Introduction

Departmental Faculty

Salary & Benefits

Stipend Levels

Loan Deferments

Travel Expenses

ACOG Junior Membership

Vacation Policy

Rotation Descriptions by PG-Year

Resident Education and Duties

Educational Goals

Duty Hour Policy

Attendance Policy

Nondiscrimination Policy

Interpersonal Skills/Patient Satisfaction

Primary Care/Continuity Clinics

Teaching Conference Schedule

Topics for Minimally Invasive Surgery Lectures

Acceptable Case List Abbreviations

Recommended Reading List
Call Guidelines

Guidelines for Situations Requiring Personal Evaluation by Residents at UWHC

Staffing Emergency Department Patients at UWHC

HIPAA Guidelines

Medical Records

Schedules

Master Rotation Schedule

Ambulatory Clinics and Continuity Clinics Schedule

ROTATION DESCRIPTIONS

PGY-1

Meriter Obstetrics and Night Float

Obstetrical Ultrasound

UWHC Gynecologic Oncology

University Health Service & Family Planning

Emergency Medicine

PGY-2

Meriter Benign Gynecology

UWHC Gynecologic Oncology

UWHC Reproductive Endocrinology

Clinics Rotation

Ultrasound/Research

St. Mary's Obstetrics Night Float

TLC
PGY-3

Meriter Perinatal Clinic
Meriter Senior Night Float
Meriter Benign Gynecology
St. Mary’s Obstetrics
Elective
Research/Float
PG-4 Float

PGY-4

Meriter Obstetrics
Meriter Benign Gynecology
UWHC Gynecologic Oncology
UWHC Gynecology, Urogynecology and Pelvic Surgery
St. Mary’s Gynecologic Surgery

ACGME Case Logs

Performance Evaluation

Remediation Policy
Due Process

Resident Presentations and Conferences

Grand Rounds
Perinatal Conference
Didactic presentation

Features of Effective Slides
A Letter to the Next Speaker

Stop Annoying Your Audience

Principles of Effective Writing

Journal Club

Format for Journal Club

Finding a Job

Recruitment Firms

Letters of Reference, Telephone Communications

Board Certification

Additional Resources
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
INTRODUCTION

The University of Wisconsin residency program in Obstetrics and Gynecology consists of rotations at the University of Wisconsin Hospital and Clinics, Meriter Hospital, St. Mary's Hospital Medical Center, the University’s Student Health Service, Wisconsin Planned Parenthood and various other outpatient clinics. All are located in Madison, Wisconsin. The University's Department of Obstetrics and Gynecology is responsible for the organization, content, and the overall administration of the residency program.

Residency is a combination of education and service under the supervision of the full time and volunteer faculty of the Department. You will participate in the care of women who are private patients as well as patients from your own clinics. In the hospitals participating in this residency, there is no difference in the level of participation, services or quality of care for either group. Your appearance, attitude and concern for the patient's health and feelings will determine in large measure the degree of success of the personnel and institutions essential to your education.

It is important to understand the pattern of clinical care utilized by the faculty of the University. Departments are organized into practice units which may be department-wide, divisional or even smaller subgroups. Each unit emphasizes a team approach to patient care. The team consists of staff physicians, residents and medical students. Levels of responsibility assigned to various members of the team are delegated by the staff physician with regard to experience, background and capability of the individual. The relationship of the staff physician to all patients under his or her direct care is signified by his or her signature and notes at various places in the record and on the discharge summary or letter. (The rules of the medical staff of the University Hospital require that all progress notes by residents or medical students be countersigned by a staff physician.)

The staff physician renders service to patients in varying degrees. The maximum service would be performance of all procedures. The minimum level of service would be supervisory review of the patient's history and findings with confirmation of major points by personal examination, and supervision of technical procedures. The goal is to provide good care for all patients while affording educational opportunities for students, residents, and others. Attending physicians will almost always be present during surgery, deliveries and other procedures. Their responsibility is to provide supervision and teaching appropriate to that resident's or student's level of training.

It should also be recognized that faculty appointment does not require competence in all of the specialized techniques of modern reproductive medicine. Even senior staff may defer to subspecialty colleagues with regard to management plans and specialized procedures.

Patient fees are important to the function of the Department, the Medical School and the hospitals participating in the residency. Documentation of staff supervision and participation in patient management is important in avoiding third-party challenges to billings for services rendered. Compliance with all aspects of documentation is necessary, including signatures of verbal orders and timing, dating, and staff signature on chart notes. All dictated notes must state clearly the staff
physician's level of involvement in the case.

Management plans discussed and formulated with staff should be stated in the progress notes. Services (equipment, dietary consultation, respiratory therapy, etc.), all laboratory tests and procedures (even those you perform yourself) should be entered on the order sheet and patient record. In cases where the patient is managed totally by the resident, it is the Department's policy to submit no professional charge, but documentation of all care should be present.

The clinical (volunteer) faculty are very important to this program. Their experience and willingness to share their patients are essential for your education and training. The volunteer faculty participates in the residency out of dedication to postgraduate medical education and without remuneration from the University. You provide them with assistance, and they provide you with the benefit of their knowledge and access to patients. They will "turn over" surgery and procedures in proportion to their assessment of your overall abilities. Your contacts with their patients must always be professional, appropriate, and enhance their care. You should document discussions of patient management, orders, and procedures for the patients of the volunteer faculty just as you would for the full time faculty.

In addition to your role as student, physician and trainee, you have an important role as a teacher of medical students and junior residents. Residents often have more extensive and direct contact with medical students than do the faculty. Therefore, you will have the most immediate opportunity to teach clinical skills, to evaluate student performance and to be a role model for students considering Obstetrics and Gynecology as a career.

During residency you will rely upon many members of the health care team: nurse-practitioners in the high risk obstetrical clinic, nurses in the inpatient units and outpatient clinics, and operating rooms; diabeticians, social workers, ultrasound technicians and many others. These people have knowledge, skills, and experience from which you may learn. All are members of the health care team, and your interactions with them should be professional and cooperative.

The residency includes many learning opportunities other than patient care. Attendance at the weekly grand rounds and case review conferences is required of all residents, and first year residents are required to attend the July and August didactic lectures. Elective surgical cases may not be scheduled in conflict with grand rounds. Scheduled didactic sessions are also required unless prevented by emergency clinical responsibilities. Other teaching conferences should be attended by the residents on specific services: e.g., the weekly perinatal conference, and FHR tracing conference for residents on obstetrics at Meriter Hospital, the weekly oncology conference, the general gynecology conference, and the endocrinology conference.

Each resident is required to carry out a research project during the residency, and to present the results at a special Research Day during his or her senior year. The full time faculty may advise you in the selection of a project, and will guide you in the planning and implementation of the project. You should choose your project by the end of your first year. Do not wait until your third year elective rotation to start planning your project.
Each resident is also expected to present a Grand Rounds topic. The faculty will be happy to help you select a topic and guide you during the preparation of your talk. In addition, residents will prepare and present other conferences as requested.

Library resources are available at each hospital participating in the residency to assist you in general learning and in the preparation of your presentations. Each resident will also be provided with access to an electronic data-retrieval system to many scientific and general databases. These can be accessed through computers at all hospitals.

The Department provides support for each resident to attend a national scientific or clinical meeting or postgraduate course during the residency. This meeting must be approved by the Residency Education Committee, and is generally attended during the senior year. The Department will also provide support for residents, whose research is selected for presentation at a national or regional meeting, to attend that meeting.

We wish you well and are proud to have you as a member of our department.

Laurel W. Rice, M.D.
Professor and Chair
Department of Obstetrics and Gynecology
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

FULL-TIME AND CLINICAL FACULTY

Professors
David H. Abbott, 263-3583
Ian Bird, 417-6314
Thaddeus Golos, 263-3567
Thomas M. Julian, 263-5573
Douglas W. Laube, 287-2494
Ronald Magness, 417-6314
C.B. Martin (Emeritus)
Laurel W. Rice, 287-2495 (Chair)
Gloria E. Sarto, 417-5566 (Emeritus)
Dinesh M. Shah, 417-6099 (MFM)

Associate Professors
Joseph P. Connor, 263-1209 (Gyn Onc)
Sabine Droste, 417-6099 (MFM)
Theresa M. Duello, 262-7456
Ellen M. Hartenbach, 263-1209 (Gyn Onc)
David M. Kushner, 263-1210 (Gyn Onc)
Dan Lebovic, 263-1218 (Repro Endo)
Barbara J. O'Connell, 267-5433
Katharina Stewart, 417-6099 (MFM)
Jing Zheng, 417-6314

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Tova Aabove, 274-5300
Caryn Dutton, 287-2830
A.C. Evans, 263-1209 (Gyn Onc)
Manish Patankar, 263-1209
Stephen Rose, 263-1210 (Gyn Onc)
Sana Salih, 263-1218 (Repro Endo)
Ziming Yu, 417-6314

Clinical Professor
Klaus Diem, 287-2830

Clinical Associate Professors
Gregory D. Bills, 265-7601
Brenda Jenkin, 242-6840
Maureen Mullins, 242-6840

Clinical Assistant Professors
Cynthie Anderson, 242-6840
Clinical Assistant Professors (cont.)
Laura J. Berghahn, 242-6840
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Larry Charme, 561-858-8998
Dolores Emspak, 265-7601
Joel B. Henry, 265-7601
Mary S. Landry, 265-5600
Kim C. Mackey, 265-7601
Paul A. McLeod, 287-2830
Kim Miller, 828-7610
Meghan E. Ogden, 265-7601
Timothy Raichle, 274-5300
Sherwin M. Rudman, 828-7610 (Emeritus)
Laura A. Sabo, 828-7610
Maria E. Sandgren, 265-7601
Erik J. Wait, 274-5300
Suzanne Welsch, 265-7601

Clinical Instructors (Fellows)
Heather Bankowski, 417-6099 (MFM)
M. Heather Einstein, 263-1209 (Gyn Onc)
Jesus I. Iruretagoyena, 417-6099 (MFM)
Chanel Tyler, 417-6099 (MFM)

Clinical Professors (Volunteer)
Joseph S. Fok, 252-8160
William S. Koller, 252-8160
Karl Rudat, 252-8160
Herbert F. Sandmire, (414) 468-3443

Clinical Associate Professors (Volunteer)
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Susan R. Davidson, 258-6762 (MFM)
Jenny Hackforth-Jones, 233-9746
Paul G. Harkins, (715) 387-5161

Clinical Assistant Professors (Volunteer)
Jean Demopoulos, 260-6003
Karla Dickmeyer, 233-9746
Bruce C. Drummond, 825-3500
Christopher A. Federman, 824-4200
Robert K. Gribble, (715) 387-5161
Paul R. Meier, (715) 387-5161
Rick F. Renwick, (608) 782-7300
Mary L. Stoffel, 233-9746
Faculty appointments and committees

Chair: Laurel W. Rice

Vice chairs: Klaus Diem and Ellen Hartenbach

Division directors: Maternal Fetal Medicine: Dinesh M. Shah
Reproductive Endocrinology and Infertility: Dan Lebovic
Gynecologic Oncology: David M. Kushner
Gynecology: Klaus Diem
Combined Generalists: Gregory Bills
Generalists: Brenda Jenkin
Research: Ronald Magness

Residency Director: Sabine Droste

Associate Residency Director: Laura Sabo


SALARY AND BENEFITS

2007-08 House Officer Stipend Levels
July 1, 2007
(2008/2009 Stipend Levels not available at time of manual update.)

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5/08

"STUDENT STATUS" FOR DEFERMENT OF RESIDENT LOANS

On November 21, 1989, the Congress completed action on the Omnibus Budget Reconciliation Act of 1989. A provision of that bill prohibits the use by medical residents of the "student status" deferment of loans which are authorized by Title IV of the Higher Education Act. These loans include Stafford Student Loans, Supplemental Loans for Students, and Perkins Loans. The reconciliation provision does not affect residents' eligibility for the two year internship deferment. Since the University of Wisconsin has not regarded residents as students, the House Staff Office procedure has been to certify loan deferments only for the first two years of training. Therefore, the provisions of the Omnibus Budget Reconciliation Act will not affect the policies of our office. Residents can still defer loans for the first two years of training. After this time, the Omnibus Budget Reconciliation Act provides that lenders extend "forbearance on the payment of educational loans."
TRAVEL AND EXPENSE GUIDELINES

1. During the four-year residency, each resident may be awarded one outside meeting. Approved meetings will be paid up to a maximum of $1200. The meeting approval is conditional on satisfactory progress in training, adequate recording of ACGME resident statistics, and an 80% or better attendance record at scheduled conferences and didactic sessions.

3. Junior Fellowship membership in the American College of Obstetricians and Gynecologists is paid by the department upon completion of the application by the resident.

4. Only under unusual circumstances will meetings be approved during the first year of residency training.

5. In addition to the meeting referred to above, with approval of the Resident Education Committee, residents may be reimbursed for travel expenses to a meeting where a paper is presented.

6. Residents planning to attend a meeting may only do so with staff approval, following the same procedure as for a vacation request. An e-mail documenting approval by the director of the rotation and plans for cross-coverage must be sent to the program coordinator’s office.

7. Transportation will be reimbursed at coach fare. Mileage will be reimbursed at the going rate up to the equivalent coach air fare. Receipts will be required for any reimbursement.

8. Hotel accommodations: Single occupancy rate will be allowed. Receipt is required. If spouse accompanies resident and a double room is used, only the single occupancy rate will be reimbursed.

9. Meals: Up to $30/day will be allowed. Meals should be itemized individually by the day. Reasonable amounts for meals will be allowed, no receipt required, unless over $25.

10. Obtain travel expense reporting forms from the house staff secretary. Submit completed forms with receipts to the residency coordinator. Reimbursement will not be made unless proper travel expense reporting forms are used. Expenses must be submitted for reimbursement within 6 months.

11. Instead of the meeting, a qualifying senior resident in good standing may request up to $600.- in reimbursement for the one-time purchase of books, CDs or other educational materials.

6/08
The Department sponsors each of its residents as a junior fellow of the American College of Obstetrics and Gynecology. Please obtain the application form from the program coordinator. The department pays both the application fee and annual dues during your residency. With Junior Fellowship comes a subscription to Obstetrics & Gynecology (The Green Journal).
VACATION AND LEAVE POLICIES

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

Departmental Rules
- Residents are allowed a total of 15 weekdays and up to 12 weekend days of vacation per year.
- Residents are granted personal days off during the designated holiday block. This block comprises approximately 15 days around the Christmas and New Years holidays. Scheduling is coordinated by the scheduling committee (represented by the Chief resident, Vice-Chief resident, a PGY-4, PGY-3, and PGY-2).
- Vacations are coordinated by the scheduling committee, ensuring that the manpower needs for the affected services are adequately met.
- Vacations are subject to the guidelines established by the scheduling committee and approval by the program director or department chair. (See rotation descriptions by PG-Year.)
- A maximum of five weekdays may be taken off during a single rotation, unless special arrangements have been made.
- Vacations are explicitly discouraged during the first week of any rotation, during the week that the senior residents take the written Board examination, and during the dates of the CREOG in-training examination.
- Vacation time will not be approved for out-of-department rotations on TLC and ER.
- Absences without approval will be taken without pay, and may result in disciplinary action.
- Call missed due to family/medical/etc. leave, WILL NOT need to be made up.

Absence Request Procedure
1. Vacation time is requested for the entire academic year. Requests should be made in writing (e-mail is OK) to the Chief resident. The final vacation schedule is approved by the program director.
2. All non-vacation absences exceeding three working days must have the approval of colleagues in the affected call and rotation schedules, and must be approved by the senior resident (if applicable) on the affected rotation, and the attending in charge of the affected service. Final approval is granted by the program director or chair.
3. Non-vacation absence requests by residents who are not part of any regular daily service and/or call schedule (PGY-3 Research and Elective, PGY-1/2 U/S*, PGY-1 UHS*), may be submitted to the residency coordinator directly, and will be approved by the program director or chair. (*If absence on these rotations only occur during weekdays. If absence includes a
Friday, Saturday, or Sunday, then the former rule applies.)

4. Conflicting vacation requests will be resolved giving preference to seniority.
5. 2 weeks prior to the start of any scheduled vacation, completeness of each resident's case log will be ascertained (ACGME Resident Case Log System). **THIS INCLUDES ALL SURGICAL AND AMBULATORY STATISTICS TO WITHIN 4 WEEKS OF THE PLANNED VACATION START DATE! FAILURE TO KEEP THE LOG UP-TO-DATE WILL RESULT IN A MANDATE FROM THE PROGRAM DIRECTOR TO USE PART OF THE SCHEDULED VACATION TIME TO UPDATE THE CASE LOG**, and may result in last minute disapproval of the vacation altogether.

6. Absences may not be scheduled more than one year in advance.
7. Reasons for disapproval of any absence request will be communicated to the resident in writing.

**Unused Vacation Time**
Vacation time exists to be used and not "banked", but occasionally all allotted vacation time cannot be used during a given year. In that event, the resident may submit a written vacation carry over request (e-mailed is ok) for approval by the program director. Vacation carry over may not exceed half of the annual allotment, and must be used up by January 1. Carry over vacation may be limited to no call rotations.

Payment for accrued and unused vacation time will be granted upon termination up to a maximum of seven and one half working days. The weekend vacation allotment is not payable.

**Holidays**
Legal holidays are observed, but require clinical coverage like weekends. Observation of religious holidays varies from hospital to hospital.

When scheduling demands do not preclude it, legal holidays are time off with pay as per the guidelines in the current U.W. Madison Staff Benefits publication.

Residents of faiths other than the Christian one may request holiday time off in lieu of observed Christian holidays. Appropriate arrangements are to be made well in advance with the program director and the chief resident.

**Resident Retreat**
Leave is granted for the resident retreat in July.

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

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

Family Leave
UWHC will grant unpaid family leave (leave due to birth of a child, adoption or a serious health condition of a spouse, parent or child, which necessitates the Resident’s care) in compliance with state and federal laws (see medical leave section regarding paid medical leave after childbirth). In order to meet notice requirements, the Resident must contact the GME Office as soon as possible after deciding that he/she intends to take family leave.

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

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

Paid medical leave will never exceed six months (at which time the hospital provided disability insurance will begin), and in some instances may not cover the entire length of absence. For any leave exceeding the initial week approved by the Program Director, the Resident and program must notify the GME Office.

In the event of a short-term disability (i.e. a temporary inability to work as a result of illness, injury, childbirth, etc), the hospital may grant paid leave for a “usual and customary” recovery period. Paid leave after childbirth shall be four weeks, unless the Resident has continuing medical complications certified by her treating physician. All cases will be individually evaluated by the Senior Vice President for Medical Affairs / Associate Dean for Hospital Affairs and the Program Director to determine disability, reasonable recovery period, follow-up requirements, and whether some portion of the leave will be paid.

Personal Leave
A Resident may be granted a leave of absence without pay at the discretion of the Program Director. All unpaid leaves must be reported to the GME Office by the Resident and program.

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

**Military Leave**
Residents may take time off for military service as required by federal and state statutes. The Resident is required to provide advance documentation verifying the assignment and pay to the GME Office.

UWHC will pay the excess of a Resident's standard wages over military base pay for military leaves of three (3) to thirty (30) days to attend military schools and training.

For Residents who are recalled to active duty, UWHC will pay the difference between the Resident’s wages and the active duty military pay for up to one year (average hospital pay over the past year minus military pay). For the first month of recall, UWHC will pay the difference between the Resident’s base pay and hospital pay. For the next eleven months, UWHC will pay the difference between the Resident’s total monthly military pay (limited to base pay, Basic Allowance for Housing and Basic allowance for Subsistence) and the Resident’s hospital pay. If the Resident’s active duty pay is more than his/her hospital pay, UWHC will not compensate any wages.

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

5/08
# ROTATION DESCRIPTIONS BY PG-YEAR FOR 2008-2009

## PGY-4

<table>
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<th># weeks</th>
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<tbody>
<tr>
<td>1.</td>
<td>Meriter OB senior</td>
<td>10 wks</td>
<td>1/wk MER HR</td>
</tr>
<tr>
<td>2.</td>
<td>Meriter gyn surgery</td>
<td>10 wks</td>
<td>(no call)</td>
</tr>
<tr>
<td>3.</td>
<td>St. Mary’s gyn surgery</td>
<td>10 wks</td>
<td>1/wk STM</td>
</tr>
<tr>
<td>4.</td>
<td>UWHC gyn-onc</td>
<td>10 wks</td>
<td>Home call UWHC</td>
</tr>
<tr>
<td>5.</td>
<td>UWHC benign gyn</td>
<td>10 wks</td>
<td>Home call UWHC</td>
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(*Must take one week of vacation on Meriter gyn surgery)

## PGY-3

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<tbody>
<tr>
<td>1.</td>
<td>Meriter senior night float</td>
<td>4 / 4 wks</td>
<td>-----</td>
</tr>
<tr>
<td>2.</td>
<td>Meriter gyn surgery</td>
<td>8 wks</td>
<td>1/wk MER HR</td>
</tr>
<tr>
<td>3.</td>
<td>St. Mary’s OB</td>
<td>4 / 4 wks</td>
<td>1/wk STM</td>
</tr>
<tr>
<td>4.</td>
<td>PG-4 float</td>
<td>4 wks</td>
<td>1/wk where needed</td>
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<tr>
<td>5.</td>
<td>Meriter OB</td>
<td>8 wks</td>
<td>1/wk MER HR or LR</td>
</tr>
<tr>
<td>6.</td>
<td>Research</td>
<td>4 / 4 wks</td>
<td>per float schedule/ no call</td>
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<tr>
<td>7.</td>
<td>Elective</td>
<td>4 wks</td>
<td>(no call)</td>
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(*Must take one week of vacation on Research)

## PGY-2

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<td>St. Mary’s night float</td>
<td>4 / 4 wks</td>
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<td>2.</td>
<td>UWHC – REI</td>
<td>8 wks</td>
<td>Home call UWHC</td>
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<td>3.</td>
<td>Meriter gyn surgery</td>
<td>8 wks</td>
<td>1/wk MER HR or LR</td>
</tr>
<tr>
<td>4.</td>
<td>Clinics</td>
<td>8 wks</td>
<td>1/wk STM</td>
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<tr>
<td>5.</td>
<td>Ultrasound/Research</td>
<td>4 wks</td>
<td>(no call)</td>
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<td>6.</td>
<td>UWHC gyn-onc</td>
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<td>Home call UWHC</td>
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<td>7.</td>
<td>TLC</td>
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(*Must take one week of vacation on Ultrasound/Research)

## PGY-1

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<td>Meriter junior night float</td>
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<td>2.</td>
<td>Meriter OB low-risk</td>
<td>8 / 8 wks</td>
<td>1/wk MER LR</td>
</tr>
<tr>
<td>3.</td>
<td>Student Health</td>
<td>4 / 4 wks</td>
<td>Home call UWHC</td>
</tr>
<tr>
<td>4.</td>
<td>UWHC gyn-onc</td>
<td>8 wks</td>
<td>Home call UWHC</td>
</tr>
<tr>
<td>5.</td>
<td>ER</td>
<td>4 wks</td>
<td>per ER</td>
</tr>
<tr>
<td>6.</td>
<td>Ultrasound</td>
<td>4 wks</td>
<td>1/wk MER LR</td>
</tr>
</tbody>
</table>

(*Must take one week of vacation on Student Health)
June 2008

Dear Doctor:

The members of this department are very pleased to have you in our residency training program in Obstetrics and Gynecology.

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

Learning objectives are clearly stated for each rotation and formal teaching sessions are organized to meet the General and Special Requirements for Ob-Gyn residency programs.

Measurement of the successful attainment of learning objectives occurs through a defined process of resident evaluation, including evaluation by peers, co-workers and patients, the CREOG in-training examination, and twice yearly progress reviews by the program director.

The program endeavors to train compassionate professionals who have a comprehensive medical knowledge base of the specialty, can translate that knowledge into effective patient care, and communicate effectively with patients, their families and the healthcare team. We hope to train “lifelong learners” who will continually strive to improve their own practice, and who effectively use system resources for the benefit of their patients. The ACGME has termed these goals the “Competencies” of Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and Systems-Based Practice. An effort will be made to not only teach, but also to evaluate these competencies.

It is our intention that each trainee will assume graded and increasing responsibility. Sensitivity and responsiveness to our residents' needs are central to the success of the educational mission. To this end, help will be offered as for physical, emotional and didactic special needs.

Records will be kept of all those trained, to allow satisfactory proof of performance and advancement through the residency program.

Whenever appropriate, residents will be consulted in departmental program decisions, and are encouraged to make policy recommendations in open forum, and through their representative to the Resident Education Committee.

Each institution or program participating in the residency training program will provide a contractual agreement committing to ensure that residents are supervised in carrying out their patient care and other learning responsibilities. The level and method of supervision will be consistent with stated guidelines for Graduate Medical Education Programs.

Residents receive a stipend, liability insurance, health insurance, disability insurance, life insurance, a call room, meals on call in the parent institution, laboratory coats, necessary clerical services, library facilities, computer access, and limited research funding. Three weeks of vacation, necessary medical leave and professional meeting times are also provided.
In return, it is our expectation that our residents will:

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

We are all looking forward to a four year long collaboration that will result in you becoming the best physicians you can be. We are also hoping to build relationships that will lead to the establishment of friendships and mutual trust.

Sabine Droste, M.D.
Program Director
The University of Wisconsin-Madison, Department of Obstetrics and Gynecology Residency Training Program endeavors to be in full compliance with the work hour restrictions as mandated by the ACGME.

No resident is to be on duty more than 80 hours per week. The Ob/Gyn RRC’s mandate of one day off in seven averaged over a four-week period is maintained. Continuous on-site duty will not exceed 24 hours and be followed by a minimum 10 hour rest period. The 24 hours on duty “rule” is only to be exceeded by up to six hours for scheduled didactics, or to attend RRC required outpatient clinics. Most off hours clinical activity is covered by a night float schedule at two of our three hospital affiliates, but even call schedules that provide for call from home may not exceed every third night, averaged over a four-week period. Moonlighting is not permitted. Continuity Clinics for night float residents are on Friday mornings. The department faculty is expected to monitor residents closely for signs of fatigue. This especially applies to services where nocturnal duties are covered by residents on call from home. These residents are expected to be excused by noon at the latest, if they were in the hospital working for a substantial proportion of the preceding night’s call shift.

The program is not planning to apply to its RRC for a 10% exception.

Residents are required to record their daily work hours in E*Value. This will be monitored for violations and timeliness in inputting hours.

Violation of this duty hour policy may be communicated in writing, by telephone, by e-mail, or in person, to the program director or program coordinator. Any such complaint will be followed up on as soon as feasible.

6/08
UW-Madison Dept. of Ob-Gyn Work Hours

**Rules**

1. Resident **must** have 10 hours off between shifts.

2. Resident **must** have 24 continuous hours off each 7 days (averaged over 4 weeks).

3. Resident **may not** work more than 80 hours per week (averaged over 4 weeks).

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

10 Hour Rule

- Monday – Friday, rounding begins at 6:00 am, which means you **must** leave by 8:00pm.
- If you are in a c-section or delivery and stay past 8 pm, then you **must** come in late the following morning so that you have 10 hours off between shifts.
- If you are in a gyn surgery and stay past 8:00 pm, then you **must** come in late the following morning so that you have 10 hours off between shifts. The 4th year resident may occasionally break this rule for exceptional learning cases. (If this happens, enter in the comments section on E-Value why you left late).
- Notify senior resident that night that you will be late the next day.

24 Hour Rule

- Saturday, on-call resident will come in at 7:00 am to round.
- Sunday, on-call resident will come in at 5:45 am to round. Sign out will be completed by 6:00 am, and the Saturday call person will leave.
- No rounding should begin before 5:30 am, unless the patient is already awake.
- If you are in a c-section or delivery and leave after 6:00 am, then you **must** come in late the following morning so that you have 24 hours off between shifts. (if this happens, enter in the comments section on E-Value why you left late).
- Notify senior resident that day that you will be late the next day.

**UW work hours and call**

10 Hour Rule

- Monday – Friday, rounding begins at 6:00 am which means you **must** leave by 8:00 pm.
- **Only exception** is if the senior resident is in the OR with a great learning case. This should only be used by the senior resident. If this happens, enter in the comments section on E-Value your reason for leaving late. This is an exception to the 10 hour rule; therefore you do not need to come in late for rounding the next day. Keep in mind, this should not happen often.

80 Hour Rule

- Keep track of your own work hours. Let the senior know if you are close to a work hour violation. You will be sent home.

Home Call Rule

- When you are on home call, if you are in the hospital for > 4 hours after 10:00 pm, you **must** leave by 12:00 pm the next day.
**General Rules**

**DO NOT LIE** on your E-value entries. We need to be sure the system is set up so we **never** violate the work hour rules. We can’t tweak the system without knowing where it may be failing.

Paperwork, OR dictations and discharge summaries/dictations are not valid reasons to stay late and break work hour rules. You need to take time during the day to do these. If you are having trouble getting dictations/summaries done, let the senior resident know.

Many times you will have to pass off uncompleted work. Do the best you can to finish, but remember that you have to leave on time. So, learn to organize, be concise and pass it on.

**E-Value System**

1. Use only the following options:
   a. Planned Work Hours- this is for all scheduled hours given to you on the call schedule regardless of the day to the week. (ex. Sat. Meriter Call is “Planned work hours”)
   b. Called in from home- this is for UW Home call when you come back to the hospital.
   c. Vacation- Your vacation is Monday-Friday, **NOT** Saturday through the following Sunday.

2. Please count work hours as continuous if you finish night float at 8:00 am and start RCC at 8:30 am. Don’t log as two separate shifts as this is flagged as not having 10 hours off between shifts. Should consider this planned work hours from start of night float shift at 7:00 pm until completion of RCC.
Attendance Policy for Scheduled Didactic Conferences

The "core" didactic series of conferences occurs for the benefit of resident education. Residents are excused from routine clinical activities at all three hospitals during M&M, Grand Rounds, Resident Didactics, and during regularly scheduled divisional conferences. Therefore, absences from these conferences will be excused only for illness, vacations, out of town rotations or for coverage of high acuity emergency cases.

Arrival at core conferences is expected to be prompt. The Chair or Program Director may elect to track late arrivals (by removing resident sign in sheets 15 minutes after the scheduled start of a conference) and to consider chronic non-attendance or late attendance in the annual resident performance evaluations.

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

6/08
University of Wisconsin  
Dept. of Obstetrics and Gynecology Residency Program  
Nondiscrimination Policy

The Department is committed to providing equivalent educational experiences to all its residents, regardless of race, gender, ethnic origin or training level. The Department also recognizes that patient’s have a choice with respect to their healthcare providers.

Therefore, if a patient declines the involvement of a particular resident in her care, the patient will no longer be cared for on the UW Ob-Gyn teaching service. There are no provisions for having another resident of different gender, race, ethnic origin or training level cover the responsibilities of the originally assigned resident, regardless of clinical activity or resident availability, with the exception of an emergency. Questions about clinical care are to be routed directly to the patient’s attending.

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

9/05 (reviewed 6/08)
INTERPERSONAL SKILLS AND PATIENT SATISFACTION

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

“I’d say the most important factor in many of our cases – besides negligence itself – is the quality of the doctor-patient relationship. People just don’t sue doctors they like. . . We’ve had people come in saying they want to sue some specialist, and we’ll say ‘We don’t think that doctor was negligent. We think it’s your primary care doctor who was at fault.’ And the client will say, ‘I don’t care what she did. I love her, and I’m not suing her.’ . . . The best way to avoid getting sued is to establish good relationships with your patients. The secret to creating those relationships is really very simple – it’s not rocket science. You have to treat your patients with respect. Take time to talk with them, and even more important, to listen.”

Researchers from Vanderbilt performed a six-year study in which they looked at complaints against 645 physicians. They found that 8% of these physicians generated over half of the malpractice suits. A follow-up study with 900 maternity patients found that doctors with high complaint and malpractice claim rates were characterized as rude, uncaring and inattentive, and failed to return phone calls. Treat your patients with respect and dignity because it is the professional thing to do.

**Tips for Better Relationships with your Patients**

- Review the patient's chart *before* you enter the exam room.
- Address your patient by name.
- Sit down during the appointment.
- Focus on your patient. The appointment is important to them. Don’t take phone calls.
- Avoid the appearance of rushing the appointment. Don’t look at your watch.
- Ask about the patient's family, work, weight loss, or prior health.
- Maintain eye contact.
- Convey alertness, interest, and attentiveness. Use nonverbal cues such as nodding.
- Listen without interrupting to your patient's description of their problems and self-diagnosis.
- Ask them about their concerns.
- Rephrase what the patient says to indicate your understanding of his or her concerns.
- Speak in language they can understand. Avoid using jargon.
- Don’t talk about other patients you have seen that day.
- It’s OK to admit that you don’t know. Find the answer and get back to them in a timely manner.
1 Committee on Quality of Health Care in America, Institute of Medicine. 2001. Crossing the Quality Chasm: A New Health System for the 21st Century


PRIMARY CARE/CONTINUITY CLINICS

Objectives:

The primary care continuity clinic has been developed to provide the optimal patient care experience in gynecology and obstetrics. It is our hope that the resident physician in dealing with his/her own private patients will develop a feeling for what the real practice of medicine all about.

The role of the modern ob/gyn physician is being redefined to place an increasing role in providing primary and preventive health services to women of all ages. The continuity clinics will focus on these issues along with providing consultative services specific to obstetrics and gynecology.

The importance of a solid knowledge base in physical exam and diagnosis, preventive medicine, immunization, and risk assessment for specific age groups will be continually addressed with each patient encounter.

By the end of the three year clinic, the residents will be comfortable handling the basics of primary care issues seen in every day practice. These include, but are not limited to:

1. Thyroid disease
2. Hypertensive disease
3. Adult onset diabetes
4. Dyslipidemia
5. Renal Disease
6. Common G.I. concerns
7. Headaches
8. Neurology for the non neurologist
9. Common Skin Disorders
10. Immunizations
11. Asthma and pulmonary disease
12. Common Orthopedic and musculoskeletal concerns

The residents will be introduced to the business side of medicine and be increasingly responsible for learning the billing and coding system of the modern day practice and apply this to the patients that they care for.

In order that the clinic experience be as educational and efficient as possible, I would like the residents to be familiar with the following guidelines of clinic operation:

1. Please be on time for your clinic - the clinic is as important to your education as your hospital duties. Your hospital attendings are aware of your clinic days. Should there be a problem with you leaving please let me know and this will be addressed with the appropriate staff.
2. It is expected that the residents will review their patients lab work and dictation with the staff to develop a coordinated care plan.
3. Any procedures must have a staff present.

4. Charts are never to be taken home!!!!!!!

5. Prompt correspondence with patients is essential.

6. Vacations must be scheduled at least 6 weeks in advance to allow for rescheduling of your patient appointments. Any additional requests must be approved in writing by the Resident Continuity Clinic director six weeks in advance.

7. You must keep a file system (provided) with important follow-ups. This will be reviewed on a regular basis.

All residents are required to give a minimum two-week notice when they will be gone from scheduled service responsibilities due to a Continuity Clinic surgery. If a two-week notification is not possible, the resident is responsible for finding coverage for either their Continuity Clinic case or any cases they may be missing at their rotation site.

A book list of recommended readings in primary care will be provided at the start of the clinic year. These books, if not purchased, may be signed out for your reading pleasure.

6/08
## TEACHING CONFERENCE SCHEDULE

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Type</th>
<th>Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>7:00 a.m.</td>
<td>Ob Sign-Out &amp; Didactics</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>7:00 a.m.</td>
<td>Gyn Didactics</td>
<td>Meriter Cafeteria</td>
</tr>
<tr>
<td></td>
<td>12:00 noon</td>
<td>REI Rounds</td>
<td>UWH H4/655</td>
</tr>
<tr>
<td>Tuesday</td>
<td>7:00 a.m.</td>
<td>Ob Sign-Out &amp; Teaching Rounds</td>
<td>UWH H4/655</td>
</tr>
<tr>
<td></td>
<td>7:00 a.m.</td>
<td>Gyn Didactics</td>
<td>Meriter Cafeteria</td>
</tr>
<tr>
<td></td>
<td>7:30 a.m.</td>
<td>Perinatal Conference</td>
<td>Meriter Hosp-Atrium</td>
</tr>
<tr>
<td></td>
<td>7:30 a.m.</td>
<td>OB Education Conference</td>
<td>SMH Bay 1</td>
</tr>
<tr>
<td></td>
<td>12:00 noon</td>
<td>REI Rounds</td>
<td>UWH H4/655</td>
</tr>
<tr>
<td>Wednesday</td>
<td>7:00 a.m.</td>
<td>Ob Sign-Out &amp; MFM Didactics</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>7:00 a.m.</td>
<td>Gyn Didactics</td>
<td>Meriter Cafeteria</td>
</tr>
<tr>
<td></td>
<td>7:00 a.m.</td>
<td>Didactic Session (Shay)</td>
<td>SMH L&amp;D</td>
</tr>
<tr>
<td></td>
<td>7:30 a.m.</td>
<td>Gyn Onc Weekly Chapter Review</td>
<td>UWH H4/655</td>
</tr>
<tr>
<td></td>
<td>12:00 noon</td>
<td>REI Rounds</td>
<td>UWH H4/655</td>
</tr>
<tr>
<td>Thursday</td>
<td>7:00 a.m.</td>
<td>Morbidity &amp; Mortality Conf./*</td>
<td>Bolz Auditorium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Journal Club/Resident Meetings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8:00 a.m.</td>
<td>Grand Rounds*</td>
<td>Bolz Auditorium</td>
</tr>
<tr>
<td></td>
<td>9:00 a.m.</td>
<td>Resident Didactic Series*</td>
<td>Bolz Auditorium</td>
</tr>
<tr>
<td></td>
<td>10:00 a.m.</td>
<td>MIS Lecture/Simulation Lab</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>10:30 a.m.</td>
<td>Gyn Oncology Tumor Board</td>
<td>VA Hospital</td>
</tr>
<tr>
<td></td>
<td>11:30 a.m.</td>
<td>Gyn/Onc Preoperative Conference</td>
<td>VA Hospital</td>
</tr>
<tr>
<td></td>
<td>12:00 noon</td>
<td>REI Rounds</td>
<td>UWH H4/655</td>
</tr>
<tr>
<td>Friday</td>
<td>7:00 a.m.</td>
<td>Ob Sign-Out &amp; Tracing Rounds</td>
<td>Meriter 5-E Sim Lab</td>
</tr>
<tr>
<td></td>
<td>7:00 a.m.</td>
<td>Gyn Didactics w/Diem</td>
<td>Meriter</td>
</tr>
<tr>
<td>Cafeteria</td>
<td>7:00 a.m.</td>
<td>Pathology Conference</td>
<td>Meriter Cafeteria</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(third Fri. of month)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12:00 noon</td>
<td>REI Rounds</td>
<td>UWH H4/655</td>
</tr>
<tr>
<td></td>
<td>12:00 noon</td>
<td>UHS Didactics</td>
<td>UHS</td>
</tr>
<tr>
<td></td>
<td>12:30 p.m.</td>
<td>PGY-2 REI Presentation</td>
<td>UWH H4/655</td>
</tr>
</tbody>
</table>

Grand Rounds are held at Meriter Hospital, September-May. Morbidity and Mortality Conference is held throughout the year. (During the summer months, M&M Conference/Resident Didactic Series begins at 7:30 a.m.)
Topics for Minimally Invasive Surgery Lectures

1. Electrosurgical principles
2. Hysteroscopic fluid media and complications
3. Hysteroscopic instruments and ablation techniques
4. Complications of laparoscopy
5. “Hands-on” laboratory - putting together laparoscopic and hysteroscopic instruments
6. “Hands-on” laboratory – laparoscopic instruments, cystoscope & proctoscope
7. Laparoscopic suturing and knot tying
8. Technologies: Laser, harmonic scalpel, Lig-a-sure, Argon beam, and PK
9. Laparoscopy in the obese and pregnant patient
10. Laparoscopic basics: patient preparation and positioning, entering the abdomen, port placement, and closure

5/08

ACCEPTABLE CASE LIST ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;P Repair</td>
<td>Anterior and posterior colporrhaphy</td>
</tr>
<tr>
<td>Ab</td>
<td>Abortion</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>BS&amp;O</td>
<td>Bilateral salpingo-oophorectomy</td>
</tr>
<tr>
<td>CD</td>
<td>Cesarean delivery</td>
</tr>
<tr>
<td>cm</td>
<td>Centimeter</td>
</tr>
<tr>
<td>D&amp;C</td>
<td>Dilatation and curettage</td>
</tr>
<tr>
<td>D&amp;E</td>
<td>Dilatation and evacuation</td>
</tr>
<tr>
<td>DHEAS</td>
<td>Dihydroepiandrosterone sulfate</td>
</tr>
<tr>
<td>E</td>
<td>Estrogen</td>
</tr>
<tr>
<td>FSH</td>
<td>Follicle stimulating hormone</td>
</tr>
<tr>
<td>gms</td>
<td>Grams</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>HRT</td>
<td>Hormone replacement therapy</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine device</td>
</tr>
<tr>
<td>Kg</td>
<td>Kilogram</td>
</tr>
<tr>
<td>PAP</td>
<td>Papanicolaou smear</td>
</tr>
<tr>
<td>PROM</td>
<td>Premature rupture of membranes</td>
</tr>
<tr>
<td>PTL</td>
<td>Preterm labor</td>
</tr>
<tr>
<td>SAB</td>
<td>Spontaneous abortion</td>
</tr>
<tr>
<td>SVD</td>
<td>Spontaneous vaginal delivery</td>
</tr>
<tr>
<td>T</td>
<td>Testosterone</td>
</tr>
<tr>
<td>TAH</td>
<td>Total abdominal hysterectomy</td>
</tr>
<tr>
<td>TSH</td>
<td>Thyroid stimulating hormone</td>
</tr>
<tr>
<td>TVH</td>
<td>Total vaginal hysterectomy</td>
</tr>
<tr>
<td>VBAC</td>
<td>Vaginal birth after cesarean</td>
</tr>
<tr>
<td>VIP</td>
<td>Voluntary interruption of pregnancy</td>
</tr>
</tbody>
</table>
RECOMMENDED READING RESOURCES FOR RESIDENTS

PGY-1

Beckmann CRB, Ling FW, Barzansky BM, Herbert WNP, Laube DW, Smith RP: Obstetrics and Gynecology (5ed), Lippincott Williams & Wilkins, 2006


ACOG Compendium of selected publications

Berek J, Hacker N: Practical Gynecologic Oncology (4ed), Lippincott Williams & Wilkins, 2005


Callen: Ultrasonography in Obstetrics and Gynecology (5ed), Saunders, 2008

PGY-2

DiSaia P, Creasman: Clinical Gynecologic Oncology (7ed), Mosby, 2007


Katz: Comprehensive Gynecology (5ed), Mosby, 2007

Rock J, Jones HW: TeLinde's Operative Gynecology Updates (10ed), Lippincott Williams & Wilkins, 2008

Speroff L, Fritz M: Clinical Gynecologic Endocrinology and Infertility (7ed), Lippincott Williams & Wilkins, 2005

ACOG Compendium of selected publications

Eight articles a month: suggest beginning with Obstetrics and Gynecology (the green journal) and expanding to the American Journal of Obstetrics and Gynecology (the gray journal)
PGY-3


ACOG Compendium of selected publications

Recommend expanding journal articles to 12 per month

Cochrane Library Reviews

PGY-4

Sweet R and Gibbs R: Infectious Diseases of the Female Genital Tract (4ed), Lippincott Williams & Wilkins, 2002


Bent A, Cundiff G, Swift S: Ostergard’s Urogynecology and Pelvic Floor Dysfunction (6ed), Lippincott Williams & Wilkins, 2007

Simpson, Golbus: Genetics in Obstetrics and Gynecology (3ed), Saunders, 2003


ACOG Compendium of selected publications

Sixteen articles per month

6/08
OB-GYN CALL GUIDELINES

General Rules

1. Adherence to the ACGME resident duty hours requirements are to be ensured in scheduling call.
2. The call schedule will be made out for a 12 month period of time. The schedule will be completed by June 15.
3. Schedules are to be made out fairly. Weekend call days (Fri pm, Sat, and Sun daytime), will be tracked carefully.
4. The following describes the format for completing the call schedules:
   a. The call schedule will be created by a committee with a representative from each upcoming class, including the Chief and Vice-Chief. The Chief and Vice-Chief will review the entire schedule and any inequities or necessary revisions will be discussed with the committee.
   b. Personal requests for weekend time off other than vacations are the responsibility of the individual residents. Call coverage must be arranged by switching with other residents.
   c. The final call and vacation schedule for the academic year will be distributed no later than June 15.
   d. Requests for changes due to perceived inequities to the schedule, should be made in writing to the Chief resident.
   e. Requests for changes to the schedule will be evaluated and resolved by a consensus of members of the scheduling committee.
   f. Conflicts that cannot be resolved by the scheduling committees will be resolved by the administrative Chief resident.
   g. The administrative Chief resident may choose to discuss any conflicts with the residency director if s/he is unable to settle the conflict.
   h. The residency director’s decision on how to resolve the matter will be final.
   i. In order to avoid a conflict of interest, residents who have conflicts with their own call schedule are expected to recuse themselves from the call schedule committee that is charged with the resolution of that conflict. A replacement resident from the same postgraduate year may be appointed by the administrative Chief resident.
   j. The administrative Chief resident will maintain an on-going tally of weekend days worked and total days off.
5. Any changes in the format above should be agreed upon by the majority of residents, as well as the residency director.
6. Final schedules are to be submitted to the residency coordinator no later than the 15th of the month preceding the beginning of any new rotation.
7. Friday call starts at 5 p.m., not 7 p.m. If the “on-call” person is done with their clinical duties (i.e., gyn cases) early, they must start their call at 3 p.m. This applies to St. Mary’s and Meriter Hospital. St. Mary’s Friday call for “Clinics” resident starts at 1 p.m.
8. NO COMPLAINTS SHOULD BE DIRECTED TO THE RESIDENCY COORDINATOR – she has no role in making or negotiating call or vacation schedules.
Schedules for the three hospitals are as follows:

**UW Clinical Sciences Center**

"Junior" Call Rotation
- Every 3rd or 4th night from home
- PGY-1 UHS, PGY-1 Gyn Oncology, PGY-2 Gyn Oncology, and PGY-2 Endocrinology
- PGY-2 takes solo call

"Senior" Call Rotation
- Every 3rd or 4th night from home
- Backup from home for PGY-1’s, occasional solo call may be required.
- PGY-4 Benign Gynecology, PGY 4 Gyn Oncology
- No call when PGY-2 on Onc service or PGY-3 are on

**Meriter Hospital**

"Junior" Call Rotation General Rules:
- Weekdays begin at 0600
- Weekends begin at 0700, Friday call starts at 1700, earlier if able
- The night float service begins at 1900
- The night float resident signs out the floor during morning rounds at 0700 and then leaves after teaching session (no later than 0900)
- The night float resident attends Thursday morning conferences (no later than 0900)
- The night float may not take a vacation or be gone to a meeting
- Continuity clinic will be every other Friday morning for the Night Float resident

PGY-1 schedule
- The 2 PGY 1’s on OB alternate responsibility for covering L&D from 0700-1900 Mon-Thurs
- The 2 PGY 1’s on OB, the PGY-1 on ultrasound, and the PGY-2’s in the call pool alternate responsibility for 24 hour L&D call on Fridays and Saturdays, and the 12-hour day shift on Sunday

Schedule with an Emergency Medicine or Family Practice Resident on OB:
- Two residents will each cover one 12 hour L&D shift and one 24 hour on-call shift per week (either Fri or Sat)
- One resident will cover three 12 hour shifts per week (e.g. two 12 x hours + 12 hours on Sun)
- Allowances will be made to enable the Family Practice resident to consistently attend their own clinic on Tue and Thu afternoons
- If an OB PGY-1 is on vacation, the FP resident fills the vacant schedule, and the above does not happen.

PGY-1 Night float Schedule:
- The night float resident covers L&D Sunday-Thursday 1900-0700
- Is off Friday 0700 - Sunday 1900
- Takes one 24-hour call per night float rotation
- Continuity Clinic will be every other Friday morning for the night float resident.
**PGY-1 Vacations (when no float resident available to cover):**

- The remaining PGY-1 covers three 12-hour shifts during the day on Monday-Thursday, and is on call for 24 hours on either Friday or Saturday.
- The PGY-2 in the high risk call pool covers one 12-hour shift on the floor on Monday-Thursday, and falls into the low risk OB weekend call pool.

"Senior" Call Rotation

- The PGY-4 and PGY-3 provide floor and clinic responsibility 0600-1900 Monday-Thursday.
- The PGY-4 Obstetrics, PGY-3 and PGY-2 Meriter Gynecology, and PGY-3 Obstetrics alternate responsibility for 24-hour high risk call and the 12-hour Sunday call.
- High risk call includes coverage of the Meriter benign gynecology service patients.

**PGY-3 Night float Schedule:**

- The night float senior resident covers high risk obstetrics and the benign gynecology service patients Sunday-Thursday 1900-0700
- Is off Friday 0700 – Sunday 1900
- Takes one 24-hour call per night float rotation
- Continuity Clinic will be every other Friday morning.

**St. Mary's Hospital**

- The PGY-4 on Gynecology
- The PGY-3 on high risk obstetrics. Weekdays begin at 0600, weekends begin at 0700.
- Weekend call coverage (Fri and Sat 24-hour, Sun 12-hour) of the OB high risk and gynecology service patients is alternated by the PGY-4 St. Mary’s gynecology, PGY-3 St. Mary’s OB, and PGY-2 or PGY-3 Clinics resident.

**PGY-2 Night float Schedule:**

- The night float resident covers high risk obstetrics and gynecology service patients Sunday-Thursday 1900-0700
- Is off Friday 0700 – Sunday 1900
- Takes one 24-hour call per night float rotation
- Continuity Clinic will be every other Friday morning.

**PGY-3 on PG-4 Float Rotation:**

- May float for vacation coverage
- Will cover RCC as “Clinics” resident
- Will cover St. Mary’s GYN on Wednesday pm and Fridays
- Will be in either St. Mary’s or Meriter High Risk call pools

**Emergency Call Coverage**

Illnesses and family emergencies can wreak havoc with the program's fairly tight weekday and call schedules. It is therefore important that everyone recognize the need to be helpful and flexible. Ideally, vacancies in the schedule will be covered by volunteers, who will be solicited by the administrative chief resident. Only if no volunteers can be found, will the program director designate who will cover call, using the following guidelines:
- Residents who are either pre- or immediately post call will not be considered.
- Residents at an unsuitable training level will not be considered.
- Residents on off-service call rotations will only be considered as a last resort.
- Residents likely to be "drafted" for call at the PGY-2 level or beyond include
  - The PGY-2, -3, or -4 on Meriter gynecology
  - The PGY-3 on Research
  - The PGY-2 on Clinics
  - The PGY-3 on PG-4 float rotation
  - The UW PGY-4 on Gynecology
  - The UW Endocrinology PGY-2
  - The UW PGY-4 on Gyn Oncology
- Residents likely to be “drafted” for weekday absences at the PGY-2 level or beyond include
  - The PGY-2 on Clinics
  - The PGY-3 on Research
  - The PGY-3 on PG-4 float rotation
  - The PGY-2, -3, or -4 on Meriter gynecology
  - The PGY-2 on Ultrasound/Research
- Any Meriter "senior" resident who is neither pre- nor post-call.
- Vacancies in the UW "junior" schedule will be covered by assigning the backup senior resident to primary call.
- The program director's assignment of call in cases where there are no volunteers will be non-negotiable.

6/08
1. All residents on call are expected to be accessible to the hospital within 15 minutes of a call identifying a problem.

2. These guidelines are not to be considered all-inclusive. A resident's judgment will be required in many situations not specifically noted.

- All admissions
- ER calls when asked to see a patient, without negotiation!
- All after hours emergency consults
- Temperature > 100.4, P ≥ 120, UO ≤ 30cc/hr average
- Unstable vital signs
- Anytime a nurse asks you to, regardless of your telephone impression
- Moderate/severe abdominal pain
- Acute abdominal distension
- Intractable nausea and vomiting
- Possible wound infection or dehiscences (drainage, redness, separation, etc.)
- Excessive vaginal bleeding (≥ 1 pad per hour or if quantity unclear)
- Chest pain
- Shortness of breath or O2 saturation on pulse oximeter < 90%
- Swollen, painful extremity, i.e., R/O DVT or arterial thrombosis
- To provide counseling prior to initial transfusion (if not already done by team).
- Transfusion reaction or question of transfusion reaction.
- Drug reaction
- Patient death
- All patients being evaluated for an adnexal mass, pain, abnormal bleeding, or who have a positive pregnancy test, should be seen.

6/08
STAFFING EMERGENCY DEPARTMENT PATIENTS WITH EMERGENCY DEPARTMENT ATTENDINGS

Because of medical-legal and accreditation requirements, all patients seen in the Emergency Department need to be staffed with and seen by a faculty physician. Telephone staffing with subspecialty faculty should continue, but telephone staffing does not satisfy the requirements. The requirements may be most easily satisfied by discussing the patient with the Emergency Department attending physician.

Please discuss all patients with the Emergency Department attending physicians before sending the patient home. This discussion can be accomplished quickly. The Emergency Department attending physicians may or may not have already examined the patient you are seeing. In either case, please mention your assessment and plan for the patient.

The procedure for the evaluation and treatment of sexual assault survivors and University of Wisconsin Hospital and Clinics Policy and Procedure information is available in the Program Coordinator’s office, 6-Center, Meriter Hospital.

6/08
“HIPAA 201” for Clinical Staff
Highlights of UWHC’s HIPAA Policies

Definitions

**Protected Health Information (“PHI”):** Any patient health information that includes a patient’s name or other identifier, like MR#, birth date, or any other code or number

**Use:** The sharing, application, utilization, examination, or analysis of PHI by employees within our health system (UWHC, UWMF, UW-Madison, Chartwell, Wisconsin Dialysis)

**Disclosure/Release of Information:** Giving out Protected Health Information to people or organizations outside our health system

Access and Use of PHI:

**Minimum Necessary Rule:** Make sure you only access and use the minimum amount of PHI necessary to do your job (e.g. you are taking care of the patient)

**Uses Requiring Patient Written Authorization:** Some research, fundraising, and marketing uses of PHI require the written authorization of the patient. If you are involved in any of these activities, please review the relevant policies in more detail (see below for URL link to UWHC policies)

Safeguarding PHI

The following are common sense steps to take when using PHI

- Keep conversations about patients or with patients in private, using a low voice—avoid elevators, open hallways and cafeterias whenever possible
- Reduce visibility of records
- Keep patient records in secure locations—do not remove from UWHC sites
- Protect your personal passwords from others
- Log off the computer when done or minimize application when stepping away momentarily
- Immediately remove confidential documents from printer or copier
- Discard protected health information in recycle bins for shredding.
- When sending faxes:
  - Ensure the FAX number is correct before sending the document
  - Use a cover sheet with confidentiality language

Tips for Communicating About Patients with Staff *Within* Our Health System

**Verbal Communications Regarding Patients**
- Whenever possible, keep the conversation private or use a low voice
Communications about Patients via E-Mail
- Use “wisc.edu” not Hotmail or other personal e-mail addresses
- Avoid patient’s full name; use initials, first name, last initial, birth date, or MR # instead
- Do not send/forward work e-mail to personal e-mail
- If accessing your work e-mail from home, secure e-mail from household members and shred any printed materials

Sending PHI via interdepartmental mail
- Send information in sealed envelopes

Sending PHI via FAX
- Use cover sheet with confidentiality language

Communications/Release of Information to Persons Outside our Health System

Verbal Conversations Regarding Treatment with other Health Care Providers
- Whenever possible, keep the conversation private or use a low voice

Sending or Faxing Treatment or Payment Related PHI
- Written patient authorization is required if information released is related to a protected diagnosis (HIV, Mental Health, AODA)
- Document release of information with form “Release of Information/Patient Authorization Not Required”
- If request for PHI is not related to treatment or payment, refer person to Health Information Services

Communications/Releases of Information to Patients or Those Involved in Their Care

Communicating with Patients By Phone:
- Use patient’s home phone number unless patient has requested alternative number
- Whenever possible, talk directly with patient

If Leaving Patient’s a Voice Message:
- Leave the least information possible
- It is okay to leave more details if the information is necessary for the patient’s safety or convenience, like you need to tell them what to do pre-operatively
- Never leave lab or test results or information suggesting diagnosis

Communicating With Patients Via E-mail:
- Both you and the patient must agree to it, but if you do, you must provide the patient a copy of the Provider/Patient E-mail Information form. (The form will be available as an appendix to the “Provider/Patient E-mail” policy #6.23)
• Any e-mail that gives the patient’s progress, test results, or treatment advice must go in the patient’s medical record

• Follow some common sense principles such as:
  o Plan to respond to the patient within 3 business days
  o Avoid jokes or phrases that could be misconstrued
  o Set e-mail on auto-reply or have someone check your e-mail when you’re away

*Disclosures or Release of PHI From the Patient's Medical Record to the Patient or Patient's Legally Authorized Representative:*

• Patients should not be left alone with medical record (concerns about the integrity of the record)

• You may provide copies of information from the medical record to the patient or the patient’s legally authorized representative WITHOUT WRITTEN authorization if providing the information is part of the standard of care (e.g. giving a prescription, referral, discharge instructions, etc., letter letting patients know diagnostic test are normal) and/or is directly related to the care you are providing (e.g. medication list etc., providing lab values etc).

• If patients or their legally authorized representative requests copies of “historical records” (e.g. “I want my op note from last year”) or records not related to the treatment you are providing (e.g. “I want a copy of the progress notes from a different health care provider”) you may give them copies of the documents out of the medical record, but they must sign the “Authorization for Disclosure of Medical Records.” Alternatively, you may send them to Health Information Services (HIS) to process the request.

• Requests for substantial or complete records must be directed to HIS

*Verbal Disclosures of PHI to Family & Friends Involved in the Care of the Patient:*

• Use your professional judgment to determine if the patient would object to you discussing their medical condition and treatment with their family member or friend, if you are not sure, ask the patient

• Provide the person with the minimum amount of information necessary for their involvement in the care

• Where possible, direct discussions directly to the patient or to the patient’s contact person

**Other Information Governing Communications/Releases of Information About Patients**

*Verification Requirement for all Disclosures*

• If the person or organization asking you for information is unknown to you, you must take appropriate measures to verify that they have the right to receive the information about the patient. You may do one or more of the following:
  o Verify the person’s relationship to the patient
  o Ask for photo or other ID
  o Verify name, organization, call-back number
  o Ask for request on letterhead
• If the person requesting information is a government official, insurance representative, or attorney, please refer him to Health Information Services

**Disclosures to Law Enforcement:**
• All calls for security and/or law enforcement needs must be directed to UW Police and Security at 263-7065
• Some disclosures for law enforcement purposes will need to be tracked on the “Accounting of Disclosures” form—watch for further guidance regarding disclosures to law enforcement personnel (both UW Police officers and local police and law enforcement)

**Disclosures to the Media**
• Refer the person to the Nursing Supervisor or Public Affairs

**All Other Requests for Information:**
• Refer the person to Health Information Services

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**Violations for Non-Compliance with HIPAA**

**Types of Violations**
• Type I—inadvertent breach of patient confidentiality (e.g. dial wrong fax number)
• Type II—fail to follow UWHC’s HIPAA policies
• Type III—inappropriately looking at patients records without a clinical or business need to know it
• Type IV—using or disclosing patient information for self gain (you get paid) or to harm someone

**Corrective Actions**
• UWHC’s overall goal is to promote compliance through education, re-education, and process improvement.
• Repeated Type I and Type II violations will lead to progressive measures such as verbal and written reprimand to suspensions without pay and possible termination
• Type III—3-5 day suspension without pay
• Type IV-automatic termination

**UWHC’s Notice of Privacy Practices:**

By April 14, 2003, most health care providers were required to give patients a copy of its *Notice of Privacy Practices* that let patients know:
• What rights they have with regard to their health information
• How to exercise those rights
• What the health care provider is permitted and required to do with their health information
• When the patient’s authorization is required
• Who to contact with questions or complaints
### Patient Rights under HIPAA

- Right to access, obtain copies and request amendments to medical and billing records
- Right to request restrictions on uses and discloses of PHI
- Right to request a “accounting” of certain disclosures
- Right to request “alternative communications”

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#### For more information:

Please see UWHC’s HIPAA policies at [www.hosp.wisc.edu](http://www.hosp.wisc.edu). Search under “HIPAA” for all HIPAA related policies

You may also contact UWHC’s HIPAA Privacy Officer, Beth DeLair at 262-4926, ce.delair@hosp.wisc.edu
Medical Records

The timely and accurate completion of medical records is among any resident's most important responsibilities. Patient charts are medically and medico-legally vital documents that must be accessible at all times, and may never be removed from the hospital.

Each hospital has its own specific guidelines for the formats of H&P's, operative notes and discharge summaries, but certain general rules apply to all institutions: (Additional information is available in the Program Coordinator’s office, 6-Center, Meriter Hospital)

1. State Law requires that verbal orders be countersigned within 24 hours. The MD signing does NOT have to be the MD giving the order - so sign all verbal orders from your service when you see them.

2. Orders and notes must be dated, timed and legibly signed with your name AND professional designation (i.e. John Doe, MD)

3. H&Ps must be completed at the time of the patient's admission. The referring and admitting attending MDs should be clearly identified to facilitate follow-up.

4. Medical student write-ups do NOT count as a completed H&P or progress note, and simple counter-signature is NOT sufficient. A complete H&P/note or completion of an admission form by the resident is necessary.

5. Operative summaries must be dictated within 24 hours, no exceptions.

6. Discharge summaries are ideally dictated at the time of discharge by the resident most familiar with the patient's care. Many services identify a resident responsible for discharge summaries that were not completed in this fashion.

7. Clinic and procedure notes should clearly state the involvement of the attending physician.

Any delay or deficiency will become a medical records infraction for the attending physician of record, which may even result in suspension of hospital privileges for that physician. Attendings generally don't like that!

COMPLIANCE – If it seems like your attendings over-supervise you, especially if you are a senior resident, please read the rules under which they must operate:

Coding and Compliance

Introduction
Preparing for medical practice out in the community involves learning not only the medical specialty you have chosen, but also some of the rules that go along with billing and compliance.
These few pages contain just a few of the issues with documentation. Please contact the Ob/Gyn Provider Billing Coordinator (287-2491) with any questions.

**Dating Notes**
**Always date notes with the date that the note is written**
- If you are documenting a service performed on another date, date the note with the current date, but refer to the date of service within the note/dictation.

**New versus Established Patient**
- A new patient is one who has not been seen within the past three years by any provider of the same specialty and within the same group practice, regardless of clinical location.

**Key Issues for Teaching Physicians**

**Joint Service**
- A service performed by a resident/fellow while the attending physician is present in the room. The attending physician must also personally perform the “key portion” of the exam.

**Separate Service**
- A service performed by an attending physician before/after a resident/fellow performed a service.

**TO BE CONSIDERED BILLABLE BY ATTENDING PHYSICIAN, ANY TRANSCRIBED NOTE...**

1. **Dictated by a Resident/Fellow**
   - Must have attending physician note for presence

2. **Dictated by a Medical Student**
   - Must have a separate complete attending physician note. The dictated review of systems or past medical, family and social histories may be used to determine the level of service only if the attending physician verifies these with the patient and it is referenced in the attending physician note.

**SCRIBE**

A scribe should only act in that capacity to document services that the billing physician personally performs. Therefore, a scribe should only document services that he/she actually observes the physician perform or transcribe what the billing physician dictates. By definition, a physician may not, and should not, have a scribe document billable services if only the scribe performed them.

Example: “I, John Doe, am acting as scribe. The history, exam, and medical decision making was performed by Dr.__________.” The billing physician then countersigns the above statement.
PROCEDURAL SERVICES

Minor Procedures (less than 5 minutes)
1. Teaching physician must be present for entire procedure.
2. Teaching physician’s personal documentation must reflect presence during procedure.

Major Procedures (more than 5 minutes)
1. Teaching physician must be present for key portion(s) of the procedure.
2. Teaching physician’s personal documentation must reflect presence during key portion(s) of the procedure.
3. If present for the entire procedure, presence may be indicated by the teaching physician, resident or operating room nurse.

Scope Procedures

Teaching physician must be present during entire procedure, including scope insertion, diagnostic viewing, and scope withdrawal.

INAPPROPRIATE PRESENCE DOCUMENTATION BY AN ATTENDING PHYSICIAN

1. Co-signature only (handwritten or electronically signed)
2. “Seen, examined and agree with above” or any variation on this theme.
3. “History and exam review with resident and confirmed. Agree with assessment and plan as above.”

Primary Care Exception

The Primary Care Exception designation for a clinic means that the patients who are seen in this type of clinic consider the residents along with the supervising staff to be their primary source of healthcare. The resident sees patients independently, and the supervising staff does not need to see and examine the patient. However, at the conclusion of the visit the attending discusses the encounter and treatment plan and then writes/dictates a summary of that visit. If any procedures are performed, the attending must be present and document what transpired in order for a staff charge to be generated.

Requirements for Qualification

1. Location in outpatient hospital/office setting
2. Residents must have completed at least six months of an approved residency program
3. Staff supervision is limited to four residents
4. Patients must consider the center to be the continuing source of their health care

The Staff Physician

1. Cannot have any other responsibilities
2. Must assume management responsibility for beneficiaries/patients
3. Must ensure appropriate services are provided
4. Must review history, exam, diagnosis(es), tests, and therapies with the resident during or immediately after each visit
5. Must document personal participation

**Qualified range of services**

1. Acute care for undifferentiated problems
2. Chronic care for ongoing conditions including chronic mental illnesses
3. Coordination of care furnished by other providers
4. Comprehensive care not limited by organ system or diagnosis

**Limited Codes**

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The primary care exception does not apply to levels 4 or 5 new/established patient codes, or procedures. If the patient requires these types of services, the staff physician must see the patient and follow the general teaching physician documentation/participation guidelines (GC).

If the teaching physician participates (hands-on) in the service and the service is still within the applicable codes series, it is still within the applicable codes series, it is appropriate to apply the GE modifier and document according to the exception guidelines. If the service is other than what is considered primary care exception, the physician should follow the general teaching physician guidelines and apply the GC modifier.

**Documentation Requirement for Primary Care Exception (8/97)**

Many physicians have asked what extent of documentation is required when working under the primary care exception rules.

Since CMS has stated that they would like the documentation to be “patient specific,” we would recommend also including the fact that you agree/disagree with the diagnosis of _____ or agree/disagree with the treatment plan of _____.

**Evaluation and Management Documentation Guidelines**

Anatomy of a code

1. **History**
   - Chief complaint/reason for the encounter
   - History of present illness
   - Review of systems
   - Past medical, family and social history
2. Exam

3. Decision Making
   - Diagnoses/treatment options
   - Amount/complexity of data
   - Level of risk

Documentation Required for Assigning a Level of History
All services must have the chief complaint documented

History of Present Illness (HPI)
Brief
   - 1 to 3 elements documented
Extended
   - At least 4 elements documented

Review of Systems
   Problem pertinent
   1 system reviewed
   Extended
   - 2 to 9 systems reviewed
Complete
   - 10 or more systems reviewed

Past Medical, Family and/or Social History
   Pertinent
   - At least one item from any of the three areas must be documented
Complete
---
   Established Outpatient, Subsequent Hospital Services
   - At least 1 item from two of the three areas must be documented
   New Outpatient, Initial Hospital, Consultation Services
   - At least 1 item from each of the three areas must be documented

Documentation Required for Assigning a Level of Exam (1995 Guidelines)
   - Problem focused: Limited to affected body area or organ system (one body area or system related to problem)
   - Expanded Problem Focused: Affected body area or organ system and other symptomatic or related organ system(s) (additional system up to total of 7)
   - Detailed: Extended exam of affected area(s) and other symptomatic or related organ system(s) (additional systems up to total of 7 or more depth than above)
   - Comprehensive: General multi-system exam (8 or more systems) or complete exam of a single organ system

Documentation Required for Assigning a Level of Decision Making
Number of Diagnoses/Treatment Options
- Self limited/minor problem (i.e., cold or insect bite)
- Established problem, stable or improving
- Established problem, worsening
- New problem, no additional work-up planned
- New problem, additional work-up planned

Amount and/or Complexity of Data Reviewed
- Review and/or order of clinical lab tests
- Review and/or order of radiological tests
- Review and/or order of medical tests
- Discussion of test results with performing physician
- Review/summary of old records/history obtained from someone other than the patient
- Independent review of imaging, tracing, specimen

Risk of Complications and/or morbidity or mortality (See table of risk)
- Uncomplicated
- Number of medical problems are occurring simultaneously
- Illness/injury poses a threat to life or bodily function

6/08
ENTRIES INTO THE MEDICAL RECORD
(from Meriter Hospital, but applies to all)

The Regulating Agencies of medical care which include CMS (Centers for Medicare/Medicaid Services), the State of Wisconsin and the Joint Commission all require that all entries in the medical record include the elements listed in the bullets below. If any entry lacks even one element, it will be regarded as being non-compliant. If any of these Agencies decide to audit Meriter’s charts, which they will often do periodically or if there is a complaint about medical care, and charts are found with deficiencies in these areas of documentation, Meriter may be forced to pay back the charges for the non-compliant orders. For example, if 100 charts are audited and 10% of the MRI orders do not have all of these elements, CMS could extrapolate that to 10% of all MRI orders for a year or two which would have to be paid back to CMS. This could amount to millions of dollars.

A properly authenticated entry into the medical record, including orders and all progress notes, must contain the following elements:

- DATE
- TIME
- SIGNATURE
- PROFESSIONAL DESIGNATION
- LEGIBILITY

Proposed Penalties for Attending Physician Non-compliance (Must be >75% Compliant)

1. 1st Occurrence: Informational letter from Medical Records
2. 2nd Occurrence: Warning letter from Pres. of Medical Staff and Medical Affairs.
3. 3rd Occurrence: Loss of privileges for 2 weeks
4. 4th Occurrence: Appearance before the Medical Executive Committee

(Note from PD: attendings will be held responsible for the noncompliance of their residents!)

6/08
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* RSCH rotation consists of some vacation coverage, as well as dedicated research time.

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UW=University Hospital; MH=Meriter; SM=St. Mary’s; NF=Night Float; RSCH=Research/Float rotation; TLC=UW ICU; UHS/PP=University Health/Planned Parenthood

5/21/08
St. Mary’s GYN – coverage by PGY-3 “PG-4 float” to allow PGY-4 to attend Dr. Mullin’s and Dr. Ablove’s clinic.

| CLINICS – 2
<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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<tbody>
<tr>
<td>AM</td>
<td>Breast Clinic</td>
<td>UHS</td>
<td>Osteoporosis clinic</td>
<td>St. Mary’s</td>
</tr>
<tr>
<td>PM</td>
<td>Colposcopy</td>
<td>Gynecology-East Towne</td>
<td>Meriter clinic-CC</td>
<td>Research*</td>
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*Friday on-call coverage at St. Mary’s starts at 1300

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Location/Time</th>
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<tbody>
<tr>
<td>Abortion clinic</td>
<td>Planned Parenthood, Dr. Christianson, 0800</td>
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<tr>
<td>Breast clinic</td>
<td>UW Hospital, 1st floor, atrium, 0800</td>
</tr>
<tr>
<td>Colposcopy/general gyn</td>
<td>Planned Parenthood, Dr. Dutton, 1300</td>
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<tr>
<td>Continuity clinic</td>
<td>Meriter Hospital – 2 Center</td>
</tr>
<tr>
<td>Gynecology-East Towne</td>
<td>UW East Towne, 4122 East Towne Blvd., Tues-Berghahn/Jenkin, Wed-Mullins</td>
</tr>
<tr>
<td>Osteoporosis clinic</td>
<td>UW West, Junction Rd, 2nd floor, 0800</td>
</tr>
<tr>
<td>UHS</td>
<td>University Health Service, Dr. Landry</td>
</tr>
<tr>
<td>St. Mary’s</td>
<td>OB coverage 1030 – 1900</td>
</tr>
<tr>
<td>Urogynecology</td>
<td>Dr. Ablove, 5543 E. Cheryl Pkwy., Fitchburg</td>
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</tbody>
</table>
**KEY:**
PGY-4’s – 10 week blocks, rotating schedule
PGY-3’s –
  • SM-OB: Thursday PM clinic
  • MH-NF: Every other Friday AM (opposite SM-NF PGY-2)
PGY-2’s –
  • SM-NF: Every other Friday AM (opposite MH-NF PGY-3)
  • Clinics: Wednesday PM
PGY-1’s –
  • MH-NF: Every other Friday AM with MH-NF PGY-3
  • Only low risk OB patients
  • No Continuity Clinic during Oncology rotation

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<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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<tbody>
<tr>
<td>High risk clinic (0830-1145)</td>
<td>Ingrisano, Kerkuta, Lin, Trautman</td>
<td>Schmehil, Small-Bement, Steinle, Ziebarth</td>
<td>High risk clinic (1130-1245)</td>
<td>MH-GYN (4), MH-NF (3)<em>, SMH-NF (2)</em>, MH NF (1)*, Littlefield</td>
</tr>
<tr>
<td>UW-GYN (4)</td>
<td>Bennett, Bruegl, Sullivan</td>
<td>MH-OB (4), CLINICS (2), Glowacki, Klemin</td>
<td>SMH-GYN (4), UW-ONC (4), SM-OB (3)</td>
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</table>

*Every other Friday clinic while on night float. The 2 and 3 usually rotate weeks.*
ROTATION DESCRIPTIONS

MERITER OBSTETRIC SERVICE
PGY-1 ON MERITER OB

GENERAL DESCRIPTION

- The junior residents provide antepartum, intrapartum, and postpartum care for the private patients of the OB generalist faculty, FM attendings and for patients cared for in the UWPS resident clinics.
- The resident’s clinical activities are supervised by the senior OB resident (PGY-3 or 4), and the patient's attending physician or assigned UW faculty member. All residents are answerable to Dr. Dinesh Shah for programmatic and educational issues.
- Service operations are described in more detail to follow.

SPECIFIC RESPONSIBILITIES

1. Except when off duty or specifically scheduled elsewhere, the PGY-1 days is expected to be available in the Birthing Center or Perinatal Clinic from 0600 to 1700 or 1900, at the discretion the PGY-4 and attending staff. The PGY-1 night float is expected to be available in the Birthing Center between 1900 and 0730. Residents must carry pagers.
2. See “Call” section for call rotation.
3. The schedule includes 2 PGY-1 residents, the night float PGY-1 & PGY-3, and intermittently and emergency medicine or a family medicine resident on OB elective.
4. The resident on L&D on any given day is referred to as the On-Call or First Call Resident. S/he has primary responsibility for patients admitted to Labor and Delivery.
5. Between the hours of 7 pm and 7 am, the night float resident will cover that service. (See “Call” section)
6. On weekends and holidays, off duty time starts when rounds have been completed, and the service has been signed out to the oncoming on-call residents (8:00 a.m.).
7. On weekdays, morning rounds should be completed by 7:00 a.m., to permit participation by all residents in sign out rounds and scheduled didactic activities.
8. Daytime residents’ duties alternate between L&D and triage coverage. Triage includes walk-in patient triage, procedures in L&D (tubals, C-sections, versions etc.), and phone calls from the postpartum floor at the discretion of the senior resident or staff.
9. A major responsibility for the junior residents is the hands-on teaching and supervision of the third year medical students. This includes demonstration of how to obtain a history and physical on an actively laboring patient, reviewing fetal heart rate tracings, evaluating labor progress, assessing a patient in triage, etc.. The service’s teaching functions will be shared by the more senior residents.
10. All residents have the responsibility to complete medical records in a timely fashion. Particular attention should be paid to the countersigning of verbal orders and to the completion of the handwritten discharge summary form on obstetrical patients. Discharge summary dictation responsibilities are assigned by the service PGY-4.
11. One of the first year residents is responsible for turning in the General OB Services' M&M summaries on Monday afternoon before Thursday's M&M rounds.
12. The junior residents, in a weekly rotation, are responsible for obtaining at least one and preferably two patient charts and FHR tracings for case presentation at the monthly Labor Case Management Conference on Friday mornings.

13. The junior residents are expected to attend all scheduled didactic sessions, which includes the summer core lecture series for the PGY-1’s. In addition, residents are held responsible for independent reading and study, based on the recommended reading list for OB and the resident learning objectives.

6/08
MERITER OBSTETRIC SERVICE OPERATIONS

SERVICE STRUCTURE

The UW obstetric service consists of five distinct patient populations: patients from the resident continuity clinics, patients under the care of UW and non-UW generalist Ob-Gyn attendings, patients being followed by family practice physicians, high risk resident clinic patients, and patients under the particular care of the perinatology faculty. Patients who present to the hospital without an assigned physician are cared for by the in-house attending physician on call, and are treated administratively as a resident clinic patient.

Patient management is provided in a hierarchical fashion, where a PGY-1 or 2 provide direct patient care, and work closely with the assigned nurse. The PGY-1 or 2 is under the supervision of the PGY-3 or -4 OB senior resident, and all residents are answerable to the patient's attending physician. The Senior resident should be considered any resident clinic 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. The senior resident and/or attending physician may take over direct patient management at his/her discretion.

Patients on the UWPS Antepartum service are generally managed by a second, third or fourth year resident under the supervision of one of the perinatologists. A PGY-1 may be involved at the discretion of the supervising Senior resident.

Specific work is assigned by the senior resident. Junior residents are answerable to the OB senior resident, and all residents are answerable to Dr. Droste for administrative and programmatic issues.

WEEKDAY OPERATIONS

Junior Resident on L&D or night float call

- Has primary responsibility for all low risk admissions to labor and delivery
- Covers low risk laboring and antepartum patients.
- Attends emergency procedures and all deliveries.
- Notifies the senior resident of major deviations from normal (e.g. prolonged labor, multiple gestations, breech, pre eclampsia, infections, labor suppression).
- Contacts the senior resident whenever the workload becomes overwhelming - a PGY-1 or 2 should never hesitate to ask for help.
- Discusses patient management with the attending physician
  - on admission,
  - when labor augmentation is needed,
  - when rupture of membranes occurs,
  - when pain meds or an epidural are indicated,
  - when fetal distress is suspected,
  - when internal monitors are indicated,
  - when non-progression is suspected,
  - when a primiparous patient is completely dilated or a patient is laboring rapidly,
  - per attending instruction, and
- whenever complications arise.

PGY-1 Night Float Resident
- Assists with morning rounds.
- Attends M&M on Thursday mornings.
- Is otherwise off-duty after 7:30 a.m.

Junior Resident for Triage and Procedures
- Sees patients presenting to triage.
- Scrubs scheduled cases (sections, versions, tubals etc.).
- May see low risk 6 N admissions (hyperemesis, hypertension, preop etc.).
- Accepts phone calls from patients or from the floor.
- May attend the perinatal high risk clinic if labor and delivery workload permits.

OB Clinic PGY-3
- Sees antenatal patients presenting to the Meriter high risk clinic
- Is available to answer patient phone calls
- Completes the outpatient clinic record
- Reviews high risk antenatal patients’ lab-work
- Works closely with the medical students in clinic
- Takes direction from the attending staff or fellows supervising high risk clinic
- Follows HR clinic patients when they are inpatients, whenever possible

Meriter Senior Nightfloat PGY-3
- Assures smooth operation of the entire Obstetrics Service at night
- Supervises the PGY-1 nightfloat
- Is aware of all patients admitted to the Birthing Center
- Accepts calls from all floors in the event of junior resident non-availability
- Personally manages high risk patients (regardless of service assignment) when appropriate, or when requested by the patient's attending physician.
- Is available (L&D workload and acuity permitting) to evaluate patients on the Gyn service or Gyn patients presenting to the ER.
- Acts as an intermediary for junior residents, nurses and attending physicians when the timeliness or appropriateness of patient management is in doubt. (See Birthing Center Chain of Command.)
- Attends M&M on Thursday mornings.

OB Chief Resident
- Assures smooth operation of the entire Obstetrics Service
- Delegates junior resident duties in response to workload and patient acuity
- Notifies the floors of duty assignments
- Is aware of all patients admitted to the Birthing Center
- Accepts calls from all floors in the event of junior resident non-availability or to resolve questions about coverage
- Is available to assist and consult the junior residents
- Manages high risk patients (regardless of service assignment) personally when appropriate, or when requested by the patient's attending physician. For HR clinic patients that responsibility
may be to the PGY-3 on high risk OB.

- Acts as an intermediary for junior residents, nurses and attending physicians when the timeliness or appropriateness of patient management is in doubt. (See Birthing Center Chain of Command.)

NIGHT, WEEKEND AND HOLIDAY OPERATIONS

- The senior resident on call (a PGY 2, 3, or 4) meets with the junior resident on call at the beginning of the shift, to review the service. The junior resident attends to triage and L&D, and subsequently notifies the senior resident of all complicated admissions. The junior resident should notify the senior resident if L&D acuity does not allow triage supervision. The senior resident also accepts calls from the gynecology service, and may attend gynecology surgeries when activities on labor and delivery permit.

ROLE OF THE IN-HOUSE ATTENDING

The Residency Review Committee for Ob-Gyn mandates that all obstetrical services with residents have a fully trained Ob-Gyn attending physician in-house at all times. The University of Wisconsin residency program is in full compliance with that rule. Participation in the in-house coverage is a condition for participation in the resident service.

The role of the in-house physician is to provide back up to the resident, if needed. Many patients will have their own private physician to assist the resident with management decisions. Resident clinic deliveries are staffed by the UWMF attending designated as Res Clin on the OB Call Schedule. Maternal transports are accepted by the on-call MFM attending, but management may be signed out to the UWMF in-house generalist on-call. Note that on some days (usually Fridays), the Transport/Res Clinic attending is not the designated in-house attending.

In an emergency, or for an otherwise unattended delivery, the junior resident should first call the senior resident. The senior resident will then decide whether or not involvement of the in-house attending is warranted. The decision to call the in-house attending, should be the senior resident’s (unless that resident is unavailable), and is not up to nursing staff or unit clerks.

SOME GENERAL NOTES

Residents are excused from routine clinical duties during scheduled didactic sessions:

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<tr>
<th>Days</th>
<th>Time</th>
<th>Activities</th>
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<tr>
<td>Weekdays</td>
<td>7:00 - 7:30 a.m.</td>
<td>Sign Out Rounds</td>
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<tr>
<td>Mondays</td>
<td>7:30 - 8:30 a.m.</td>
<td>Resident OB Didactics</td>
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<td>Tuesdays</td>
<td>7:30 - 8:30 a.m.</td>
<td>Perinatal Conference</td>
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<tr>
<td>Wednesdays</td>
<td>7:30 – 8:30 a.m.</td>
<td>MFM Didactics</td>
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<tr>
<td>Thursdays</td>
<td>7:00 - 8:00 a.m.</td>
<td>Morbidity and Mortality Conference</td>
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<tr>
<td>Thursdays</td>
<td>8:00 - 9:00 a.m.</td>
<td>Departmental Grand Rounds</td>
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<tr>
<td>Thursdays</td>
<td>9:00 - 10:00 a.m.</td>
<td>Resident Didactics</td>
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<tr>
<td>Fridays</td>
<td>7:30 – 8:30 a.m.</td>
<td>L&amp;D Conference</td>
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During these times a single resident will be available by pager to respond to clinical emergencies. In addition, there is no resident coverage during the annual resident retreat, and no senior resident
Residents must attend their continuity clinic as per the schedule in this manual. Continuity clinics are not to be canceled except while on out of town electives, vacation, or during illness. The senior OB resident will designate appropriate cross-coverage.

Residents are expected to cover resident and high risk clinic patients < 20 weeks' gestation in the ER. A clinic patient is any patient who identifies the UW Antenatal Clinic or one of the residents’ continuity clinics as her source of prenatal care, and who has either been seen or has already made an appointment to be seen in the near future.

The OB residents will initially evaluate UW Family Medicine resident patients who present to triage for anything other than a term labor evaluation. The Family Practice team is responsible for the patient, her paperwork and orders, once she requires admission.

Normal term labor will be evaluated by the triage RN, who may contact the patient's attending physician directly. The junior resident may be called to evaluate a slide to confirm membrane rupture. The senior OB resident should be called if there is a perceived emergency.

All issues of controversy should first be discussed with the OB senior resident. Ideally, most matters can be resolved at that level.

In cases where a resident is faced with a high acuity situation, for which appropriate, timely staff backup is not available, the senior resident is specifically directed to invoke the Meriter Birthing Center "Chain of Command".

The senior resident should discuss the situation with the attending physician. If no resolution is achieved at this level, the UWMF in-house generalist or MFM attending should be contacted. A detailed description of additional steps in the Birthing Center Chain of Command follows below.

6/08
WHO  All Birthing Center RNs

WHAT  A process to resolve conflict in patient care situations

WHEN  Whenever there is a question regarding patient care, patient safety or when the RN is uncertain how to proceed when faced with a conflict situation

WHERE  On 4/5/6N (L&D, postpartum and/or nursery)
Since 2001, there have been a number of documented discussions between OB, Family Medicine and the residency program, but the resulting agreements have never been collated into a single document. The following is a summary of all pertinent past agreements. None of this is new, and all of it is based on the need for patient safety and appropriate educational supervision of residents as mandated by the ACGME.

**Triage Evaluation, Communication, Procedures and Ultrasound**
- Term (> 36 weeks’ EGA) labor evaluations are done by nursing staff in triage. The Family Medicine attending or DFM resident is responsible for completion of the admission paperwork and orders on uncomplicated labor patients.
- Patients < 36 weeks’ EGA who present to triage for evaluation will be seen by the OB resident assigned to triage (typically a PGY-1).
- Patients > 36 weeks EGA who present to triage with non-labor problems will also be seen by the OB resident assigned to triage.
- During the summer, the senior resident on the OB service may see the latter two categories of patients until the new PGY-1 residents have been sufficiently oriented to assume independent responsibility for triage evaluations.
- The OB resident will call the DFM faculty on call for OB by calling the pager listed for the appropriate call group, either personally or via the triage RN or unit clerk. The callback number that is given **will be the resident’s pager**, eliminating the need for the resident to wait in triage for callback. If that initial call is not returned within a reasonable time, the responsibility of contacting the attending will revert to the OB charge nurse, thus freeing the OB resident to attend to their other clinical duties.
- The FM attending will determine whether the patient’s primary physician (resident or faculty) needs to become involved. It will then be the responsibility of the DFM attending on call to communicate with the primary MD, **not** the OB resident’s. Residents are instructed to refer deviations from this expectation to the charge nurse.
- The DFM attending will clearly communicate to all parties whether there will be a DFM resident involved in the patient’s care.
- OB residents may not act as consultants and thus cannot perform procedures for which the attending MD has no privileges. This may include instrumental delivery, repair of complicated lacerations or other help with obstetrical complications. Junior OB residents may assist with cesarean sections staffed by a Family Practice attending with C-section privileges. If the assistance of a senior OB resident is requested, an OB attending consultant must also be identified.
- Residents are not credentialed for the independent performance of obstetrical sonograms upon which management decisions are to be based. This includes assessment of fetal lie, placental location or fetal well-being, such as BPPs. All potentially actionable scans must have an interpreting attending physician identified and must be documented with appropriately labeled images.
- The OB senior resident is not permitted to act as an independent obstetrical consultant without OB faculty backup. This applies to requests from Family Medicine faculty as well as from nursing staff.
An OB attending is to be notified for
- Placement of epidural
- Prolonged second stage (>2 hrs without or > 3hrs with an epidural)

An OB attending is to be formally consulted for
- PPROM < 36 weeks
- Abruption
- Fetal demise
- Preterm labor requiring IV meds (presumably also an oral nifedipine load)
- Mild preeclampsia (even if not requiring magnesium)
- Instrumental delivery if no privileges
- TOLAC needing medical induction
- Malpresentation
- Dystocia

A patient is to be referred to an obstetrician for
- History of classical C-section
- Uterine malformation
- Incompetent cervix with cerclage
- Breech
- Multiple gestation
- IDDM
- Preeclampsia requiring IV magnesium

In every case, the family physician is expected to have personally evaluated the patient before requesting OB consultation, according to Meriter policy, the request is to be made in person or by phone, attending to attending.

These guidelines also require the in-house presence of the attending physician for patient in active labor, defined as 7 cm cervical dilation in primigravidae or 5 cm in a multipara.

Residency Program Policy Regarding Intrapartum Emergencies

Whenever a junior resident feels overwhelmed by an intrapartum complication in a patient cared for by a family physician, s/he may decline further involvement in the patient’s care, unless an obstetrical consultant is identified. Because junior residents may not have the necessary confidence in their judgment, such a request may be communicated by the senior resident on service.

Revised 7/08
PGY-1 OBSTETRICAL ULTRASOUND

This is a 4 week rotation in the OB ultrasound unit which is located in the Perinatal Clinic at Meriter hospital. It features state of the art scanning equipment (2 GE Voluson 730 Expert and 2 GE E-8 machines with full 2, 3 and 4D abdominal and vaginal transducer complements) as well as a fully digital image processing and reporting system (GE Viewpoint). The unit is staffed full-time by RDMS sonographers, masters level genetic counselors and a dedicated faculty perinatologist. On Friday mornings, a pediatric cardiologist is also available to help interpret fetal echocardiograms.

Exams are performed for antenatal clinic patients and an ever-increasing number of referrals. Patients are referred by outside physicians seeking second opinion targeted exams. The unit also provides imaging support for the full range of invasive prenatal diagnostic procedures, including amniocentesis, CVS and fetal blood sampling. The 1st trimester prenatal diagnosis program is certified by the Fetal Medicine Foundation.

In addition to providing US training for residents in Obstetrics and Gynecology, the unit is a part-time training site for the University of Wisconsin’s RDMS program, and for UW’s residency program in Radiology. The unit has its own ultrasound reference library, and additional texts and journal articles are available from the attending faculty’s personal reference collections (bibliography on file in the ultrasound reading room).

Rotations in OB ultrasound take place primarily during PGY 1. An additional ultrasound elective may also be scheduled during year 3.

While completion of the minimum rotation sequence will result in the program director’s certification of the resident as competent to perform basic OB ultrasound, an elective is strongly encouraged, if the resident also desires training sufficient to eventually meet the AIUM’s certification “guidelines for training of physicians who evaluate and interpret diagnostic ultrasound examinations”. This certification requires the equivalent of at least three months of ultrasound training and the supervised performance, evaluation or interpretation of at least 300 scans. A typical ultrasound schedule consists of over 150 scans per week, only some of which the resident can attend. Ultrasound training at Meriter includes early pregnancy evaluation and endovaginal scanning, but formal Gyn ultrasound is not taught.

The resident on the Meriter US rotation participates in the call schedule at St. Mary’s (see Call section for details), and attends his/her Continuity Clinic.
Ultrasound Certification

- Each resident must have a staff physician orient him or her to the ultrasound machine.
- Each resident must have a staff physician observe them perform five ultrasound scans.

**Orientation to Ultrasound Machine**

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**Ultrasound Scan Performance**

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<tr>
<td>Number of fetuses</td>
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<td>Position of fetus</td>
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<td>Placenta location</td>
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<td>BPP</td>
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<tr>
<td>Basic Biometry (gestational age, EFW)</td>
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The Gynecologic Oncology Division is dedicated to the delivery of comprehensive compassionate health care to women with all stages of gynecologic malignancy. The activities of the division include direct patient care, education of practicing physicians and physicians in training, and both preclinical and clinical research. Residents are closely involved in the division’s activities and assume increasing responsibility as they progress through postgraduate training.

Residents are responsible for all aspects of inpatient care. The chief resident will assign cases to the junior residents and will coordinate the daily schedule and workload for residents and medical students. Residents will see new tumor patients. A resident should be present for all surgical cases. Graduated responsibility will allow maximal participation in surgical cases. Residents will attend the Tuesday and Friday clinics where active chemotherapy patients are seen. Residents will also participate in Thursday tumor board.

Attending staff will rotate the responsibility for inpatient coverage. It is expected that the chief resident will be in close contact with the assigned attending staff to coordinate the time for daily rounds. The covering attending staff should be notified immediately of any patient care emergencies, concerns regarding seriously ill patients, consults, or admissions.

Through such direct participation in the care of women with pelvic malignancies, it is anticipated that the graduating resident will be able to meet all gynecologic oncology education objectives of the Council on Resident Education in Obstetrics and Gynecology (CREOG) outlined in the learning objectives manual. It is anticipated that the Oncology rotation will be both an enjoyable and educational experience for residents and students.

**GYNECOLOGIC ONCOLOGY RESIDENT GENERAL GUIDELINES**

1) If the patient is in the OR, you will be there with her. When the patient goes into OR you will go in and stay with her until you take her to the recovery room.

2) One resident should be designated to be available for floor problems.

3) Every patient contact must be documented.
   a) Phone calls and prescriptions should be dictated.
   b) All outpatient encounters (clinic, ER, outpatient surgery) require a dictated note. This includes such mundane events as staple removal and wound checks.

4) Discharge summaries must be dictated the day the patient leaves, or the first day you return, if you are not present the day of discharge. Keep them short and try to list all referring MD’s.

5) If a Gyn Onc patient is required to be seen in the K4/2 Clinic, a call must be made to the clinic to ensure room availability. (263-7010)

6) All dictations should follow the formats listed in the Gyn Oncology handbook.
7) Inpatients are assigned to the PGY-1 & -2 residents by the chief resident.

8) PGY-1 & -2 residents will have “OR days” and “clinic days”. These should be scheduled at the beginning of the week and should be equally divided.

9) On Thursday morning at 10:30 there will be a Tumor Board where residents present four cases and pathology is reviewed.

10) Lists of the patients for Tumor Board must be given to Dr. Hafez in Surgical Pathology the Monday prior, and must include patient MR number.

11) On Thursday morning at 11:30 there will be a preoperative conference where residents present cases for the upcoming week.

12) On Wednesday morning at 7:30 there will be a weekly Gyn Onc Chapter Review session.

JUNIOR RESIDENT RESPONSIBILITIES GYN-ONCOLOGY SERVICE

1) Write note daily on all your hospitalized patients. Co-signing the student note does not meet this requirement. The care of your patient is your sole responsibility. The students may assist and the PG-4 may supervise, but accurate notes, orders, and decisions are primarily your responsibility.

2) Check path and lab results on our patients daily; keep result book up-to-date.

3) Answer patient and nurse calls promptly. Pages must be answered immediately; patient calls within 30 minutes. All patient contacts (day & night) must be documented in writing or typed on computer form and printed in triplicate.

4) Participate in surgery as assigned by PG-4, within the constraints of clinical duties.

5) Read appropriate sections of surgical atlas and the text prior to any procedure.

6) Review relevant anatomy prior to any procedure.

7) Present cases at weekly tumor board. Be prepared to discuss the relevant textbook features of the disease, and the management plan.

8) Present the complete pre-operative test results for all your surgeries planned for the following week. Schedule these evaluations so the information is available for this meeting.

9) Prepare your assigned chapter to present to the team and faculty.

5/08
Resident Orientation to Gyn/Onc

(Takes place at the beginning of each rotation.)

1. Responsibilities and expectations
2. Learning goals
3. Work hours
4. History and physical in FDS
5. Pre-operative patient book
6. 3rd year medical students
7. 4th year medical students
8. Attending problems/issues
9. Error-prone abbreviations, verbal order, sign-date-time, etc.
10. Gyn/Onc efficiencies project-OR
<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
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<tr>
<td>6:00-6:30</td>
<td>Morning Rounds F6/6</td>
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<td>M&amp;M/Journal Club</td>
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<td>7:30</td>
<td>OR-inpatient</td>
<td>OR-outpatient &amp; inpatient</td>
<td>Weekly chapter review-H4/655</td>
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<td>8:30</td>
<td>• OR-inpatient</td>
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<td>• Gyn/Onc New pt. Clinic – K4/2</td>
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<td>9:00</td>
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<td>Resident Conferences</td>
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<td>10:30</td>
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<td>Gyn/Onc Tumor Board-VA Hosp. Rm DM-231 Level M</td>
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<td>11:30</td>
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<td>Gyn/Onc Preoperative Conference VA Hosp. Rm DM-231 Level M</td>
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<td>1:00</td>
<td>• Gyn/Onc follow-up Clinic-K4/2</td>
<td>PGY-2 Continuity Clinic</td>
<td>Gyn/Onc follow-up Clinic-K4/2</td>
<td>PGY-4 Continuity Clinic</td>
<td>Gyn/Onc follow-up Clinic – K4/2</td>
<td>Gyn/Onc follow-up Clinic – K4/2</td>
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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
Hormonal contraception and IUDs
Managing side effects of hormonal contraception
Headache I and II
Sexual history taking
Eating disorders

Craig Roberts
Amy Miller
Sharon Woodford
Allan Rifkin
Paul Grossberg
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.

5/08

PGY-1 ON EMERGENCY MEDICINE

This four week block is spent in the ER at UW Hospital. The schedule is made out by the Medicine Chief resident. The rotation is under the supervision of Dr. Joseph Cline, 263-9753.
PGY-2 MERITER BENIGN GYNECOLOGY

GENERAL DESCRIPTION

- Participates in major and minor gynecologic surgeries.
- Participates in educational activities of service.
- Responsible for the care of gynecologic surgical and medical patients.
- Provides ER evaluation of emergency room patients during the hours of 7:00 a.m. to 5:00 p.m.

SPECIFIC RESPONSIBILITIES

1. Reports to the patient's personal attending physician for issues pertaining to direct patient care, and the Meriter in-house attending for clinical emergencies not covered by a designated attending physician. Keeps PGY-4 updated on the same. Reports to Drs. Klaus Diem or Kim Mackey for programmatic and educational issues pertaining to the Meriter Gynecology rotation.
2. Participates actively in the patient care and didactic activities of Meriter’s benign Gyn service, including the Meriter Gyn Clinic, as assigned by the PGY-4.
3. Attends surgical cases as assigned by PGY-4.
4. Attempts to meet in person and obtain a brief history on each surgical patient prior to surgery.
5. Assists with the admission and work up of "add-on" Gyn surgical patients - day of surgery admission (DOSA) H&P's are the responsibility of the patient's attending physician.
6. Assists with surgery and performs procedures as designated by the patient's attending physician.
7. Manages the daily care of all gynecology patients.
8. Is available to work up and admit emergency ER admissions to the Gynecology service when requested by the patient's attending physician.
9. Is available, at least by pager, until 7:00 p.m.
10. Attends Thursday morning conferences, unless prevented by a clinical emergency.
11. Participates in the Meriter Senior Call schedule (see Call section for details).

6/08
PGY-2 UWHC GYNECOLOGIC ONCOLOGY

Specific Responsibilities

Same as PGY-1 on Gyn Oncology (refer to that section), except that there is no PGY-4 backup for UWHC on-call at night, and the resident is responsible directly to the on-call attending physician.

5/08

PGY-2 REPRODUCTIVE ENDOCRINOLOGY

The purpose of this document is to orient the resident to the curriculum, routine, responsibilities and expectations of the reproductive endocrinology service at the University of Wisconsin. It is our goal that the individuals rotating on our service will become familiar with the physiology, diagnosis, and treatment of reproductive and hormonal problems as described by the CREOG guidelines. The series of clinical interactions, lectures, and readings that are outlined are not optional, and the evaluation of the resident will directly reflect his/her level of knowledge and preparedness.

I. The Outpatient Clinics

Specific Objectives

1. The resident will observe and learn interview techniques with specific reference to potential contributors to infertility or reproductive problems.
2. The resident will develop the ability to present patient problems and plans in an organized and comprehensive manner, learn the subtleties of the basic infertility evaluation, and the indications for each of the diagnostic techniques.
3. The resident will understand and be able to outline steroid biosynthesis and abnormalities as they may relate to various reproductive problems.
4. The resident will understand the principles and practice of ovulation monitoring and ovulation induction.
5. The resident will learn the technique of vaginal sonography to specifically include appreciation of normal anatomy, identification of ovaries, identification of early intrauterine pregnancy and pregnancy abnormalities, and identification and diagnosis of follicular development.
6. The resident will learn the technique of intra-uterine inseminations.

II. Hysterosalpingograms/Sonohysterograms

Objectives

1. The resident should understand the indications for hystero grams and sonohysterograms, as well as the information expected to be obtained by a well-performed study.
2. The resident should be familiar with the varying techniques of performing hysterosalpingograms and sonohysterograms.
3. The resident will be expected to observe the staff initially and ultimately to perform hysterosalpingograms and sonohysterograms under faculty supervision.

III. Operating Room

Objectives

1. The resident will be expected to fully understand the diagnosis, indications for surgery, and potential management alternatives of every patient going to the operating room.
2. The resident will learn the principles of diagnostic laparoscopy for infertility as well as the techniques of performing operative laparoscopy with one or more accessory punctures.
3. The resident will become familiar with instrumentation for advanced laparoscopy including safe use and appropriate maintenance of the equipment.
4. The resident will learn the common complications of laparoscopy, the best techniques to avoid these complications, and techniques and management of all major complications of laparoscopy.
5. The resident will increase his/her technical skills in operative laparoscopy to include lysis of adhesions, treatment of endometriosis, tuboplasty, myomectomy, and tubal anastomosis procedures under direct and ongoing supervision by the attendings.
6. The resident will learn indications and techniques of both diagnostic hysteroscopy and operative hysteroscopy in a manner analogous to objectives of laparoscopy.

IV. Conferences

Residents and students on our service are expected to attend all resident conferences. Attendance at these conferences is required, not optional.

V. Oral presentations

Objectives

1. The resident will improve their oral presentation skills. She/he will be expected to formally present a pre-approved topic weekly while rotating on the REI service. She/he will also be expected to formally present patient cases for morbidity and mortality conferences twice monthly. This presentation will be rehearsed at some point prior to the actual conference with one of the REI attendings.

VI. Administrative Responsibilities

Residents must keep case reports of all patients seen. As our rotation is primarily outpatient rather than inpatient, it is therefore expected that the residents will keep a list of outpatients seen along with diagnosis and any procedure performed by the resident or with which the resident assists.

As on all rotations, the responsibility of dictating discharge summaries for inpatients will be assumed by the resident on the service. In general, operative notes are dictated by the resident. The responsibility for dictation should be discussed with the faculty member involved should there be any question.
An important part of the resident's rotation is evaluation of the faculty. It should be obvious from this document that the Reproductive Endocrinology faculty expects that the residents and students rotating on the service will be committed to learning the basic information in the discipline. Likewise, the resident should expect that the faculty will devote the time and effort required to teach effectively.

VII. Vacation and Absenteeism Policy

Residents rotating on the Reproductive Endocrinology service are to take no more than one week of vacation during this period. No resident is to be pulled from the service to assist on other services without the specific approval of Dr. Lebovic. Failure to attend section activities or absenteeism from significant portions of the rotation may result in remedial work during elective time.

VIII. Evaluation

The faculty will assess the performance of each resident by observing his or her ability to evaluate outpatients, preparedness at didactic sessions, self-initiated learning, and technical skills. In addition, there will be an oral exam at the conclusion of the rotation. The faculty will provide a written assessment of the resident to the Chairman's office with individual comments by each faculty member. Time will be scheduled throughout the rotation to discuss resident performance.

IX. Conclusion

The faculty of the Division of Reproductive Endocrinology understand that only a small percentage of residents will choose to pursue careers in this discipline. However, we also recognize that the time spent with our division is likely to be the only formal exposure of a resident to reproductive endocrinology. Therefore, there is significant pressure for both faculty and residents to get the most out of this time. Residents should expect that an enthusiastic commitment to learn will be rewarded with an enthusiastic commitment to teach.

6/08
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.

5/08

PGY-2 ULTRASOUND/RESEARCH

This year the PGY-2 will be in U/S Monday-Thursday and will do research on Fridays. They will also be excused from ultrasound for their assigned RCC half day.
Specific Responsibilities

1. Normally works with obstetrical attendings on matters of patient care. Works with FP attendings only when OB consultation has been requested.
2. Reports to the patient's personal attending physician (OB or Family Medicine) for issues pertaining to direct patient care, the St. Mary's in-house attending for clinical emergencies not covered by a designated attending physician, and to Dr. Chris Federman or Dr. Gary Waters for programmatic and educational issues.
3. Works with the Family Medicine and Practice (FP) residents in the care of low risk obstetrical patients and participates actively in the obstetrical education of the on-call FP residents.
4. Interprets antenatal fetal testing for private OB attendings.
5. Maintains awareness of patients admitted for cervical ripening procedures.
6. Together with the PGY-3 rounds on and manages the day to day care of antepartum and postpartum patients followed by the OB attendings.
7. Assumes primary responsibility for the care of complicated OB patients:
   - C-sections
   - Multiple gestation
   - Diabetes requiring insulin
   - Preterm ROM < 36 weeks' gestation
   - Preterm labor for suppression
   - Forceps deliveries, including rotations
   - Preeclampsia and severe chronic hypertension
   - Preterm fetal demise
   - Malpresentations (breech, face, brow, compound)
   - Placenta previa
   - Abruption
   - FHT abnormalities and fetal scalp sampling
   - Severe postpartum hemorrhage
   - Other diagnoses at the discretion of the attending obstetrician
8. Rounds on and manages the postoperative care of C-section patients.
9. Makes sure that appropriate attending supervision is available for all clinical activities.
10. Schedules and prepares for Wednesday morning OB conferences at 7:00 am.
11. Attends the first hour Thursday morning conference and continuity clinic in compliance with the ACGME resident duty hour guidelines.
12. Assist with all "emergent" Gyn surgical cases as a second priority to birthroom duties.

5/08
OB residents round on all high risk, cesarean, ante-partum and assigned patients.

Communicates concerns or problems with the on-call doctor or primary attending.

Triage patients:
All patients less than 35 weeks gestation and other high risk patients are to be seen by the OB residents if the patient is assigned to an OB/Gyn doctor or a family practice doctor has obtained an OB consult.

Low risk patients who have been waiting greater than 30 minutes may be seen by the OB resident to expedite the triage process, improve patient care and assist the FP resident. FP residents are there to learn and must not be bypassed unless patient care is compromised.

Expectations of the OB resident include:
Proactive communication with the FP resident regarding all laboring patients. OB residents will assume a helpful and managerial attitude toward all patients except the Family Practice Clinic continuity patients. OB residents should think of themselves in a leadership role and will continue to manage patients with direct supervision from the OB attending.

OB residents will anticipate probable c-sections and operative deliveries to remain involved in these experiences. In general, the goal it not to have the FP resident “drowning” while the OB resident sits idle. Conversely, FP residents can be involved with appropriate level triage patients such as ROM, if the OB resident is busy in consecutive c-sections.

The goal is to build collegiality, which is an important tool to learn in the practice of medicine.
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:

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<td>Trauma Surgery</td>
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<td>Transplant Surgery</td>
<td>Urology</td>
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<td>Peripheral Vascular Surgery</td>
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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:
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

2. Fellow
   - Pulmonary/Critical Care
   - Anesthesia/Critical Care

3. Residents
   - Internal Medicine
   - Anesthesiology
   - Surgery

4. Interns
   - Anesthesiology
   - Urology
   - Internal Medicine
   - OB/GYN
   - Orthopaedics
   - ENT
   - Plastics
   - Neurosurgery

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 FiO₂ ≥ 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. Resuscitation Status Orders

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

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intubation/mechanical ventilation</td>
<td></td>
</tr>
<tr>
<td>Chest Compressions</td>
<td></td>
</tr>
<tr>
<td>Defibrillation/Countershock</td>
<td></td>
</tr>
<tr>
<td>Antiarrhythmic Drugs</td>
<td></td>
</tr>
<tr>
<td>Vasoactive Drugs</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

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      Lumbar Puncture
Mechanical Ventilation    Paracentesis
Central Line Insertion     Thoracentesis
Pulmonary Artery Catheter Insertion Chest Tube Insertion
Arterial Line Insertion     Bronchoscopy
Peripherally inserted Central Line

I have read and understand this form.
COMMONLY PERFORMED PROCEDURES AND THE MORE COMMON POSSIBLE ASSOCIATED COMPLICATIONS

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 heartbeat 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

DECISION MAKER FOR PATIENT

DECISION MAKING CAPACITY

Yes  No

Medical Decision Making by Patient  Default Medical Decision Making

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
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 Health 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:
- 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 Glasgow 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 patient's 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.
PGY-3 MERITER PERINATAL CLINIC RESIDENT

GENERAL DESCRIPTION

- The Perinatal Clinic resident’s primary responsibility is the patients receiving antenatal care in the Meriter High Risk Clinic.
- The Clinic Resident functions under the direction of the Maternal-Fetal Medicine faculty or fellows assigned to cover the Perinatal Clinic. The clinic resident reports to the OB chief resident and the assigned MFM faculty or fellows. All residents are answerable to Dr. Dinesh Shah for programmatic and educational issues.
- The PGY-3 helps cover the ante- and intrapartum care of patients on the University’s Perinatal Service in conjunction with the PGY-4.
- Service operations are described in more detail to follow.

SPECIFIC RESPONSIBILITIES

1. 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.
2. 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.
3. Specific clinical duties include participation in morning rounds on patients on the OB Service.
4. 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.
5. On days when a PGY-1 attends the resident clinic, the Perinatal Clinic resident may cover that intern’s duties on Labor and Delivery (usually triage and scheduled procedures).
6. The resident is primarily responsible for 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. These activities occur under the guidance of the faculty members or fellows in the Division of Maternal-Fetal Medicine.
7. The resident should make every attempt to attend as many Maternal-Fetal Medicine consultations as possible.
8. Whenever possible, the Perinatal Clinic resident (usually working in conjunction with the OB Chief) attends scheduled deliveries and other operative cases on High risk clinic patients.
9. A major responsibility for the PGY-3 is the supervision of third and fourth year medical students who may attend the clinic. This includes the demonstration of appropriate methods for patient evaluation, supervision of pelvic examinations, explanation of
management rationales and review and correction of student progress notes.

10. Although dictation of the discharge summary by the resident most familiar with a patient’s case (this includes the PGY-4!) is specifically encouraged, the Perinatal Clinic resident is ultimately responsible for the 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.

11. The resident is excused from his/her duties to attend continuity clinic.

12. The perinatal clinic resident year resident is responsible for attendance at all scheduled didactic sessions., and may be asked to participate as presenter of a case during Tuesday’s Perinatal Conference.

13. The PGY-3 is responsible for reading and independent study based on the reading list and learning objectives.

5/08

PGY-3 MERITER SENIOR NIGHTFLOAT

GENERAL DESCRIPTION

- The third year resident has comprehensive responsibility for the clinical and educational operations of the entire Meriter Obstetric Service at night. S/he directs the activities of the junior nightfloat resident, and of the on-call medical students.
- The senior nightfloat resident reports to the patient's personal attending physician (OB or Family Medicine) for issues pertaining to direct patient care, the in-house attending for clinical emergencies that are not covered by another designated attending physician, and to Dr. Shah for programmatic and educational issues.
- OB service operations are described in more detail in “PGY-1 Meriter Obstetrics” section.
- L&D acuity permitting, the senior nightfloat resident also has comprehensive responsibilities to the Meriter Gynecology service (see below).

SPECIFIC RESPONSIBILITIES

1. 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.

2. 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, at the request of the attending gynecologist, may evaluate attending patients presenting to Meriter ER with Gyn complaints. The senior nightfloat resident in expected to evaluate all resident clinic patients (OB- or Continuity Clinic) patients presenting in the Emergency Department.

3. The senior nightfloat resident has broad responsibilities for the operations of the entire obstetrical service, assuring that there is an integrated and teamwork-oriented approach to patient care. While the junior OB nightfloat residents may function in direct consultation with the attending faculty, the senior nightfloat resident remains available to assist and to
provide advice and guidance whenever necessary.

4. For resident OB clinic patients, the Senior nightfloat 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.

5. The PGY-3 is expected to be knowledgeable and informed about 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 nightfloat may choose to take over the management of a particularly complicated patient or s/he may delegate this responsibility to the junior resident.

6. At night, the PGY-3 is the individual charged with facilitation of communications with the nursing staff, and should be 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).

7. The senior resident may assist with the care of CNM or Family Practice patients, as long as these activities are under the guidance of a full-time or volunteer faculty physician with appropriate clinical privileges. The senior resident is not available to act as an independent consultant.

8. The senior nightfloat resident attends scheduled am didactic sessions, and attends her/his am Continuity Clinic in compliance with ACGME resident duty hour guidelines.

9. The PGY-3 is responsible for self-directed reading and study, as per the suggested reading list and the Learning Objectives.

6/08

PGY-3 MERITER BENIGN GYNECOLOGY

GENERAL DESCRIPTION

- Participates in major and minor gynecologic surgeries.
- Participates in educational activities of service.
- Responsible for the care of gynecologic surgical and medical patients.
- Provides ER evaluation of emergency room patients during the hours of 7:00 a.m. to 5:00 p.m.

SPECIFIC RESPONSIBILITIES

1. Reports to the patient's personal attending physician for issues pertaining to direct patient care, and the Meriter in-house attending for clinical emergencies not covered by a designated attending physician. Keeps PGY-4 updated on the same. Reports to Drs. Klaus Diem or Kim Mackey for programmatic and educational issues pertaining to the Meriter Gynecology rotation.

2. Participates actively in the patient care and didactic activities of Meriter’s benign Gyn service, including the Meriter Gyn Clinic, as assigned by the PGY-4.

3. Attends surgical cases as assigned by PGY-4.

4. Attempts to meet in person and obtain a brief history on each surgical patient prior to
5. Assists with the admission and work up of "add-on" Gyn surgical patients - day of surgery admission (DOSA) H&P's are the responsibility of the patient's attending physician.
6. Assists with surgery and performs procedures as designated by the patient's attending physician.
7. Manages the daily care of all gynecology patients.
8. Is available to work up and admit emergency ER admissions to the Gynecology service when requested by the patient's attending physician.
9. Is available, at least by pager, until 7:00 p.m.
10. Attends Thursday morning conferences, unless prevented by a clinical emergency.
11. Participates in the Meriter Senior Call schedule (see Call section for details).
12. Completes and submits M&M case list the Monday before Thursday conference.

6/08

PGY-3 ST. MARY’S HOSPITAL OBSTETRICS

Specific Responsibilities

1. Normally works with obstetrical attendings or matters of patient care, works with FP attendings when OB consult is requested.
2. Reports to the patient's personal attending physician (OB or Family Medicine) for issues pertaining to direct patient care, the St. Mary's in-house attending for clinical emergencies not covered by a designated attending physician, and to Dr. Chris Federman or Dr. Gary Waters for programmatic and educational issues.
3. Works with the Family Medicine and Practice (FP) residents in the care of low risk obstetrical patients and participates actively in the obstetrical education of the FP residents.
4. Interprets antenatal fetal testing for private OB attendings.
5. Maintains awareness of patients admitted for cervical ripening procedures.
6. Rounds on and manages the day to day care of antepartum patients admitted by the OB attendings.
7. Assumes primary responsibility for the care of all complicated OB patients:
   - C-sections
   - Multiple gestation
   - Diabetes requiring insulin
   - Preterm ROM < 36 weeks' gestation
   - Preterm labor for suppression
   - Midforceps deliveries, including rotations
   - Preeclampsia and severe chronic hypertension
   - Preterm fetal demise
   - Malpresentations (breech, face, brow, compound)
   - Placenta previa
   - Abruption
• FHT abnormalities and fetal scalp sampling
• Severe postpartum hemorrhage
• Other diagnoses at the discretion of the attending obstetrician
• See PGY-2 section for cases appropriate for the FP resident on SMHMC OB.

8. Rounds on and manages the postpartum care of complicated patients who were followed by one of the OB resident in labor.

9. Rounds on and manages the postoperative care of C-section patients.

10. Makes sure that appropriate attending supervision is available for all clinical activities.

11. Schedules and prepares for the Wednesday morning OB conferences in conjunction with a designated staff physician at 7:00 am. Each resident is required to personally give one conference while on the service.


13. Orient the PGY-2 nightfloat to the SMH OB rotation.

14. Assist with "add-on" Gyn surgical cases as a second priority to birthroom duties while on call.

15. Participates in the St. Mary’s call schedule (see Call section for details).

5/08

St. Mary’s Birth Suites – OB Resident Duties
Developed February 2006
OB Improvement Team

OB residents round on all high risk, cesarean, ante-partum and assigned patients.

Communicates concerns or problems with the on-call doctor or primary attending.

Triage patients:
All patients less than 35 weeks gestation and other high risk patients are to be seen by the OB residents if the patient is assigned to an OB/Gyn doctor or a family practice doctor has obtained an OB consult.

Low risk patients who have been waiting greater than 30 minutes may be seen by the OB resident to expedite the triage process, improve patient care and assist the FP resident. FP residents are there to learn and must not be bypassed unless patient care is compromised.

Expectations of the OB resident include:
Proactive communication with the FP resident regarding all laboring patients. OB residents will assume a helpful and managerial attitude toward all patients except the Family Practice Clinic continuity patients. OB residents should think of themselves in a leadership role and will continue to manage patients with direct supervision from the OB attending.

OB residents will anticipate probable c-sections and operative deliveries to remain involved in these experiences. In general, the goal it not to have the FP resident “drowning” while the OB resident sits idle. Conversely, FP residents can be involved with appropriate level triage patients such as ROM, if the OB resident is busy in consecutive c-sections.
The goal is to build collegiality, which is an important tool to learn in the practice of medicine.

**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 housestaff 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
4. Cytology Laboratory, Contact Dr. Daniel Kurtycz 262-9461
5. Mammography at UWH, Contact Radiology Housestaff Secretary 263-8310
6. Obstetrical Ultrasound at Meriter Hospital, Contact Barb Trampe, RDMS 267-6359
7. Pregnancy Terminations, Contact Dr. Dennis Christensen, 251-7000
8. Pelvic Dissection at UW Department of Anatomy (limited availability), Contact Dr. Edward Bersu 262-3476
9. Sexually Transmitted Disease Clinic at Student Health Service, Contact the Student Health Service 262-7330
10. Urogynecology at UWH, Contact Dr. Thomas Julian 263-5573
11. Research, Arrange through identified staff mentor. (See “Resident Research and Presentations” section for affiliated basic science labs)
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.

6/08

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.

6/08

UW-MERITER OBSTETRIC SERVICE

PGY-4 OB Chief Resident

GENERAL DESCRIPTION

- The fourth year resident has comprehensive responsibility for the clinical and educational operations of the entire Meriter Obstetric Service. S/he directs the activities of the junior residents on service, and of the medical students.
- The OB chief resident reports to the patient's personal attending physician (OB or Family Medicine) for issues pertaining to direct patient care, the in-house attending for clinical emergencies that are not covered by another designated attending physician, and to Dr. Shah
for programmatic and educational issues.

- Service operations are described in more detail in “PGY-1 Meriter Obstetrics” section.

SPECIFIC RESPONSIBILITIES

1. 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 a.m. and 5:00 p.m. The resident must carry a pager.

2. The PGY-4 takes OB night call in the "Senior" call rotation (see Call section for details).

3. In addition to clinical duties on the obstetric service, the fourth year resident's on-call responsibilities may include cross-coverage for Meriter gynecology patients (including emergency surgery), and the rendering of supervision and assistance to the on-call junior resident.

4. The senior resident has broad responsibilities for the operations of the entire obstetrical service, assuring that there is an integrated and teamwork-oriented approach to patient care. While the junior OB residents may function in direct consultation with the generalist faculty, the senior OB resident remains available to assist and to provide advice and guidance whenever necessary.

5. For resident clinic patients, the Senior 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.

6. The senior resident organizes and leads morning rounds. On weekdays, s/he is responsible for organizing the 7:00 a.m. sign out rounds.

7. The PGY-4 is expected to be knowledgeable and informed about 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 PGY-4 may choose to take over the management of a particularly complicated patient or s/he may delegate this responsibility to another resident.

8. The OB chief resident is responsible for maximally effective manpower distribution, and may assign any of the more junior residents to appropriate duties. These assignments should generally not be questioned.

9. The PGY-4 is the individual charged with facilitation of communications with the nursing staff, and should be 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 (under Meriter OB Service ops) and Teaching Service Policy below for details.)

10. The senior resident may assist with the care of CNM or Family Practice patients, as long as these activities are under the guidance of a full-time or volunteer faculty physician with appropriate clinical privileges. The senior resident is not available to act as an independent consultant.

11. The PGY-4 is responsible for making the daily assignment schedule, and for approving vacations on the OB service.

12. The senior resident has final responsibility for timely medical records completion on the obstetrical service. S/he is expected to participate in the dictation of discharge summaries, and to assign these dictations to more junior housestaff, in such a way as to
assure their timely completion.

13. The fourth year resident attends scheduled didactic sessions, and ensures the timely collection of cases and fetal heart rate tracings for Friday's "Labor Case Management Conference".

14. The PGY-4 is responsible for self-directed reading and study, to assure adequate preparation for passage of the written Ob-Gyn Boards.

6/08

OB TEACHING SERVICE POLICY

In order to protect the OB-Gyn residents’ educational experience on Meriter Obstetrics rotations, the following protocols will be followed:

All routine labor evaluations of term (>36 weeks’ gestation), except for resident continuity or obstetrical clinic patients, will be performed by triage nursing or hospital staff. Preterm patients and patients with problems unrelated to normal term labor will continue to be evaluated by house staff.

At times of unusually high patient census (given normal resident manpower, >/= 10 labor or preterm labor patients on 4/5), unit acuity (i.e. ICU patients), or at times of resident manpower shortage, the senior resident on OB will be notified of ALL new admissions to either the labor floor or to the antepartum service. This notification can either be by triage staff or the patient’s attending physician. Considering the available manpower, unit acuity, number of laboring patients and other hospital activities (i.e. Gyn cases), the senior resident may elect not to accept the new admission onto the resident teaching service. In general, teaching service preference will be given to complicated and/or antepartum patients, or patients likely to require an operative intervention.

If a patient is not admitted to the teaching service, the charge nurse will be informed, and management will be by the patient’s attending MD in conjunction with unit nursing staff.

The charge nurse will subsequently remain responsible for maintaining communication with the patient’s attending physician. Any request for residents to become involved in the care of a patient, who is not on the teaching service, will be communicated directly by the attending physician to the senior resident. The unit clerk and nursing staff will have no role in this process.

The appropriateness of senior resident invocation of the teaching service “cap” will be reviewed periodically by the residency director, in consultation with OB attending staff.

Housestaff will round only on teaching service patients. At times of high census, students may be asked to make am rounds on routine postpartum patients, while housestaff will continue to round on all teaching service patients who are postop, have an antepartum problem, or any patient on Magnesium or an antibiotic. Attempts will be made to complete notes and orders before a.m. sign-out rounds on these patients, but housestaff may not see routine postpartum patients until later in the day.
In order to assure appropriate resident supervision at all times, a patient may be dropped from the teaching service, if, after appropriate notification, the patient’s attending physician or a clearly designated alternate is not in house when a nullipara is at 7 cm, or a multipara is at 4-5 cm cervical dilation and in active labor, or if an attending physician fails to respond to resident concerns about the maternal medical condition, or about the fetal status.

Problems with the content or implementation of this policy will promptly be brought to the residency director’s attention.

6/08

PGY-4 MERITER BENIGN GYNECOLOGY

GENERAL DESCRIPTION

- Has comprehensive responsibility for the clinical and educational operations of the entire Meriter Benign Gynecology Service, including the Meriter Gyn Clinic.
- Directs the activities of the PGY-3 and PGY-2 residents and the medical students.
- Reports to the patient’s personal attending physician for issues pertaining to direct patient care.
- Participates in major and minor gynecological surgeries.
- Provides ER evaluation of emergency room patients during the hours of 7:00 a.m. to 7:00 p.m.
- Weekends are protected time for final preparation of the senior research project.

SPECIFIC RESPONSIBILITIES

1. Reports to Drs. Klaus Diem or Kim Mackey for programmatic and educational issues pertaining to the Meriter Gynecology rotation.
2. Assigns residents on the benign service to surgical procedures. When there are not enough residents to cover all surgeries, discusses coverage with attending staff.
3. Ensures medical students are assigned to surgical cases.
4. Provides the OR with daily resident coverage at the beginning of the rotation for the entire rotation. Notifies OR of planned absences.
5. Responsible for knowing about any pre-operative and post-operative problems with surgical patients.
6. Pathology Conference: Keeps track of interesting pathology cases and checks with Dr. Diem for his recommendations. Provides three to seven cases to Pathology the third Friday of the month in preparation for Pathology Conference the last Friday of the month. Prepares a brief history on each case.
7. Is available to work-up and admit ER admissions to Gynecology Service when requested by the patient’s attending.
8. Ensures preparation for didactic sessions by team Monday, Tuesday, and Wednesday mornings.
9. Attempts to meet in person and obtain a brief history on each surgical patient prior to surgery.
10. Assists with the admission and work up of “add-on” Gyn surgical patients – day of surgery admission (DOSA) H&P’s are the responsibility of the patient’s attending physician.
11. Assists with surgery and performs procedures as designated by the patient’s attending physician.
12. Attends Thursday morning conference, unless prevented by a clinical emergency.

6/08

PGY-4 UWHC GYNECOLOGIC ONCOLOGY

Specific Responsibilities

1) Supervise work rounds each morning M-F. See and examine all ICU patients and all seriously ill patients and document impression and plan.
2) Monitor daily the completion of the path/lab book.
3) Participate in all radical surgeries.
4) Monitor PG-1 and –2 preparation for Thursday preoperative conference.
5) Select 3-4 interesting cases from recent surgery or outpatient new patient consultations to present at Thursday Tumor Board.
7) Post daily census with accurate resident designation at Nurse's station each morning to let RN's know who to page.
8) Assign chapters to be presented by residents at weekly chapter review.
9) Back up PGY-1’s on UWHC call.
10) Supervise and teach medical students (3rd yr), including assignment of presentation topics for the week.

Refer to “PGY-1 UWHC Gyn Oncology” section for service operations.

6/08

PGY-4 UNIVERSITY HOSPITAL GYNECOLOGY AND PELVIC RECONSTRUCTIVE SURGERY

University of Wisconsin Hospital and Clinics (UWHC) Gynecology rotation

The UWHC Gynecology rotation is staffed by a PG-4 and attending physician. The responsibilities of the service include coverage of emergency room, inpatient consults during the day, gynecology clinics, staffing the gynecologic surgeries at UWHC, and supervision of medical students.
Responsibilities of the PG-4:

The PG-4 is responsible for managing the Gynecology Service.

Gynecology clinic

1. The PG-4 attends clinic all day Thursday and Friday, Tuesday afternoons, and Monday mornings. The resident will see patients along with Dr. Julian and may do preoperative evaluations on patients they might otherwise not see.

2. The PG-4 triages all urgent and emergent patients.

3. Patient results review and notification will be done by the attending physician.

Dictations

All notes are dictated on WISCR. Include the referring physician on all dictations.

Emergency room

The PG-4 will provide daytime and on call consultation for all emergency room patients and requested consults to obstetrics and gynecology.

Pagers

Beepers should be on from 7 AM to 5 PM every day. If you are not available, please notify the page operator who is covering your pager.

Surgical procedures

1. The PG-4 is responsible for assisting at surgical procedures on the service. Surgery days are Tuesday morning for ambulatory cases and all day Wednesday for hospitalized patients.

2. The PG-4 is responsible for knowing about any pre-operative and post-operative problems with surgical patients.

Inpatient responsibilities

The PG-4 is responsible for knowing about every patient on the inpatient Gynecology Service and inpatient consults.

Medical students

The PG-4 is responsible for supervision and education of medical students assigned to the
Consultations

1. The PG-4 is responsible for requested gynecologic consultations. The supervising staff should be informed about the consultations and will see the patients. All inpatient and Emergency Room consults should be dictated on WISCR (dictation number is 10).

2. All consultations on pregnant patients should be staffed with the MFM attending physicians.

Off service responsibilities include:

1. Monday afternoon Continuity Clinic.

2. Morbidity and mortality conference, Journal Club, Grand Rounds, and other educational conferences as dictated by the residency program director.

Conferences:

No scheduled conferences or rounds. You will work directly with the attending physician.

6/08

PGY-4 ST. MARY’S HOSPITAL GYNECOLOGY

Responsibilities

1. Reports to the patient's personal attending physician for issues pertaining to direct patient care, the St. Mary's in-house attending for clinical emergencies not covered by a designated attending physician, and to Dr. Chris Federman for programmatic and educational issues.

2. Reviews the O.R. schedule the preceding afternoon to plan availability and time required for A.M. rounds.

3. Makes daily rounds on gynecology patients.

4. Completes morning rounds prior to the first scheduled case (7:30 a.m.)

5. Attempts to meet in person and obtain a brief history on each surgical patient prior to surgery.

6. Admits and works up "add-on" Gyn surgical patients - day of surgery admission (DOSA) H&P's are the responsibility of the patient's attending physician.

7. Performs or assists with scheduled Gyn surgical cases and procedures as delegated by the patient's attending physician.

8. Dictates operative summaries on the day of surgery.

9. Is available until 7:00 p.m. when not on call.

10. 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.

11. Attends Dr. Federman's Tuesday morning Gyn lecture.
12. Attends the Wednesday morning OB conferences whenever possible.
14. Assist with all "add-on" Gyn surgical cases as a second priority to birthroom duties while on call.
15. Participates in the St. Mary’s call schedule.
16. Attends her/his Continuity Clinic.

5/08
ACGME CASE LOG – Tracking Your Clinical Experience

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

Each resident is responsible for keeping an accurate, up-to-date record of their clinical experience. Residents are given a Case Log instruction manual, which explains how to correctly enter their surgical procedures and ambulatory patient encounters. Also, consult your fellow residents when “stats” questions arise, to ensure that you gain full credit for your clinical experience.

*Residents are required to up-to-date their case log monthly.* The Education Program Manager and Residency Coordinator will be monitoring the Case Log system to ensure timely record keeping.

If you have questions regarding the Case Log system, contact the Residency Program Coordinator, 263-1228, or the Education Program Manager, 417-7906.

6/08
EVALUATION

The primary purpose of the evaluation process is to promote resident learning and provide evidence of resident competence. A secondary purpose of evaluation is to measure the effectiveness of the residency program. Our program uses a variety of formative and summative evaluations.

Formative Evaluation

Formative evaluation has a prospective focus in that it assesses today’s performance with the intent of improving future practice. This is an ongoing process that helps the resident identify their professional strengths and weaknesses. Formative evaluation provides the feedback that is essential to a resident’s professional development.

Residents are constantly receiving feedback during the day from their attendings, fellow residents, other healthcare providers and patients. And there are several formal types of formative evaluation:

- Faculty members have the opportunity to electronically submit “on the fly” evaluations that express praise or concern regarding resident performance.
- Chief residents on appropriate services provide face-to-face performance evaluations for junior residents.
- Resident surgical skills are assessed periodically using a specially designed surgical skills evaluation tool.
- Patients in the Residency Continuity Clinic complete surveys about the resident performance in the areas of communication and interpersonal skills.

Summative Evaluation

Summative evaluation is a retrospective process conducted at the end of a rotation, semi-annually, and annually. The purpose of summative evaluation is to assess completed work and to identify patterns and trends in resident performance. This information is a guide for the residents and the residency program in developing educational plans for the future. Summative evaluations use ACGME competencies as criteria to evaluate resident performance.

Here are several summative evaluations that residents receive:

- At the conclusion of each rotation, faculty will evaluate the residents on their service. On some services the faculty meet to generate a single evaluation for the resident. On other services faculty fill out resident evaluations individually.
- Residents also evaluate the work of their fellow residents on each service at the conclusion of rotations. Senior residents evaluate the work of the junior residents and share those evaluations in face-to-face meetings. Junior residents evaluate senior performance in anonymous evaluations that are compiled every six months and shared with the senior resident.
- Professional associates (nurses and allied health providers) and will be asked to evaluate the resident’s performance at the conclusion of each rotation.
• Medical students evaluate resident teaching at the conclusion of their six-week clerkship.
• The CREOG written exam is given each January to all residents and tests medical knowledge and problem solving as applied to patient care.
• A summative surgical skills evaluation is completed annually for each resident.
• The program director reviews all written evaluations, verbal feedback, and CREOG exam scores semi-annually and then meets with each resident. These meetings provide an opportunity for the program director and resident to discuss resident performance and goals for the next six months. This review process is documented on the Biannual Resident Progress Review form and place in the resident’s portfolio.
• Prior to resident graduation, a final evaluation is prepared by the program director, which certifies that the resident is competent to practice independently. This document will be maintained in the institution's permanent files.

It is important that residents are able to review their evaluations in a timely manner. The residency program maintains an online portfolio for each resident and scanned evaluations are uploaded to the resident portfolio for their regular review. Review of these evaluations allows the resident to reflect on their performance and make changes where necessary.

REMEDICATION

In selecting individuals for our program we have made a commitment to fully support their development into competent, productive and independent Ob/Gyn physicians. Since residents arrive with varied backgrounds, aptitudes, and skill sets, it is expected that each will travel a unique path in their professional development. Remediation is an educational resource that exists to provide residents with additional support when needed.

Remediation is a natural extension of the evaluation process. When deficits are highlighted by the evaluation process, most residents will make necessary corrections on their own. Remediation exists for those residents who require direct, formal educational support from the residency program. While residents are encouraged to seek remediation support, it is more often the case that the residency program will initiate a remediation program based on clinical evaluations, faculty and staff reports, or CREOG exam results.

The process for implementation of remediation typically proceed as follows:

• The need for remediation becomes evident to the Program Director (e.g. poor rotation evaluations; CREOG exam scores below 30th percentile).
• Meeting with the resident. The Program Director meets with the resident to review evaluations and gain the resident’s perspective on the situation.
• Problem identification. The Program Director investigates to determine the source of the problem - physical, emotional, cognitive, interpersonal, structural (e.g. time management).
• The Program Director meets with the Education Program Manager and/or qualified faculty to develop a preliminary remediation plan.
• Meeting again with the resident. The Program Director reviews the remediation plan with the resident, solicits resident input, sets a timeline with performance benchmarks,
and, if required, selects a remediation mentor. The written remediation plan is signed by
the resident and the Program Director, a copy is provided to the resident, and a copy
becomes part of the resident’s file. The remediation plan is implemented at that point.

- The Residency Education Committee (in session without resident representatives) will
  review the remediation plan at their next meeting.
- The Program Director or their representative periodically checks on resident progress
toward meeting remediation goals.
- Remediation is reviewed at the next bi-annual resident meeting with the Program
  Director.
- Once remediation goals are met, the Program Director and resident will sign off on the
  remediation plan and the form will be placed in the resident’s file.

Remediation is an educational process, not a punitive process. However, the need for
repeated remediation may indicate the resident’s inability or unwillingness to successfully
deal with the challenges of residency and may require moving to probation process for
resolution.

**Residency Program Evaluation**

The residency program must be flexible enough to respond to changing Residency Review
Committee requirements, modifications in faculty composition and changing conditions in the
medical marketplace. The ability of the program to meet the residents’ ongoing training needs to
be continuously evaluated. To this end, resident input is solicited for each major component of
the program.

- The faculty will be evaluated by the residents anonymously using the E*Value system.
  Resident teaching evaluations are important components of faculty performance reviews
  and contribute to decisions about faculty promotion and retention.
- Residents will also evaluate their clinical rotations using the E*Value system.
- Resident evaluations of the faculty and clinical rotations are collected anonymously,
pooled, and shared with faculty members, the chair and chiefs-of-service semi-annually.
- Residents are encouraged to share their concerns and suggestions for program
  improvement with the respective chiefs-of-service, the administrative chief resident, or
  with the program director. These issues will be placed on the agenda of the Resident
  Education Committee. Individual resident feedback on the program will also be sought
  in their semi-annual meeting with the program director.
DUE PROCESS FOR RESIDENTS

The Program Director reviews the written evaluations of the resident's performance that were submitted to the Director of the residency program after each service rotation, the CREOG in-training examination score(s), and patient case logs. The resident program and service rotation are discussed with the resident and his/her review of teaching and other deficiencies and suggestions for improvement of the program are requested. The resident's difficulties, if any, are discussed. After the meeting a written report of the resident's progress is submitted and placed in the resident's personnel file. Residents who receive substandard ratings or about whom significant concerns have been registered by other faculty members are referred to the Resident Education Committee for further discussion.

The Resident Education Committee, composed of members of the full time faculty, the Chief Resident, clinical faculty, the Director of the Residency Program and the Department Chair, has the responsibility to evaluate the performance of residents referred by the faculty for consideration because of alleged below-standard performance. This committee meets at least quarterly and as needed to provide a mechanism of evaluation and to provide educational recommendations to the faculty of the Department.

Residents referred to the committee because of below-standard performance or other problems may be interviewed by the committee and faculty evaluations of performance on service rotations and other assessments, medical student comments, and CREOG scores may be reviewed. Additional documented information from affiliated or integrated hospital staff members who have worked with the resident may be requested and reviewed.

After a review of the aforementioned evaluations with the resident, s/he may be asked to submit a written response to the committee or meet with the program director. When this response is received and reviewed, the committee again meets and may make recommendations to improve his/her performance. If family, marital, psychiatric, and goal problems are identified as being pertinent to performance these are also discussed, if appropriate, and professional counseling or other solutions are sought.

If the resident's performance has been sufficiently poor to merit consideration for dismissal, a defined period of probation may be recommended to the faculty of the Department for consideration. During probation the resident endeavors to improve his/her performance by methods recommended by the Committee, and is monitored by the faculty as a whole and Program Director. More detailed supervision and observation by faculty members may be sought, and written evaluations at the end of the probationary period will be submitted to the committee for consideration.

The Residency Education Committee is advisory to the Department faculty who decide upon the resident's status in the program. One of the following courses of action may be taken:

1) Immediate dismissal from the program by the Associate Dean or Director of Clinical Affairs in consultation with the chief of service as provided by institutional guidelines.
2) Probation for a defined period of time. During the probationary period the resident's performance is carefully evaluated. Written evaluations of that performance will be submitted to the faculty from those individuals responsible for supervision. These evaluations will be considered prior to further action.

3) After the period of probation the resident may be dismissed from the program or asked to submit a resignation if his/her performance continues to be unsatisfactory. If performance has improved and has been maintained at a satisfactory level, the probation may be rescinded.

4) A grievance procedure (see House Staff Manual) is available to review actions taken by the Department if the resident believes that s/he has been unfairly treated.

5) If the resident is dissatisfied with the Department's review, s/he may contact the hospital grievance officer for appeal according to institutional guidelines.

6/08
RESIDENT PRESENTATIONS AND CONFERENCES

Grand Rounds

Sometime during the PGY-3 or -4 year, each resident will be asked to present the Departmental Grand Rounds. Typically, topics have been clinical, addressing issues of interest or controversy, but basic research based presentations, or topics dealing with adult education are also options. We encourage identification of a faculty mentor for the talk.

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

Presentations should be about 45 minutes in duration. Handouts are optional, but a list of selected references should be available for distribution.

In order to allow for optimal preparation, resident Grand Rounds presentations will be scheduled following each resident's Elective rotation. This means that some of the residents may be giving Grand Rounds as a PGY-4.

Perinatal Conference

In conjunction with a UWPS faculty member, the PGY-3 on UWPS may be asked to present one obstetrical case at the Meriter Perinatal Conference. Typically, the resident will present the case and the faculty member the discussion, although the work may be divided in any appropriate way.

For this conference, AV materials should be limited to legible overheads or Power Point presentations.

The PGY-3 will be approached directly by one of the MFM faculty members if her/his participation in a conference will be invited.

6/08
GENERAL TIPS FOR PREPARING A DIDACTIC PRESENTATION

1. When you are asked to select a topic or area of interest, a faculty member will then be available to assist you in topic selection, pertinent references, and points to be emphasized during the early stages of formulating the talk.

2. Prepare visual aids designed to clarify and emphasize critical concepts (see below).

3. Conduct an exhaustive review of recent and classical literature regarding the topic.

4. Organize your presentation so that a listener will be apprised of significant principles as well as supporting data.

5. Emphasize physiological and pathophysiological principles whenever possible.

6. Rehearse your presentation with either an animate or inanimate audience. (At Grand Rounds you might have either or a combination.)

7. Limit the presentation to no more than 45 minutes to allow for adequate discussion.

8. No more than one slide per minute should be planned. LESS IS MORE!

9. Discuss the prepared presentation with your advisor so he/she will know what material has been selected and can make final suggestions.

10. Prepare a selected bibliography; Education Secretaries will type and xerox if and only if material is turned in five business days before Grand Rounds presentation.

11. Rehearse the presentation again--reorganize to provide continuity and appropriate emphasis.

12. Arrive early enough to have slides and visual aids ready for presentation.

13. Read the letter to the next speaker (below) and don’t panic!

6/08
FEATURES OF EFFECTIVE POWERPOINT SLIDES

It is generally agreed that slide quality at scientific meetings is uneven, and that ineffective slides greatly reduce the impact of papers. In the interest of improving the effectiveness of papers presented at meetings, the following list of features of effective slides, based in part on measurements made at meetings, is presented for your consideration.

1. CLEAR PURPOSE. An effective slide should have a main point and not just be a collection of available data. If this central theme of the slide cannot be readily identified, the paper probably would be improved by revising or deleting the slide.

2. READILY UNDERSTOOD. The main point should catch the attention of the audience immediately, and should be understood soon thereafter. While trying to figure out what the slide has to say, the audience is not paying full attention to what the speaker is saying, and this obviously should be minimized.

3. SIMPLE FORMAT. With a simple, uncluttered format, the slide is relatively easy to design and directs the attention of the audience to the main point.

4. FREE OF NONESSENTIAL INFORMATION. Information not directly supporting the main point of the slide and not important enough to be specifically mentioned in the verbal text probably would be better held in reserve for questions rather than included in the slide.

5. DIGESTIBLE. There is a practical limit to how many bits of new information one can reasonably expect the audience to assimilate. The speaker will not maintain contact with the audience when they exceed this limit. With an average of 7 slides in a 10-minute paper, there is available only 1+ minutes per slide. The above risk is minimized if the information presented in a slide is restricted to that which can be explained extemporaneously to the uninitiated in the allowed length of time. Fast reading of a prepared text is not an adequate substitute for judicious editing.

6. UNIFIED. A slide is not effective when all information is organized around a single central theme so that the slide tells a unified story.

7. GRAPHIC FORMAT. In graphs, qualitative relationships are emphasized at the expense of precise numerical values, while in tables the reverse is true. Hence, if a qualitative statement such as "flow rate increased markedly immediately after stimulation," can be considered to be the main point of the slide, the purpose is better served using a graphic format. A good place for detailed, tabular data is in a slide or two held in reserve in case of questions.

8. DESIGNED FOR THE CURRENT ORAL PAPER. Particularly to be avoided is the comprehensive data table designed for another purpose and containing many columns and rows of information not directly relevant to the current paper. The audience is not interested in how much work was done, only in evidence and conclusions relating
directly to the subject of the paper.

9. EXPERIMENTAL. There is no time in a 10-minute paper to teach standard technology. Unless the purpose of the paper is to examine this technology, it is best mentioned to the minimum extent necessary to maintain an unbroken logic development of the theme of the paper.

10. VISIBLE. Most meeting rooms were not designed with projection in mind. Due to low ceilings, the heads of those in front often block the lower part of the screen from view of those in the rear. As a result, horizontal slides, which make maximum use of the top of the screen, are more effective than vertical slides. Furthermore, if the projector is aligned properly for horizontal slides, vertical slides extend beyond the borders of the screen. Time is wasted and the training of thought is broken if the projector is adjusted for each vertical slide and readjusted for the next horizontal slide. Hence, projectionists are instructed not to adjust projectors for vertical slides and investigators are advised not to use vertical slides under any circumstances.

11. LEGIBLE. In a recent study, measurements of apparent projected image size were made from the rear seats of five national scientific meetings in major hotels. For those seated at the rear, the eye-screen distance averaged 10.5 times the projected image width in large as well as small meeting rooms. This ratio is useful in that it permits one to evaluate the projected legibility of illustrations prior to the meeting, when problems can still be rectified. This is accomplished by viewing the original figure, the slide, or the projected image from a distance of 10.5 times its width. For example, this ratio gives viewing distances of 14 and 34 inches for 2" x 2" and 3 1/4" x 4" slides respectively, and a surprising 10 feet for drawing 11 inches wide. Anything not legible cannot be trusted to project well at meetings.

Correlating these measurements with measurements from a standard eye chart it was calculated that the minimum legible letter size from rear seats (20/25 acuity) is 1/57 the projected image width. For typed illustrations, this translates to an area for typed information (allowing for margins) 42 spaces wide by 14 single space lines high. For optimum legibility use modern, bold type (Sans Serif type is easier to read than Roman or Script type), and double-space. Use capital letters. A carbon ribbon is preferred; fabric ribbon typing will often appear fuzzy and out of focus when projected. For illustrations to be drawn by a medical illustrator, it is suggested that the width of the figure plus margins be divided by 57 (or less, for a safety margin) and that this minimum letter and number height be marked on the rough figure as a guide for the illustrator.

Inspecting the illustration up close for legibility can be very misleading and is not recommended. Also not recommended is test projecting in a lecture theater with a screen large enough to permit the projector to be placed at the back of the room. This situation is different from that in a typical meeting, where the projector is in the middle of the audience, and results in an appreciably larger apparent image size at the rear seats.
With regard to photomicrographs, legibility problems can be severe. Bold line drawings or magnified portions of photomicrographs are possible solutions, with the original illustrations held in reserve as either a slide or a print in case of questions.

Finally, with regard to graphs, a few large, widely spaced numbers on the X and Y axes are considered to convey the magnitudes adequately for the purpose of the slide. Adding more marks provides unnecessary information, crowds existing numbers and forces the illustrator to use smaller figures than would otherwise be necessary.

12. VISUAL CONTRAST. Legibility will be increased if there are contrasts in brightness and tone between illustrations and backgrounds. Color combinations that increase visibility include white letters on medium blue and black on medium yellow. Never use black letters on a dark background.

13. THUMBSPOOT SLIDES. Hold slides as it reads correctly to you. Write sequence number on lower left corner of the mount. This gives the projectionist the correct corner to grasp when placing slides in the tray.

14. INTEGRATED WITH VERBAL TEXT. Slides should support the verbal text and not merely display numbers generated in the study. Conversely, the verbal text should lay a proper foundation for each slide. As each slide is shown, it is useful to give the audience a brief opportunity to become oriented before proceeding.

Use duplicate slides if you will refer to the same slide several times during your presentation.

15. CLEAR TRAIN OF THOUGHT. Ideas developed in the paper and supported by the slides should flow smoothly in a logic sequence, without wandering to irrelevant asides or bogging down in detail. Everything presented verbally or visually should have a clear role in support of the central theses of the paper.

REFERENCE:

Miller, D.A. and Luria, S.M., Naval Submarine Medical Research Laboratory, Groton, CT.
Dear Colleague,

While suffering through endless meetings and symposia I have always wondered why organizers do not provide "Instructions to Speakers". There are "Instructions to Authors"; any reputable editorial board provides them, and papers that are to go into prints must follow them. To give the same guidance to you, the next speaker, might further scientific communications and--who knows--project the audience. This has rarely been attempted, probably because "Instructions to Speakers" would be difficult to enforce. To a journal you have to deliver first and then wait for acceptance, whereas for a medical meeting, titles and abstracts are accepted first and then we wait for you to deliver. The audience is at your mercy. Nevertheless, you may benefit from these suggestions:

FORMULATE YOUR OBJECTIVE. Put down in one or two sentences what you most want your audience to remember, and then when you prepare your talk make sure that your message comes through. To achieve this, some repetition may be more effective than an abundance of findings and figures.

Something can be learned from the creators of television commercials. They introduce their audience to a product, convince them of its superiority, and lure them into buying, all in 30 seconds. The secret is to combine sight and sound effectively. You too have only a short time to sell your product. How do you go about this?

WRITE FOR LISTENING, NOT FOR READING. If you have to read from a manuscript, write for listening. Make short sentences. You need time to breathe. There is nothing wrong with violating grammatical rules if this makes for easy flowing communication. A complete sentence may sound formal and stiff, an incomplete one lively. You may have prepared a manuscript for printing. This will not do. Write one for reading. Do not expect your paper to be equally forceful whether spoken or read--only the Bible and Hemingway's short stories are.

PROGRAM YOUR PRESENTATION. No matter who sits in your audience, essentially you are trying to teach something. Consequently, your presentation must evolve in logical, comprehensible steps. Illustrations must be timed properly. Maintain some tension in your audience. As you unfold the results of your research, provide enough repetition to make up for fleeting attention spans. Anticipate questions and answer them as you go on. Ideally, there should be no questions when you have finished. Just ask yourself each time, before you add a slide or a sentence to your manuscript, if this will really aid you in reaching your objective. The result is "lean programming," and learning will take place.

MAKE YOUR SLIDES FIT THE PRESENTATION. Slides should be easy to read. They should contain essential information only. A slide is overloaded if your audience cannot read or interpret all of the text, curves, and figures. If there is a text to read, allow time for this and keep quiet.

On the frame of your slides mark the sequence on the right upper corner. Paper labels tend to
bend upward and stick in the projector. If you intend to show the same slide twice, provide a second copy in the proper sequence. Do not make the projectionist go back--his job is difficult enough. Nobody cares to listen to your instructions to the projectionist: "No, not this one, two before . . . no . . . ." Sometimes the safest procedure is to bring your own Carousel projector, which you have previously loaded and tested.

CONSIDER THE TIME OF DAY YOUR PRESENTATION IS SCHEDULED. If you are the first speaker in the morning allow enough time to get the projector in working order and to test lights and microphones. Count on a smaller but interested (and critical) audience.

The later in the day you are speaking the more appropriate it may become to tie your presentation into what had already been said. Be prepared to omit or abbreviate sections of your talk so as to avoid duplications. Read the abstracts of the previous papers carefully. Attend all lectures before your own presentation. If you are to speak at the end of the morning or afternoon session the program likely will be late and utmost brevity will be appreciated.

DO NOT EXCEED THE TIME ALLOWED. To exceed your time is a sure way to make your audience hostile. An uncomfortable scene evolves. You are speaking faster and faster, while the chairman paces up and down nervously, and slides are flashing by on the screen. Your presentation may come to resemble one of the silent movies of the 20's, but this is not amusing. Your colleagues have long since lost you and are just waiting anxiously for their agony to end.

If you rely on reading your manuscript, remember that a paper for a 10-minute presentation should be easily readable in 7 minutes. Besides, nobody has ever been blamed for not using up all of his time.

SPEAK TO EXPRESS, NOT TO IMPRESS. Outstanding presentations which draw enthusiastic applause usually are made by someone who speaks slowly and deliberately and who does not read from a manuscript. If you read you will probably do it too fast and your voice will sound flat. When your eyes are glued to the manuscript for fear of losing your place, your insecurity will become contagious. Your audience will be preoccupied with your suffering, not with the subject of your presentation. A "thought manuscript", for instance a small pile of cards with key words or sentences (like the sentences of this paper which have been printed in capitals), may be the answer to your problem.

Face your audience. If you have to turn to the screen and there is no appropriately positioned microphone, speak up. If there is a short pause in your presentation, let it be. There is no need for filler words and throat clearing. When your mind is preoccupied, do not keep your mouth running. Your audience will appreciate a few seconds of silence.

If you speak a dialect or if you are foreign-born and your accent is heavy, practice. I can attest to the tolerance of our countrymen for this sort of shortcoming, but when your audience cannot decide whether your presentation is in English or in your native tongue--stick to writing.

And, please, avoid mannerisms. If you interrupt each sentence by several "ah's" and "eh's", your audience may begin to wonder whether you have already made up your mind about what you are
going to say. Also, your colleagues will become irritated when they have to watch you putting your glasses on and off constantly, shifting the pages of your manuscript, balancing the pointer, or pacing the floor. Nor does anyone want to hear you rattle your keys or pop your knuckles.

Do not try to impress your audience by quoting the names of other authors. Those who know the pertinent papers do not need to be reminded; those who do not, have no use for your quotation either, because no full reference is given. References are for printing.

Unfamiliar terms and abbreviations of tests or conditions may "kill" a potentially good presentation. To define such terms in the beginning may not help either, because some will not have listened and others will forget them or mix up, and you will surely miss your objective.

HAVE A "DRY RUN". After all preparations are completed have a "dry run", preferably in front of a friendly audience. There you can test whether your presentation is properly programmed and whether you will be able to stay within your time limits. Helpful criticism may be forthcoming and you may learn some of the questions to anticipate.

Once you get to the meeting, check the microphone, the pointer, the lights on the podium, and possible signal buttons for the projectionist. Make sure you have your manuscript or notes, and the projectionist has your slides. Then sit down in front until your turn comes—and relax. You will give a fine talk.

Yours sincerely,

By Jurgen Ludwig, M.D.
Department of Pathology and Anatomy
Stop Annoying Your Audience

Peter de Jager

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In virtually any career, at some point you’re going to have to stand up and give a presentation. It could be in front of management, clients or even venture capitalists.

While speaking in front of others is hardly what one would consider a technical skill, it could, nevertheless, mean a great deal in advancing – or halting – your career path. As teaching how to give a great presentation is beyond the scope of available space in this article, I’ll take the cheap and easy road and point out what not to do.

It’s a foregone conclusion that in today’s world, giving a presentation means being accompanied by Microsoft PowerPoint. With that assumption in place, here are six pieces of advice.

1. “I know you can’t read this, but…”
I’ll lay even money that 9 out of 10 presenters will, sometime during their presentation, put up a slide so incredibly complex, detailed and convoluted that it is impossible to see, never mind decipher. As the presenter places this marvelous creation in front of you, he will say, “I know you can’t read this, but…”
Well, if you know we can’t read it, why are you showing it to us? This is, hands down, the number one biggest mistake that a speaker can make.
Suggestion: Don’t put up slides you know people can’t read.

2. You, not PowerPoint, are the presenter.
Instead of placing the bulk of your content on the slides, leave it for your presentation and use the slides merely as reminders. Slides are most effective when used to present graphical information, not to convey passion and enthusiasm for your subject.
Suggestion: To find out if your slides are “too heavy,” practice your presentation without using them.

3. The audience isn’t illiterate.
Here’s a hint: Your audience can read your slide faster than you can read it aloud. By the time you read the first sentence, they’ve read the entire slide and are bored to tears waiting for you to catch up.
Suggestion: Avoid deliberately boring your audience members.

4. Can they read it in the back?
Nobody can read 12-point type from the back of the room. If audience members cannot read your slides, you’re not communicating – you’re annoying them.
Suggestion: Use nothing smaller than 24-point type for your slides; 30-point is even better.

5. Can they read it anywhere?
There’s a very good reason why ink is black and paper is white: The high contrast between the two makes it easy to read the printed word. This isn’t news, but far too many presenters have forgotten this bit of wisdom.
Suggestion: Don’t use yellow text on a white background or black text on a dark blue background.

6. You have a finite amount of time: use it wisely.
Look, I know we’re all geniuses, and we all have enough expertise to fill 20 educational sessions. Well, tough. You’ve got 45 minutes. Adjust accordingly, choose the most important pieces from everything you know and make the presentation flow for 45 minutes.
Suggestion: Don’t take more than your allotted time – I’m up next!

Peter de Jager is a keynote speaker and writer specializing in the issues of change, technology and the future.

PRINCIPLES OF EFFECTIVE WRITING

I. Most people write badly because they do not think clearly.

II. Start by telling the reader where you are going.
   A. Make an outline of your major points.
   B. Underline and number each important section heading. This serves the same purpose as chapter titles in a book.
   C. End with a summary. A summary is not a conclusion. Your summary should introduce no new ideas. If your paper comes to a conclusion, your summary should summarize that, too.

III. The first paragraphs (or introductions) of effective articles are seldom more than three sentences long.
   A. The Wall Street Journal sells more copies than any other daily in America. Readers and editors give much of the credit to its readability, not superior content.
   B. Short sentences and short paragraphs are easier to read than long ones.

IV. Make your writing active and personal.
   A. Good writers choose the active voice over the passive voice. Active verbs add energy to your writing.

V. Avoid vague modifiers.
   A. Distinguish between lazy adjectives and adverbs and vigorous ones.
   B. Choose adjectives and adverbs that make your meaning more precise. Do not use them as mere exclamation points.

VI. Use done-to-earth language.
   A. Avoid technical jargon.
   B. Do not use statements that are fictitious or unsubstantiated - in other words, not facts.

VII. Be specific.
   A. One of the main weaknesses in writing is the overuse of generalities.

VIII. Choose the right word.
   A. Know the precise meaning of every word you use, or don't use it.
   B. Intellectual illiteracy does not breed respect. A fancy incorrect word is mainly incorrect.

IX. Make it perfect.
   A. No typos, misspellings, no errors in numbers or dates.

X. Come to the point.
   A. Take the time to boil down what you want to say, and express it confidently in
simple, declarative sentences.

B. There are only 266 words in the Gettysburg Address. The shortest sentence in the Bible may be the most moving: "Jesus wept."

XI. Write simply and naturally, the way you talk.
A. Most Americans are taught that the written language and the spoken language are entirely different. They learn to write in a stiff style and to steer clear of anything that sounds natural.
B. A first step in achieving that effect is to use only those words, phrases, and sentences that you might actually say.
C. For the same reason, a letter to the President would naturally be more formal than a letter to a relative, but it should still sound like you.

XII. Strike out words you don't need.
A. The song goes, "Softly, as in a morning sunrise" - and Ring Lardner explained that this was as opposed to a late afternoon or evening sunrise.

XIII. Use current standard English.

XIV. Don't write like a lawyer or a bureaucrat.
A. Ideas should be expressed briefly, clearly, and without ambiguity.
B. Whatever excuses lawyers or others may have, there are none for the sort of writing, known as "bureaucratese." Its symptoms are long sentences, frequent abbreviations, clauses within clauses, and a technical precision so elaborate that misunderstanding is unthinkable except that nobody can understand it in the first place.
C. If you find yourself writing like that, try putting down what you want to say the way you would say it to your reader if you were talking to him or her face-to-face. Don't worry if the result is too casual. Once you have the main idea in simple English, you'll find it easy to adjust the tone of voice.

XV. Keep in mind what your reader doesn't know.
A. Never expect people to read your mind as well as your letter or paper.
B. Watch your abbreviations. Will they be an indecipherable code to some readers? Might they be ambiguous even to those in the know?
C. If you must use abbreviations, define them the first time they appear in your paper.

XVI. Punctuate carefully.
A. A left-out comma, or a comma in the wrong place, can confuse readers. Here is a statement that most women will disagree with: Woman without her man has no reason for living. The writer actually meant to say something else: Woman: without her, man has no reason for living.

XVII. Understate rather than overstate.
A. Never exaggerate, unless you do so overtly to achieve an effect, and not to
deceive. It is more persuasive to understate than to overstate. A single obvious exaggeration in an otherwise carefully written argument can arouse suspicion of your entire case.

B. It is hard to resist the tendency to stretch the facts to support a strongly-held position, or to serve up half-truths as camouflage for bad news, or to take refuge in euphemisms. Whenever tempted, remind yourself that intelligent readers develop a nose for deceptive writing and are seldom taken in by it.

XVIII. Write so that you cannot be misunderstood.
A. Ambiguity often results from a single sentence carrying too much cargo.

XIX. Be alert to the sensitivities of others, especially ethnicity and gender.
A. As we write, you can use either "African American" or "black", but "Native American" is preferred to "Indian".
B. Use whatever happens to be the current preference of the group in question - and take the trouble to find out.
C. Avoid gender specific pronouns when possible.
1. "Every novelist hopes he will win the Pulitzer Prize" - better to write, "All novelists hope to win a Pulitzer Prize."
2. "Every novelist hopes he or she will win..." That's okay once in a while, but becomes tedious with repetition.

XX. Use plain English even on technical subjects.
A. The more technical the material, the less likely your reader will understand it unless you put it into the language we all speak.
B. An exception is when both writer and reader practice the same technical specialty.
C. Far worse is the deliberate effort to say something that you know readers won't like in a way that you hope they won't understand.
1. A nurse who dropped a baby referred in her report to "the non-facile manipulation of a newborn."
D. Bad news is not made better by being made unclear as well as unwelcome.
E. When God wanted to stop the people from building the Tower of Babel, he did not smite them down with a thunderbolt. He said: "...I'll confound their language, that they may not understand one another's speech".

Make Things Easy to Read in Written Reports

I. Use headings.

II. Keep paragraphs short.

III. Use typographic devices for clarity and emphasis.
A. Number your points.

IV. Use upper and lower case to define new headings.
A. Never use all capitals except for headings.
V. Break up large masses of type into shorter paragraphs.

VI. Your document will look less formidable if it is uninterrupted by graphs and charts.

VII. Number your appendices and separate them clearly with tabs.

HOW TO BE PREPARED FOR JOURNAL CLUB

1. Read the articles
2. Be prepared to summarize each article in 5 minutes or less
   a. Background
   b. Research question
   c. Methods (type of study)
   d. Results
   e. Conclusions
3. Be prepared to answer the following questions:
   a. Why was this study done?
   b. What is the hypothesis being tested?
   c. How well was the hypothesis tested?
      i. Patient selection
      ii. Study design
      iii. Analysis method (statistics)
   d. What are the strengths and weaknesses of the design of the study?
   e. Are the results presented accurately and thoroughly? Is there anything else that should have been presented?
   f. How generalizable are the results?
   g. How do these results compare to similar studies in the past? Is there anything that sets this study apart from the others?
   h. What are the clinical implications of this study?
   i. What are the research implications of this study?
   j. If you were to do this study now, what would you do differently?

Note: If a design method or statistical technique is used, it would be advisable to find out what the technique is, when it is supposed to be used, what its strengths are, and what its limitations are. GOOD LUCK.
I. General
   A. When discussing an article, please limit your presentation to 15-20 minutes. Residents and faculty will then have 10-15 minutes for open discussion.
   B. Consider asking a faculty member to serve as your "mentor". This individual can help you review pertinent literature, identify strengths and weaknesses of your article, and guide your presentation. They may even know why the article was selected for review.

II. Experimental Design Outline - Format For Presentation
   A. Reference (author, title, journal and site of research)
   B. Introduction (brief background information)
   C. Hypothesis (brief background information)
   D. Methods (experimental design - concise)
      1. Type of study
      2. Subjects (sample population and number)
      3. Inclusion and exclusion criteria for study group
      4. Controls
      5. Descriptive variables of the sample population
      6. Outcome variables to be measured and analyzed
      7. Types of measurements used in the study
   E. Statistical Analysis (methods of analysis and levels of significance to be accepted - concise)
      1. Descriptive statistics (graphs, tables, etc.)
      2. Inferential statistics (type of statistical analysis used to test the hypothesis)
   F. Results (analysis and interpretation of the descriptive and outcome variables - this is the most important part of the entire presentation)
   G. Conclusions (relative significance of the study as it applies to the hypothesis tested and the study data presented)
   H. Comments (literature discussion and how this study contributes to the medical literature - it is an optional section and should be omitted if the comments section does not contribute to the impact of the presentation)

III. Outline for the Critique of a Medical Report
   A. Objective or Hypothesis
      1. What are the questions to be answered? (study objectives)
      2. What is the population to which the investigators intend to apply their findings?
   B. Design of the Investigation
      1. Was the study an experiment, planned observations or a retrospective analysis of records?
      2. Are there possible sources of sample selection bias?
3. What is the nature of the control group?

C. Observations
1. Are there clear definitions of the terms used? (i.e., diagnostic criteria, measurements made and outcome variables)
2. Was the method of either classification or measurement consistent for all the subjects and relevant to the objectives of the investigation?
3. Are the observations reliable and reproducible?

D. Presentation of Findings
1. Are the findings presented clearly, objectively, and in sufficient detail to enable the reader to judge them?
2. Are the findings internally consistent? (i.e., do the numbers add up properly and can the different tables be reconciled, etc.?)

E. Analysis
1. Are the data worthy of statistical analysis? If so, are the methods of analysis appropriate to the source and nature of the data?
2. Is the analysis correctly performed and interpreted?
3. Is there sufficient analysis to determine whether "significant differences" may in fact be due to a lack of comparability of the groups? (i.e., age, sex, clinical characteristics, or in other relevant variables)

F. Conclusions
1. Which conclusions are justified by the findings?
2. Which are not justified by the findings?
3. Are the conclusions relevant to the questions posed by the investigators?

G. Constructive Suggestions
If the study could be improved, the reviewer should suggest a revised experimental design that would provide reliable and valid information relevant to the questions under study.

IV. Types of Errors in the Medical Literature
A. Most Frequent Errors Observed in Medical Reports (ranked from most frequent to least)
1. Conclusions are applied to a population without testing an adequate sample
2. No use of statistical test when needed and appropriate
3. Design of the study is not appropriate for solving the stated problem
4. Too much confidence attached to negative results from small samples
5. Improper use of statistical techniques
6. No mention of the type of test used or the significance level
7. Absence of a control group
8. Improper manipulation of data
9. Misleading charts or tables
10. Use of measured sensitivity without specificity
11. Improper conclusions drawn although analysis was proper
12. Multiple comparisons are made, yet importance is attached to statistical significance

6/03
FINDING A JOB

RECRUITMENT FIRMS

It has been decided by the past residents of the Department of Obstetrics and Gynecology that the names, addresses, e-mail addresses and phone numbers of residents will not be given to recruiting firms. The majority of residents feel that they do not like the constant attention of these recruiting firms during their senior year in the program. Should an individual residents wish otherwise, s/he should contact the Program Director.

LETTERS OF REFERENCE/TELEPHONE COMMUNICATIONS

If a resident desires a written or verbal reference from the program director, a written release of information must be on file. The resident must state completely and specifically the person, company, hospital or organization for whom he/she wants information to be provided. Without this release, no information will be provided.

ABOG WRITTEN BOARDS

All fourth year residents are reminded that you must have a valid Wisconsin Medical license to apply to take Part I (the written portion) of the Board Exam.

To apply to take the written examination, a formal application must be requested from the:

American Board of Obstetrics and Gynecology, Inc.
2915 Vine Street
Dallas, TX  75204-1069
Phone - (214) 871-1619
Fax - (214) 871-1943

Applications must be requested after September 1 of the OBG 4th year of training. The deadline for return of the application with application fee is November 17 of that same year.

The examination is taken during June of the year of graduation.

The program director must sign your entrance card to the examination. To get the card signed, all resident logs for surgical and obstetrical and ambulatory experience must be complete to within 2 weeks.

Please note: the ABOG now allows applicants for the oral boards to use a case list that includes cases seen in the last year of residency. Therefore, a meticulously kept, complete case log is not only necessary for continued accreditation of the residency program, but also very much in every resident’s best interest.

GOOD LUCK!!!!!!!!!!!
Additional Resources

This manual remains under constant revision. Errors or omissions should be pointed out to the program coordinator or the program director.

No attempt has been made to be exhaustive. The reader is referred to the following additional resources:

CREOG Learning Objectives

UW Gyn Oncology Resident Handbook

UW Hospitals and Clinics Housestaff Manual

Appointment information for house officers, given to each resident yearly with their contract

Meriter Housestaff Manual