribs into the chest to allow for the removal of air and/or fluid. This is similar to the above thoracentesis but is usually done with a larger tube.

Complications: Pain during placement, bleeding and accidental puncture of the lung.

BRONCHOSCOPY: A fiberoptic tube is inserted into the trachea (windpipe) and is used to inspect the inside of the lung, remove fluids or material that will assist in defining the diagnosis or treatment.

Complications: bleeding, lung collapse, heartbeat irregularities

D. IDENTIFICATION OF MEDICAL TREATMENT



Be attentive to previously defined documents executed by the patient (living will, Nursing Home documents, etc.) that do not specifically define a decision maker but specifically define the patients' wishes for medical treatment.

☐ Court appointed guardian

☐ Power of Attorney for Heath Care (HCPOA)
- ☐ Copy of HCPOA on file
- ☐ HCPOA activated
- ☐ Advanced Directive

☐ Authorized Representative (UWHC P&P #4. 37)
- ☐ Spouse
- ☐ Adult son or daughter
- ☐ Parent
- ☐ Adult brother or sister

□ Other close relative or in absence of any relatives, a close friend

DEFINTIONS

Decision-making capacity: the ability to receive information and understand the consequences of one's decision, and to communicate decisions to such an extent that the individual patient can manage his/her own healthcare decisions. Mere old age, eccentricity, or physical disability, singly or together, is insufficient to make a finding of capacity. Mere disagreement by the patient with the healthcare providers is insufficient for a finding of incapacity.

Guardian: A court appointed person to make medical treatment decisions on behalf of an incompetent person or a minor. The guardian is authorized to make decisions within the scope of the guardianship. Note, Wisconsin law places some limits on the authority of guardians to make decisions regarding withdrawing life-sustaining medical treatment. For more information, contact UWHC Legal Department or Patient Relations.

Power of Attorney for Health Care: a legal document completed by an adult with decision-making capacity. The document designates an individual, known as a Heath Care Agent, to make decisions for him or herself. The document also gives instructions to health care professionals as to the patient's desires about health care decisions.

Note: two other forms of Advance Directives include:

- DNR Bracelet (see UWHC P&P # 8.23)
- Declaration to Physician (Living Will)

Related UWHC Policies & Procedures:

Note these hospital policies references

- Advance Directives #4.37
- Informed Consent #4.17
- Do Not Resuscitate #8.23
- Guidelines for Giving Care When Patient's Refuse #8.24
- Guidelines for Decisions to Limit Life-Sustaining Medical Treatment #8.25

E. Admission Notes

Required on all patients and should follow the conventional format.

CC
HPI
Meds
Allergy
PMH
PSH
Social
Family
Review of Systems
Physical Exam
Impression/Assessment
Plan

An assessment or impression should include an attempt to define the principle differential diagnosis followed by a systems oriented assessment and plan.

F. Progress Notes

Daily progress notes are required on all patients on the service. As previously discussed, supervising residents should write notes on their patients and must review intern/student notes before co-signing. Progress notes should also have a defined assessment or impression followed by a systems specific assessment and plan. It is important that the progress note reflects on-going developments in addition to the initial problem and define the system specific management. The format below is encouraged.

- Subjective and interval history
- Arbitrary information
  - Meds DVT Proph
  - Lines Nutrition
- Lab/radiologic studies
- Physical examination
- Impression/assessment
- Systems specific assessment/plan

G. Event Notes

Significant developments that occur throughout the patients course should be thoroughly documented, particularly at night and especially with the cross coverage system in place as this provides the rationale for changes in therapy or condition.

H. Off Service Notes

When leaving the service, a summary note of the case should be written so as to facilitate the transition and provide continuity of care. When a patient is transferred out of the TLC after a prolonged stay (≥ 7 days), a discharge summary of the patients course to that point should be dictated. This should be stated in the chart to avoid re-dictation.

I. Procedure Notes

ALL procedures need to be documented with the generic procedure stamp found at the unit clerks desk or if unavailable in the following format:

Date with year and time
Procedure
Operator
Indication
Consent
Anesthesia/Medication
Complications
Supervised By

J. Pronouncement/Autopsy

All patients who die in the TLC require a pronouncement note and if unexpected a call placed to the staff triage officer. An attempt to obtain autopsy consent on all patients dying in TLC is expected and confirmation of this should be documented with the pronouncement note. Consent for autopsy requires completion of the autopsy form, which is available from the unit clerk. Consent or refusal must be documented on the autopsy request form and if consent is obtained, the section on the autopsy form that pertains to "physicians request of the exam" should be completed. The Medicare Conditions of Participation require that ALL imminent deaths be reported to the OPO for transplant evaluation. Clinical triggers for referral to the OPO for evaluation include severe brain injury and Glascow coma scores of ≤ 5.

K. Discharge Summaries

All patients discharged from the TLC require a dictated summary. In reality this is a small number as relatively few are discharged home and the remainder are those who die. It is the responsibility of the supervising resident of that patient (NOT the covering resident) to secure the chart and dictate the summary within 24 hours of the expiration. Failure to do so will have implications related to the rotation evaluation.

IV. Procedures

The TLC is a cornucopia of procedures related to critical care and the adage DO NO HARM has fundamental relevance in this circumstance. Procedures should be carefully planned and judgment exercised regarding their necessity and available alternatives. They should be performed without supervision only when certified to do so. Under no circumstances may junior housestaff perform procedures that they are not credentialed to undertake. Procedure experience accrues quite quickly given the patient numbers. Documentation of all procedures and attempts using the procedure stamp or format is required.

V. TLC Personnel and Services

Patient care in any multidisciplinary critical care unit is optimally accomplished by having open lines of communication and approaching this responsibility in a collaborative fashion. This is applicable to the various services as well as to the TLC staff groups below. As previously discussed, AM teaching rounds are jointly attended by a representative of each group.

A. Nursing Personnel

1. Care Team Leader

The south (beds 1-12) and north (beds 13-24) sides of the TLC each have an assigned care team leader (CTL) for that side at all times. Care team leaders are the senior nursing clinicians and are responsible for: staffing, triage and facilitation of TLC patient throughput, coordination of general unit activity, communication with the Access Center and other departments/floors and are available for problem solving on a wide variety of issues. The CTL should be apprised of all admissions and transfers in and out of the unit. All patients going on “road trips” or having bedside procedures need to be discussed with the CTL.

2. Senior Team Member

The senior team member is an experienced nurse clinician who replaces the CTL when necessary

3. Nursing Staff

The nursing staff consists of the following:

- 92 Registered Nurses
- 24 Nursing Assistants
- 6 Unit Clerks
- Float staff and Per Diem Nurses to support high census

- Clinical Nurse Manager
- Patient Care Coordinator
- Critical Care Clinical Nurse Specialist

Nurse staffing is based upon patient acuity. Generally a 1:2 nurse-patient ratio is the norm although 1:1 or 2:1 will be utilized for critically unstable patients. Admission designation of IMC or ICU status is important in establishing ratios and shift staffing. This status should be clearly defined upon admission. Each patient will have a designated nurse (on census board) committed to continuity with that patient. The nurse is an integral component of the care of the patient acting as the communicator between physicians, services and families. The nurse often acts as a patient/family advocate and should be a part of discussions with families, especially in cases of withdraw of therapy. It is the nurse with whom the following should be addressed:

- Daily plan discussed on teaching rounds
- All stat or important orders
- All procedures
- All road trips
- Family direction of care discussions

4. Nursing Standards

- Cardiopulmonary monitoring for all patients
- Vital signs q 1° or 2°
- Hemodynamic parameters q 4°
- IV infusions on volumetric pump - Do Not cancel alarms independently
- Nosocomial pneumonia prophylaxis
- Daily weights done early AM
- "Daily" (requires an order) labs done 0400
- "Daily" (requires an order) CXR done at 0500
- Neuro exams q 1° or 2°
- Nursing assessment q 4°
- Also, see Critical Care Nursing Standards of Care of the Adult ICU patient which can be found on CRIT.

6. Order Writing

Orders are in front of the brown charts, which are placed in numerical racks by the unit clerk station. The following should be observed when writing orders:

- Hospital policy mandates that all orders be signed, legible, dated, timed and include the pager number.

- Radiologic and transfusion orders should be accompanied by a written indication.
- ALL stat and important orders should be discussed with the nurse so as to facilitate implementation
- ALL medical student orders must be co-signed before being carried out.
- ALL respiratory therapy or ventilator orders should be discussed with the respiratory therapist so as to facilitate implementation.
- Verbal orders are NOT acceptable and can only be used when medical necessity precludes physician order writing. Verbal orders need to be signed, dated and timed within 48 hours. Note that unit clerks and students cannot accept any verbal orders.
- Orders should be written on rounds at the discussed patients bedside to expedite their implementation.
- CTLs and HUC's can assist in obtaining special order forms such as antibiotic, heparin and insulin standing orders.

7. Procedures

Scheduling of bedside procedures should be coordinated with the nurse or CTL. Line changes or procedures that require positional changes should be done in concert with the nurse at the bedside. Gathering and disposing of procedural supplies is the responsibility of those performing the procedure. All sharps must be disposed of properly by the operator and universal precautions utilized at all times -- this means sterile gowns, gloves, masks and protective eye wear for all procedures which are a potential biohazard.

8. Family Visitation

Visiting hours are generally between 8 AM and 9 PM although access is restricted between 7 AM – 8 AM and 7 PM – 8 PM to give nurses the opportunity to give-receive report and assess the patient prior to visitation. Families report to the TLC waiting room and call the unit to arrange times individually after discussion with the nurse. Please do not indiscriminately bring family members to the bedside without nurse clearance as a procedure, bed changing, catheter changing etc. may be in progress.

9. Road Trips

- Many critically ill patients will require transport during their stay in TLC. This should always be planned, discussed and coordinated in advance with the nurse or CTL. Implicit in transport is the provision of a comparable level of care and monitoring similar to the TLC. At the discretion of the care team

leader, a physician may need to accompany the patients on transport.

10. Charting

The patient flow chart should be kept in close proximity in the patients room when being reviewed and returned to the chart rack when finished. Flow charts and patient charts may not leave the unit except for road trips.

B. Respiratory Therapy

There are generally 2-3 respiratory therapists covering the TLC and invariably a therapist is in the unit at all times. The pager number for R.T. is on the board at the R.T. substations located in the TLC. The unit uses Servo 300c, and Servo-i ventilators (pressure, flow, volume monitoring available). Ventilator checks are done every 4 hours and ventilation flow charts are kept at the patient room door. Respiratory therapists will assist on all intubations and bronchoscopies. Routine extubations will be performed by the respiratory therapist and registered nurse. Please note the following:

- Respiratory Protocols
  - Initiation of mechanical ventilation
    Ventilation settings will be initiated by protocol unless otherwise specified
  - Weaning Protocol
    All patients will be assessed for weaning potential on a daily basis by the respiratory therapist via the weaning protocol
- All ventilator changes require a written physicians order and will be made by the respiratory therapist
- Initiation of unconventional ventilatory modes (i.e.: pressure control) requires the presence of the Pul/Crit Care Fellow or staff.

C. Nutrition

All patients in the TLC are evaluated by the TLC clinical dietician. Specific consultative support is available via the Nutritional Support Service.

The following are some helpful hints for writing nutrition orders:

1. Oral diet:
When a patient is transferred from another unit (UWHC) to TLC, his/her previous diet order should be discontinued and a new diet order is written by the TLC admitting physician. Please remember to write NPO if the patient is intubated in order to minimize food wastage.

2. Tube feeding:
A complete TF order includes: formula name, concentration (full strength or half strength), the starting infusion rate and the final goal rate. Please remember to write a D/C order when TF is held for longer than a day so that patients will not be charged. A new complete order is required when TF is resumed. Please see protocol (under Guidelines) for enteric feeding.

3. Parenteral feeding:
A TNA order form must be filled out when ordering a new TNA or making changes to an existing TNA. The deadline for TNA orders is 1400 hours. The dietitian or the pharmacist can assist you with your TNA orders. TNA solutions are compounded for infusion over a 24 hour period. TNA is hung between 2000 to 2200 hours each evening.

D. Pharmacy

The TLC North and South both have individual pharmacy stations and a pharmacist is available at all times for processing drug orders, providing drug information on dosing, pharmacokinetics, cost comparisons and recommendations for drug levels as well as drug selection/interactions. In the era of cost containment information regarding cost considerations of various drugs and how they are administered (i.e.: NG vs IV, drips vs PRN) should be solicited from pharmacy so that we practice cost efficient medicine. Note the following protocols are or will be in place for specific drugs and are located in the Appendix.

- Potassium replacement
- Paralytics
- Analgesia and Sedation
- GI prophylaxis
- Albumin
- Antibiotics guidelines
- Heparin
- Insulin drip
- DVT prophylaxis

E. Coordinated Care

1. Social Worker
A social worker is available for consultation regarding many of the non-medical issues that confront patients and families during the period of critical illness. Consequences of TLC hospitalization and its impact on families are often unrecognized by the medical staff and providing support to family members of the critically ill is a component of treating the patient.

At a time of serious illness or trauma, the Social Worker is available to provide supportive counseling, crisis intervention, and information about financial, legal, and

community resources for patients and family members.

Through collaborative efforts with other staff, the Social Worker may meet with families to assist with treatment decisions, sort out complicated questions about advance directives, or assist with the pursuit of establishing a legal guardian. The Social Worker may also assist with very fundamental concerns, such as temporary housing and emergency funding for family members.

The Social Worker can be consulted through the Action 2000 consult process or can be contacted in person or via paging. The Social Worker is usually available M-F from 8:30 to 5:00. There is an On-Call Social Worker for emergencies in the evening and on the weekend.

2. Nurse Case Manager
   A nurse care manager is constantly available to assist with discharge planning, facilitate the interaction with referring physicians/hospitals and coordinate the transfer of patients back to referral hospitals.

3. Chaplain
   A Chaplain is available for spiritual support routinely between 8 AM and 5 PM Monday – Friday and on call at other times.

VI. Laboratory and Diagnostic Studies

Judgment and discretion should be strictly utilized when ordering various studies with careful consideration given to the necessity of the test or study, the potential impact on patient management and the cost/patient charges. Appropriate lab and radiologic information should be known and available for all teaching rounds. This should not be construed to mean a plethora of standing labs are to be ordered every morning at 0400 for AM rounds. In fact, quite the opposite is true, there should be NO standing orders written but each test or study should reflect a conscious thinking process relevant to patient care. Excessive ordering of lab test is costly and depletes the patient of a precious endogenous resource-blood. Appropriate studies should be ordered for the next day on the preceding PM after review of the case and defining the necessity of studies. An important component of resident evaluation is assessment of the effective utilization of laboratory and special studies.

VII. Family-Patient Progress Discussions

Housestaff participation in family discussions is an integral component of the intensive care experience and should be encouraged as the critically ill present a unique exposure to issues regarding medical care and its continuance or withdraw. Housestaff should feel comfortable keeping the family apprised of the patient's progress as frequently as necessary. Discussions pertaining to major issues of patient care or a change in case direction should jointly involve the TLC staff, fellow and the patient's primary nurse. As previously noted a social worker is available on an as needed basis and should be

consulted as necessary. Often times the social worker is instrumental in coordinating and helping the families of TLC patients when they are confronted with the myriad non-medical problems critical illness imposes upon family members.

VIII. Housestaff Evaluation

Evaluations are done by the TLC staff with the greatest exposure to that housestaff and are forwarded to the respective departments. A mid rotation verbal discussion-evaluation with each housestaff is expected. Integral components include knowledge of and participation in cases, preparation and contributions to rounds, presentations, note writing skills and promptness/attendance.

Description under revision

PGY-3 ELECTIVE

The Elective is a four week rotation put together by the resident. There is no scheduled night-call, enabling the resident to make elective arrangements out of town, if desired. All the possibilities listed below are options that have been previously approved. An elective on any of these services will be approved, unless the resident has previously identified remedial needs that are not addressed by her/his elective plan.

Customized elective plans are possible, but subject to verification and approval by the program director in consultation with the chair and/or the Residency Education Committee. Proposed elective schedules must be submitted to the Program at least six weeks prior to the beginning of the elective rotation, accompanied by the resident's written description of his/her desired learning objectives for each elective component.

To insure malpractice coverage under the State insurance plan, all rotations outside of the University of Wisconsin System must be approved by the Associate Dean for Clinical Affairs. Please contact Rhonda Wildes to help you secure this approval. She will need the name of the sponsoring institution, the dates of the rotation, the name and address of the person responsible for evaluating the rotation, and the reason why you desire this off-site rotation. Timely submission of the request to the house staff office is essential. No rotations outside of the United States will be approved.

Previously approved elective options:

1. Anatomy Lab at UW Department of Anatomy, Contact Dr. Edward Schultz 263-2894

2. Breast Clinic at UWH, Contact Dr. Sharon Weber, 266-6094

3. Clinical and Cancer Genetics, Waisman Center & UW Cancer Center, Contact Dr. David Wargowski 263-8687

5. Cytology Laboratory, Contact Dr. Daniel Kurtycz 262-9461

6. Mammography at UWH, Contact Radiology Housestaff Secretary 263-8310

8. Obstetrical Ultrasound at Meriter Hospital, Contact Barb Trampe, RDMS 267-6359

9. Pregnancy Terminations, Contact Dr. Dennis Christensen, 251-7000

10. Pelvic Dissection at UW Department of Anatomy (limited availability), Contact Dr. Edward Bersu 262-3476

11. Sexually Transmitted Disease Clinic at Student Health Service, Contact the Student Health Service 262-7330

12. Urogynecology at UWH, Contact Dr. Thomas Julian 263-5573

13. Research, Arrange through identified staff mentor. (See "Resident Research and Presentations" section for affiliated basic science labs)

Description under revision

PGY-3, PG-4 FLOAT

This rotation is designed to ease the burden on the PGY-4 residents as they are short one resident this upcoming year. The rotation will also provide an opportunity for the PGY-4 at St. Mary's Gyn to get some outpatient gyn experience with Dr. Mullins and Dr. Ablove. The plan is for the PGY-3 to cover St. Mary's gyn on Wednesdays to allow the PGY-4 to attend Dr. Ablove's and Dr. Mullin's clinic. The PGY-3 may also be used to cover vacations for residents to ease the stress on that specific rotation. When the resident is not covering St. Mary's gyn or floating, it will be their responsibility to cover the RCC. They attend all MFM clinics, follow-up on RCC labs, answer RCC questions from nurses, and see add-on patients as necessary. The resident will take call mainly at St. Mary's, but may be on call at another hospital if needed to help with coverage.

Rotation eliminated for 2009-2010

PGY-3 RESEARCH/FLOAT

This rotation is a combination of dedicated research time and vacation float coverage. This eight week rotation includes four weeks dedicated to research and four weeks of vacation coverage. The schedule is determined by the scheduling committee based on vacation and service needs, with final approval by the residency director.

RESEARCH – Four weeks of research activity toward completion of a senior research project as detailed in the Resident Research Program. Activities should be under the project mentor.

FLOAT –

The PGY-3 on float covers vacancies on services created by resident vacations.

The PGY-3 on float falls into the call schedule for the service they are covering.

The PGY-3 on float attends continuity clinic on the day of the absent resident.

If a vacation is taken, it is to be one of the four research weeks.

Description under revision

Residency Rotation Guidelines & Objectives
Service: UW Hospital ER/Gynecologic Oncology Night Float **Level:** PGY-2 - PGY-3

OVERVIEW

Goals

Improve resident exposure to ambulatory and acute gynecologic issues. Improve patient care when "on call" for Gyn Onc service.

Duty Hours & Locations

The ambulatory Gyn night float rotation will consist of a month of night float for third- and second-year residents. This will be a "home call" rotation with the primary responsibility of gaining urgent Gyn triage experience. The resident will continue to cover the UW ER for Gyn consults. In addition, the resident will cover the Meriter ER for Gyn consults. This resident will also cover Gyn Onc floor patients and phone calls.

UWHC Coverage:

- The night float resident will arrive at UW at 1800 for gyn onc sign-out, preferably being able to do bedside rounds with the team. The night float resident will tie up any loose issues on the floor and scrub residents out of the OR after 1900 as needed.
- The remainder of UW coverage will remain unchanged from its current status (i.e. covering patient phone calls and ER consults).
- The night float resident will be available for phone sign-out to both GYN services until 0730.
- The night float resident will work Sunday night through Thursday night, 1800 to 0730.
- If the resident is not able to cover an aspect of care related to the GYN ONC service, to the patients on the floor or in the UW ER because they are involved in urgent matters at Meriter, the page will be forwarded to Gyn Onc fellow or resident on backup call. The Meriter night float resident will be available as back up for any issues at Meriter Hospital, including coverage of the ER if the UW night float resident is involved in urgent matters at UWHC. If the resident is not able to cover a call from the UW ER, they will forward the page to the benign gynecology attending.

Meriter Coverage:

- The night float resident will also receive sign out from the Benign Gyn team at Meriter (via phone at 1900) and will cover all gyn consults and questions from the Meriter ER.
- If the resident is not able to cover an ER consult or address an issue on the floor, he/she will contact the OB night float senior for coverage.

Weekend Call:

- Weekend call, consisting of Friday and Saturday as 24h call shifts and Sunday as a 12-hour call shift, will be divided amongst the UW Gyn Onc, UW Benign Gyn and REI residents. Interns will continue to have senior resident back up when on call, thus there will be four call "slots" to cover three nights of weekend call. This should allow for one 24 hour period off every 7 days.

RCC: Continuity Clinic for one half day each week per continuity clinic schedule.
Other: Attend Thursday morning M&M.

Rotation new for 2009-2010

Recommended Resources for Residents

Latest Edition of:

- Beckmann CRB, Ling FW, Barzansky BM, Herbert WNP, Laube DW, Smith RP: Obstetrics and Gynecology, Lippincott Williams & Wilkins
- Gabbe S, et al: Obstetrics: Normal and Problem Pregnancies, Churchill-Livingston
- Cunningham FG, et al: Williams Obstetrics, Appleton & Lange
- Berek J, Hacker N: Practical Gynecologic Oncology, Lippincott Williams & Wilkins
- Dickey RP: Managing Contraceptive Pill Patients, Essential Med Info Systems
- Callen: Ultrasonography in Obstetrics and Gynecology, Saunders
- DiSaia P, Creasman: Clinical Gynecologic Oncology, Mosby
- Katz: Comprehensive Gynecology, Mosby
- Rock J, Jones HW: TeLinde's Operative Gynecology Updates, Lippincott Williams & Wilkins,
- Speroff L, Fritz M: Clinical Gynecologic Endocrinology and Infertility, Lippincott Williams & Wilkins
- Gabbe S, et al: Obstetrics: Normal and Problem Pregnancies, Churchill-Livingston
- Creasy & Resnick: Maternal fetal Medicine Principles and Practice, Saunders
- Sweet R and Gibbs R: Infectious Diseases of the Female Genital Tract, Lippincott Williams & Wilkins
- Kovac SR, Zimmerman CR: Advances in Vaginal Reconstructive Surgery, Lippincott Williams & Wilkins
- Bent A, Cundiff G, Swift S: Ostergard’s Urogynecology and Pelvic Floor Dysfunction, Lippincott Williams & Wilkins
- Simpson, Golbus: Genetics in Obstetrics and Gynecology, Saunders
- Gabbe S, et al: Obstetrics: Normal and Problem Pregnancies, Churchill-Livingston
- Emans T, et al: Pediatric and Adolescent Gynecology, Little Brown

ACOG Compendium of Selected Publications

Cochrane Library Reviews

UpToDate (available to all residents)

PubMed

Note: each rotation description contains pertinent resources

Last Revision: 6/2/2009