ADOLESCENT MEDICINE ROTATION

Preceptors: Amy Lacroix, M.D.

Purpose:

1. The resident will be able to discuss personal issues with adolescent patients in a sensitive, comfortable manner, without causing increased patient anxiety.
2. The resident will be able to correctly perform a genito-urinary examination on both adolescent males and females, and recognize and treat common abnormalities and infections encountered.
3. The resident will review with sexually active patients their contraceptive options, their risks and benefits, and initiate and maintain contraceptive care for those patients.
4. The resident will understand state and national law with regard to providing care for adolescent patients, and apply it to the care of adolescent patients.
5. The resident will recognize and initiate evaluation for patients with eating disorders or obesity.
6. The resident will provide appropriate health maintenance care for adolescent patients.
7. The resident will be able to act as a consultant with a high school nurse.
8. The resident will provide appropriate health care to adolescent involved in sport activities.
9. The resident will recognize and either treat or refer adolescent patients with common behavioral and psychiatric problems.

Objectives:

1. The resident will work at counseling/talking with adolescents in a number of different settings and circumstances about sensitive issues. These settings will include adolescent clinic, STD clinic, and Benson High School, among others.
2. The resident will perform a genito-urinary exam of the adolescent patient under supervision in the correct order: explanation, external exam, obtaining specimens, and internal examination. The resident will correctly obtain any necessary specimens for diagnosis of infection or other genito-urinary abnormalities. The resident will be able to identify common abnormalities on a wet prep, to include: yeast, clue cells, white blood cells, Trichomonas. The resident will be able to recognize and treat external genital warts. The resident will be able to correctly follow up on abnormal PAP tests.
3. The resident will provide health care maintenance for sexually active adolescent females during adolescent clinic over the course of the month.
4. The resident will understand and apply the concepts of informed consent, patient confidentiality, the mature minor doctrine. The resident will be comfortable explaining those to both patients and their guardians. The resident will understand state and national laws with regard to the age of majority and rights to treat adolescents independently. The resident will understand the indications for involving patients’ guardians.
5. The resident will learn how to identify patients at risk for eating disorders and obesity. They will learn how to differentiate between patients who can be followed conservatively in the office and those who must be monitored as inpatients or referred to specialists for care.
6. The resident will apply the Guidelines for Adolescent Preventive Services or Bright Futures guidelines in providing appropriate preventive care for adolescents to include: counseling, health screening, and immunizations.
7. The resident will work with a high school nurse to provide triage services, health care recommendations, and health care counseling to adolescents.
8. The resident will complete preparticipation exams on adolescents without difficulty. They will recognize common risk factors for adolescents in sports activities and counsel teens regarding these risk factors. They will recognize and be able to treat common sports related injuries, and understand when to refer patients for further workup.

9. The adolescent resident will understand common presentation of adolescent patients with depression, anxiety, attentional problems, and psychosis, as well as drug use and abuse. They will initiate appropriate treatment for these conditions, and refer patients to other resources when appropriate.

Methods:

1. The resident will interview adolescent patients about concerns with regard to developmental changes, sexual behaviors, depression, violence, and family issues.

2. The resident will perform at least 10 examinations on both male and female patients during the month. Many of these will be under direct supervision by Pediatric staff. The resident will assist staff with diagnosis of abnormal wet preps on female patients. The resident will review the 1998 STD protocols from the CDC and will review STD symptoms in the STD atlas.

3. The resident will work with pediatric staff in providing contraceptive management to patients in adolescent clinic over the month.

4. The resident will review the pretest with Dr. Lacroix during the first week of the rotation.

5. The resident will observe patients going through initial evaluation for eating disorder and obesity in both Eating Disorder Clinic and Adolescent Clinic. They will observe Dr. Marty Harrington in his psychiatric management of adolescent and adult patients with eating disorders and their co-morbidities.

6. The resident will review the AMA’s Guidelines for Adolescent Preventive Services (1993) and the Bright Futures guidelines for adolescent health care. They will review the health screening questionnaire in adolescent clinic with each patient for whom they provide a health maintenance exam. They will recommend and provide for appropriate screening and testing of patients based on these guidelines when appropriate.

7. The resident will work at a local high school with the school nurse to help triage, screen, and counsel adolescents encountered daily in the school nurses office. If possible, the resident will discuss a health related topic with teens as a group within the school setting.

8. The resident will review the manual "Preparticipation Physical Examination", 2nd edition (1997). They will work with adolescents in adolescent clinic to provide preparticipation exams. They will also work with Orthopedic Medicine/ Sports Medicine either at clinic or on the field to provide care for teens and adults involved in sports. They may spend time with an athletic trainer providing care to teen patients in the school setting.

9. The resident will see patients in both Adolescent clinic and Child and Adolescent Psychiatry/ Eating Disorders clinic with problems which may include depression, anxiety, psychosis, ADHD, substance use and abuse.

Implementation:

1. The resident will review the normal cognitive, physical, and psychosocial changes which occur during adolescence and relate them to their patient interviews. Their resources include the provided resident education articles and Neinstein’s text, Adolescent Health Care.
2. The resident will review the normal gynecology from Neinstein’s text, Adolescent Health Care. The resident will also review normal gynecology from Emans’ text, Pediatric and Adolescent Gynecology.

3. They will review contraceptive management in both Neinstein’s Adolescent Health Care and Emans’ Pediatric and Adolescent Gynecology. They will also review the handbook Managing Contraceptive Pill Patients.

4. The resident will review the article “Consent and Confidentiality” provided in their packet of adolescent materials.

5. The resident will review normal dietary needs for adolescent patients. They will learn to use Body Mass Index as an indicator of patient underweight or overweight. The resident will review the articles on eating disorders and obesity in their Adolescent handbook.

6. The resident will review the AMA’s Guidelines for Adolescent Preventive Services (1993) and the Bright Futures guidelines for adolescent health care.

7. The resident will review the AAP manual, School Health: Policy and Practice (1993).


9. They will review the AAP handbook Substance Abuse (1988) and will also review the National Information on Drugs of Abuse website (http://www.drugabuse.gov).

Evaluation:

1. The resident will be observed working with adolescent patients in both STD and Adolescent Clinics by Pediatric/Adolescent staff.

2. The resident will be observed in adolescent clinic examining and evaluating adolescent patients. They will be expected to conduct an entire exam, evaluation, and treatment for both a male and a female patient independently by the end of the month.

3. The resident will provide contraceptive counseling and care to a patient independently by the end of the adolescent month.

4. The resident will discuss with patients and their parents adolescents’ rights to privacy with their physician in clinic. They will involve patients or responsible adults with their patients care when it is appropriate.

5. The resident will demonstrate knowledge of normal dietary needs, Body Mass Index, and complications of eating disorders by correctly answering questions in their post-test on those issues.

6. The resident will be observed providing health care to adolescent patients in adolescent clinic at UNMC. They will appropriately answer questions related to health care for adolescents on the post-test.

7. The resident will receive a written evaluation from the school nurse with regard to their ability to serve as a resource for both teens and the nurse. They will appropriately answer questions on the post-test about mandatory health screening and services provided by the school system.

8. The resident will be observed providing sports physicals to teen patients in adolescent clinic. They will appropriately answer questions related to sports activities and injuries on the post-test.

9. The resident will be observed in providing care to adolescents in Adolescent clinic for many of these behavioral problems. They will also correctly answer questions on the post-test with regard to these problems.
ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY ROTATION

Preceptors: Russell Hopp, D.O.; Mark Wilson, M.D.

Purpose:

The goal of this four-week rotation is to enhance the resident's understanding of the outpatient management and evaluation of common allergic conditions.

Objectives:

The resident should have a greater understanding of the management of common allergic conditions such as allergic rhinitis, asthma, and atopic dermatitis. Emphasis will be placed on the evaluation and practical management of chronic rhinitis, sinusitis, and recurrent infections. Furthermore, the management of infants and young children with asthma and the differential diagnosis of recurrent wheezing in infants is a covered. Inpatient management of asthma is reviewed, and applied to admitted patients.

Methods:

Clinics:

UNMC: Clinic is held weekly. A wide variety of allergy, clinical immunology, and rheumatology patients are seen. Three to five patients are seen per week.

Creighton: Pediatric Allergy, Asthma, Immunology Clinic is held twice weekly in the outpatient clinics at Creighton/St. Joseph Hospital. The majority of the patients seen are from inner city Omaha. Difficult to manage asthma is a common occurrence. Rheumatology patients are also seen at the Creighton clinic. Ten to 15 patients are seen per week.

Cogley Clinic: Cogley Medical Associates is a multi-specialty clinic in Council Bluffs, Iowa. Both adults and children are seen at this weekly all day clinic. A wide variety of common allergic patients are seen. Experience with primary care referrals is emphasized. The clinic offers on-site radiological services, and x-ray review is available. Eight to 10 patients are seen each week.

Children’s: A weekly clinic is held in association with Dr. Mark Wilson. Patients with asthma and associated allergic problems is the predominant emphasis. Four to six patients are seen each week. A monthly clinic is also held at Children’s with the emphasis on rheumatology and allergy patients. Three to four patients are seen.

Other Clinics: Allergy, Asthma, and Clinical Immunology clinics are also held in Fremont, Nebraska at a private pediatric office (5-7 patients); in Denison, Iowa, a rural outpatient clinic with a regional referral pattern (5-7 patients); and at the UNMC Ear, Nose and Throat clinic (3-5 patients). These clinics are attended either once or twice monthly.

Inpatient Responsibilities: All patients are included in the teaching program and rotation. Management of inpatient specialty patients and consultation for the general pediatric patients is the direct responsibility of
the resident on the rotation. The resident takes call from home and is expected to participate in inpatient evaluations after hours.

**Research Activities:** The resident will participate in any research projects that are in progress during their month of the rotation.

**Implementation:**

The resident is expected to review and read the recommended text, *Allergic diseases from Infancy to Adulthood* (3rd Edition, 1996), along with selected research and review articles provided by the faculty.

**Evaluation:**

Evaluation of the rotation is based on the resident's patient work-up and presentation, development of the differential diagnosis and treatment plan. The faculty is often requested to provide peer-review of manuscripts and the resident will participate in that process. Each resident will be expected to review a topic of interest and provide a short seminar reviewing the pertinent literature, problem and treatment.
ANESTHESIOLOGY

Preceptors: Elizabeth Cochran, M.D. and Frederick Youngblood, M.D. (498-6777 or 449-4847)

Purpose:

Airway management is a critical skill required by pediatricians. This rotation will give residents the opportunity to obtain these skills as well as gain knowledge about conscious sedation.

Objectives:

The resident will learn the basics for airway management and intubation as well as starting peripheral IV's during the two weeks spent at Boy's Town Hospital. The resident will learn the proper monitoring, choice of agents and side effects, and the proper administration and documentation for conscious sedation. The resident should also obtain the ability to describe risks and obtain consent for conscious sedation.

Methods:

The anesthesiologists have been very willing to allow residents in the OR and it can be a great experience but they have also been notified that the pediatric residents are expected to do more than an intubation and leave. Please stay for the entire case unless you have noon conference or your continuity clinic to attend.

Try to start the IV's for all of your own admits when you are on call and when you are on the wards, NICU, or PICU rotations. The residents are often called to start IV's after several experienced nurses have tried and failed so it is in your best interest to have as much experience as possible.

Implementation:

The resident must watch the video in the UNMC library on conscious sedation that follows the guidelines of the AAP. There is a manual with the video tape that is easy to understand and has helpful tables and medicine lists as well as drug doses and side effects. This video and book are located on the library shelves with other textbooks.

The resident must contact Dr. Mysore at the Children's PICU (955-4227) in the first two weeks of the month if possible to set up a time for a didactic session on conscious sedation early in the Children's part of the rotation. The resident should have completed the video tape prior to this session.

Evaluation:

Evaluations will be based on observed skills and mastery of certain procedures.
CARDIOLOGY

Preceptors: Scott Fletcher, M.D.; Carl Gumbiner, M.D.; John Kugler, M.D.; David Danford, M.D.; Ameeta Martin, M.D.; Zahid Amin, M.D.

Purpose:

This elective is intended for students desiring to further their knowledge of congenital heart disease.

Objectives:

1. The resident will be familiar with the various types of innocent murmurs and be able to distinguish them from pathologic murmurs.
2. The resident will be able to describe the physiology of cyanotic and acyanotic congenital heart disease.
3. The resident will recognize the clinical presentation of children with congestive heart failure.
4. The resident will be able to describe the indications for an echocardiogram.
5. The resident will be familiar with the approach to a child with suspected congenital heart disease.
6. The resident will be able to describe the clinical and physical findings associated with the common form of congenital heart disease including ventricular septal defect, tetralogy of Fallot, atrial septal defect, coarctation of the aorta, aortic stenosis, transposition of the great arteries, and pulmonic stenosis. The resident will be able to describe the pre-operative and post-operative management of those conditions.
7. The resident will be able to describe the approach to the child with Kawasaki disease.
8. The resident will be familiar with the approach to the child with supraventricular tachycardia.

Methods:

The resident on Pediatric Cardiology spends time in the pediatric outpatient clinic with each of the six pediatric cardiologists on faculty. The average number of residents on elective is two per month. There are over 1,200 outpatient visits to the pediatric cardiology clinic yearly, of which 480 patients are new. There is an average of 5 or 6 outpatient sessions/week with approximately 8-patient/session. The resident sees the patient simultaneously with the staff cardiologist.

The residents participate in the management of pediatric cardiology and cardiac surgery patients during their inpatient rotation at Children’s Hospital. This consists of approximately 150-200 surgery patients and an additional 150-200 non-surgical hospital admissions. The residents provide direct patient care for these patients under the supervision of the pediatric cardiologist and pediatric thoracic surgeon.

Implementation:

1. The outpatient experience is supplemented by a problem-based learning test and accompanying videotape which is provided to the resident at the beginning of the elective. This book consists of 20 cases requiring approximately 30 minutes/case.
2. The resident on elective will be required to research a cardiology topic in-depth and deliver a 20 minute oral presentation to the cardiology staff.
3. Each resident completes a written objective pre-test and post-test at the beginning and end of the elective month.

Evaluation:

Evaluations will be based on performance on the examinations, oral presentation, and observed clinical skills.
Purpose:

The goal of the rotations in general pediatrics at Creighton and Nebraska Health Systems is to provide a foundation for the resident to build upon in developing the skills and knowledge required to practice pediatrics in the community. The rotations provide not only the opportunity to gain the expertise necessary for primary care but also to synthesize the skills and knowledge from subspecialty rotations into the ability to practice general pediatrics at a secondary care level.

Objectives:

Continuing, self-directed learning is a basic concept of the medical profession and is a distinguishing characteristic of the practice of medicine. The clinic will give you the opportunity to develop a rational, concise and confident approach to the evaluation and treatment of common childhood problems.

The following fundamentals of general pediatrics will be emphasized:

I. Growth
II. Nutrition
III. Developmental Surveillance and Screening
IV. Immunizations
V. Screening
VI. Follow-up of the complicated premature infant
VII. Basic general pediatric problems

Methods:

UNMC
Clinic hours begin at 9:00 A.M. and 1:00 P.M.

Intern Responsibilities
- Clinic hours are from 9:00 A.M. to 5:00 P.M. Monday through Friday.
- Pediatrics Clinic orientation is the first morning of the rotation.
- If you are responsible for covering the newborn nursery, report to clinic immediately after rounds.
- Always check out with the supervisor before leaving clinic for the day.

PL-2 and PL-3 Responsibilities
- Staff patients with medical students, physician assistant students, interns, and Family Medicine residents.
- Orient new residents and students to clinic.
- Initial child abuse work-ups which are then presented to attending staff.
- Consultation to other clinics who request immediate pediatric consultation.
- Ensure that “doctor” phone calls from patients’ families are returned.
• Review all lab results for abnormalities before they are distributed to ordering residents.

**Students**
Students are told to present their patients with the following priorities, depending upon who is available at the time:
1. Staff
2. Supervising Resident
3. Intern
4. Family Medicine Resident
With this format, students should be able to present their patients to the most experienced physicians available at the time. Interns should then be able to see more patients on their own, thus allowing for more productive resident-staff interactions.

**Nutrition Course**
The Dietetics Department will coordinate a course in basic pediatric nutrition to be completed during the clinic rotation. Objectives are:
• Integrate nutritional care of patients into their total care.
• Obtain an accurate nutritional assessment.
• Demonstrate effective communication of specific diet program and dietary counseling to families in various clinical situations.
• Recognize when the services of a professional dietitian are required.

**Creighton**

**CLINIC INTERN DAILY DUTIES:**
1. Normal Newborn coverage is to be split among the interns (M-F). Please see Normal Newborn resident responsibilities. Back-up intern on call (see monthly schedule) covers weekends.
2. University general pediatric weekday inpatient coverage is to be split among the interns. (See Inpatient Responsibilities).
3. Interns are to return to clinic as soon as newborn/inpatient-attending rounds are completed.
4. Clinic is from 09:00 to 17:00 M-F.
5. Attend all conferences (Noon, PMC (Tue), and Grand Rounds (Fri).
6. The intern is to see patients with students unless the patient is assigned to a specific physician. If there is a large volume of patients and no students waiting to present, then the intern should see the patients first. After seeing the patient the intern should present or assist the student in presenting the case to staff.
7. The intern is responsible for reading and signing the student's note and correcting any mistakes or adding additional information and filling out the problem list.
8. If patients are waiting to be seen, students’ and residents should complete clinic visit documentation after all patients are seen.
9. All patients seen should be plotted on the growth chart.
10. All orders for immunizations, labs, x-rays, meds etc should be written on the “face sheet” before giving to the nurse. There should be no verbal orders except in emergency situations.
11. The intern may leave at 11:45 AM if continuity clinic is at different site.
12. The intern may leave at 16:30 for call.
13. Post-call interns must return to clinic in the afternoon. When patient census permits, staff will decide if they may leave early.
14. If a patient is to be admitted then the Intern responsible for inpatient coverage is responsible for admission orders, H&P (including dictation). If another resident has seen the patient in clinic, common courtesy should be followed and that resident should assist the intern in the admission work-up.

NORMAL NEWBORN RESPONSIBILITIES:
1. Responsibilities begin on the first day of the rotation at 07:30. If intern is unsure of where and when to report, then they should contact the senior supervising resident or the attending.
2. See all Creighton Pediatric Faculty (Drake, Edwards, Fitzmaurice, Kratochvil, Macklem, Moore, and Sindelar) newborns with students and write daily notes (may addendum/cosign student notes).
3. Teaching of basic newborn nursery principles in conjunction with Katie O'Keefe (Clinic/Newborn Nurse Coordinator)
4. Complete Physician Newborn Summary including admission/discharge physicals, discharge weight, blood type, document complicated delivery/hospital course, and discharge orders.
5. Daily rounds with attending before clinic.
6. Follow-up on any labs, x-rays, consults ordered on newborn.
7. Evaluate any newborn with change in clinical status, followed by a report to the attending.
8. Circumcision during first 2 weeks of each month for all University Service Newborns. To be supervised by attending.
9. Write a transfer note for any newborn being transferred to NICU and notify NICU resident.
10. Family Practice Resident will provide Newborn Nursery coverage on Saturday and Sunday a.m.

CLINIC INTERN INPATIENT RESPONSIBILITIES:
1. The intern responsible for inpatient coverage is responsible for admission orders, H&P (including dictation) for patients admitted from clinic, ER, or transfers (M-F). If another resident has seen the patient in clinic, then common courtesy should be followed and that resident should assist the intern in the admission work-up.
2. Intern’s responsibility is for all pediatric patients admitted to a Pediatrician (Drake, Edwards, Fitzmaurice, Holst, Kratochvil, Macklem, Moore, and Sindelar).
3. If other pediatricians have patients they would like the intern to admit or follow daily; they should do so as time permits. This is a secondary responsibility.
4. Daily (weekday) notes and rounds with attending before clinic.
5. Follow-up on any labs, x-rays, consults ordered.
6. Evaluate any patient with a change in clinical status, followed by a report to the attending.
7. Dictate all discharge summaries if patient discharged during the week (M-F).

CLINIC SUPERVISOR DAILY DUTIES:
1. Prior to first day of rotation verify that the interns have divided up coverage for newborn nursery and inpatient service if any questions, the attending should be contacted.
2. Attend clinic from 09:00 to 17:00.
3. Read and review intern responsibilities.
4. On mornings that interns are post call and unable to provide coverage in the newborn nursery/inpatient service, then the supervising resident should provide coverage for these responsibilities.
5. See patients with students. If patients are waiting to be seen and there are no students waiting to present, see patients. Discuss all patients with staff, then write note if no other patients are waiting to be seen.

6. The supervisor may leave at 11:45 AM if continuity clinic is at a different site.

7. The supervisor may leave for call at 16:30.

8. Attend Indian Chicano Clinic on Tuesday mornings after PMC.

9. Assist interns in writing orders for complicated patients being admitted.

10. Attend all conferences.

**ST. JOSEPH’S NICU ON-CALL DUTIES:**

1. Attend deliveries and write a delivery note in the chart on those babies sent to normal newborn nursery.
2. Work-up all admissions. Discuss orders with staff.
3. Cover any problem in the normal newborn nursery.
4. When a patient is seen at night a note should be written in the chart including the DATE AND TIME, outlining the problem and treatment. Creighton Pediatric staff on call should be contacted for any problems outside of the ordinary, or when unsure of management.
5. Carry code pager and respond to all trauma and pediatric code pages.
6. Work-up general pediatric inpatient admissions the ERC. Responsibilities in the NICU are a priority (unstable neonate, delivery etc). The admission should be done after NICU responsibilities completed.
7. Call is from 17:00 to 08:00 M-F and 09:00 to 09:00 on weekends.

**REQUIREMENTS FOR BACK-UP INTERNS**

1. The back-up intern is required to have their pager on and to be ready to respond if contacted. Designated hours for the back-up intern are 5:00 p.m. to 8:00 a.m. on weekdays and 8:00 a.m. to 8:00 a.m. on the weekends.
2. As the back-up intern you are expected to respond to calls from the St. Joseph Hospital ER regarding pediatric admissions. The only pediatric admission you would not be responsible for would be a family practice patient.
3. After seeing the patient in the ER or on the pediatric floor you are responsible for contacting the admitting physician to discuss the admission, your assessment and plan. You will then need to write admit orders as well as writing and dictating an H & P.
4. After completing the above duties you will not be required to further follow the patient through the night. The nurses are expected to direct subsequent questions to the attending physician on call. If this is not happening please let one of the chief residents know.
5. You are not expected to remain in the hospital overnight or on weekend days. You may take call from home however you should be able to get to the hospital in a timely manner if you are called. This means that if you have children you should have a sitter available. It is not acceptable to have to find a sitter when you are called for an admission.
6. When you are the back-up intern on a weekend day you are expected to cover newborn nursery at St. Joe’s. You should call in advance to find out how many babies are in the nursery. You can check with the Pediatric Clinic (280-4580) in advance to find out what staff person is rounding on your day. You can then speak with the staff person find out what time they want you to be ready. In most cases it will be 8:00 a.m. When you have finished your newborn nursery responsibilities you may leave the hospital, but remember to leave your pager on until 8:00 a.m. the next day for possible admissions.
7. Family Practice Residents doing CU clinic will also do newborn nursery rounds on weekend days. The FP resident will be expected to do newborn nursery rounds only. On those weekend days in which a FP resident is doing newborn rounds, there is not a back-up resident available for floor admissions.

**Implementation:**

Residents are given a filing system with topic labels for them to implement a source of information for their future practice. The intent is to encourage the reading of current literature on current pediatric practices and new developments in the care of pediatric patients. While on the rotation, residents will develop a fifteen minute presentation on a general pediatric topic with relevant articles from the medical literature.

Pre- and post-rotation tests will be given as part of the evaluation process.

**Evaluation:**

Evaluations will be based on performance on the examinations, oral presentation, and observed clinical skills.
COMMUNITY HEALTH

Preceptors: Sheryl Pitner, M.D.

Purpose:

The rotation is designed to increase the residents awareness of the agencies and resources outside of the University setting that provide valuable resources for the care of children. Additionally, this rotation will help develop skills for collaboration with community agencies and schools for your future practice.

Objectives:

1) To provide resident physicians with additional knowledge, skills, and experience necessary to practice in the community
2) To introduce resident physicians to their role as advocates for children in their community
3) To provide essential medical and health promotion activities to underserved children in our community

Methods:

1) Attend scheduled Douglas County Clinics at the Indian Chicano Health Clinic and Douglas County South location
2) Attend scheduled clinics at Project Harmony
3) Attend Child Abuse Team (CAT) meetings at Children’s Hospital
4) Prepare and give talks to the inmates at the Douglas County Youth Center
5) Prepare and give a talk to the teen parenting class at North High School
6) Attend scheduled home visit with Early Intervention
7) Schedule and attend visits at community agencies
8) Research and write a profile on a community agency that provides services to children and/or families
9) Research and report on a current legislative initiative or bill regarding the health of children

Implementation:

The resident is expected to review and read the review articles and chapters listed below:

Evaluation:

At the end of the rotation the resident will be evaluated by the attending. The evaluation will be based on input from staff at the clinics and sites visited. The resident is also required to submit their written report on a community agency and have attended the scheduled visits.
CONTINUITY CLINIC

Preceptors: General Pediatrics Physicians

Purpose:

The program must provide adequate continuity experience for all residents to allow them the opportunity to develop an understanding of an appreciation for the longitudinal nature of general pediatric care, including aspects of physical and emotional growth and development, health promotion/disease prevention, management of chronic and acute medical conditions, family and environmental impacts, and practice management. Residents must assume responsibility for the continuing care of a group of patients throughout their training. Inherent in the principle of continuity of care is that patients are seen on a regular and continuing basis, rather than on a single occasion. Isolated block experiences will not satisfy this requirement.

Objectives:

The curriculum emphasizes the generalist approach to common office-based pediatric issues including anticipatory guidance from birth through young adulthood, developmental and behavioral issues, and immunization practices and health promotion as well as care of children with chronic conditions. The resident must learn to serve as the coordinator of comprehensive primary care for children with complex and multiple health-related problems and to function as part of a health care team. Subspecialty consultants and allied health personnel must be available to residents in the care of their continuity patients.

Methods:

The continuity of care experience must include participation in a setting that is structured and designed to emulate the practice of general pediatrics and that is conducive to efficient processing and management of patients. This setting may be an office-based practice, an institutional-based continuity clinic, or a community-based center. Ideally, the residents should participate in the care of their patients through any hospitalization, assess them during acute illnesses, and be available to facilitate other services, such as school-raised evaluations and specialty referrals. A contract between the resident and attending must be signed (see Figure CC 1).

Residents must devote at least a half-day per week to their continuity experience throughout the three years, and an additional half-day session per week is suggested (See “Guidelines for Second Continuity Clinics” after the evaluation description). This experience must receive priority over other responsibilities, and may be interrupted only for vacations and outside rotations located at too great distance to allow residents to return. The periods of interruption may not exceed two months in any one year or three consecutive months at any time.
Implementation:

The program must ensure that residents are exposed to a continuity patient population sufficient in number and of adequate variety to meet the educational objectives. It must include well patients as well as those with complex and chronic problems. Patients initially managed in the normal newborn nursery, emergency department, inpatient service, intensive care unit (pediatric and neonatal), subspecialty clinics, and other sites may be enrolled in the residents' panel. Guidelines for numbers of continuity panel patients seen per half-day experience are 3 to 6 patients per resident in the PL-1 year, 4 to 8 patients in the PL-2 year, and 5 to 10 patients in the PL-3 year. Acceptable minimum standards for each resident's patient panel are approximately 50 patients for each PL-1 resident and approximately 100 patients for each PL-2 and PL-3 resident.

Record maintenance has been established with the development of the Continuity Clinic Record form (see Figure CC 2). This form must be completed in its entirety for each patient and turned in to the Residency Coordinator once a week. The information is entered into a database to generate reports on a regular basis for the Program Director.

Teaching staff who serve as attendings in the continuity clinic must have expertise in the area of general pediatrics and be able to function as role models in general pediatrics. They must be actively involved in direct patient care to maintain their expertise and credibility. These and other competing responsibilities, however, must not compromise their availability for supervision and consultation with the residents.

Evaluation:

Evaluation is based on the number of patients in the resident's continuity panel. An evaluation is also completed by the continuity clinic attending (see Figure CC 3). The information from your continuity clinic panel and evaluation will be reviewed twice a year with the Program Director.
DERMATOLOGY

Preceptors: Kristie Hayes, M.D.; Ramon Fusaro, M.D.; Michelle DiBaise, PA

Purpose:

Upon completion of this rotation, you should be familiar with common dermatologic diseases.

Objectives:

The resident will be able to demonstrate knowledge of the following:
A. The anatomy and physiology of the skin, hair, and nail.
B. The pigmentary, inflammatory, and immune responses of the skin.
C. The dermatologic manifestations of common or severe systemic diseases including the following viral exanthsms: Kawasaki’s syndrome, meningococcemia, erythema multiforme, toxic epidermal necrolysis, Letterer-Siwe disease, neurofibromatosis, systemic lupus erythematosus, dermatomyositis, scleroderma, morphea, diabetes mellitus, eczema, psoriasis, diaper reactions.
D. Content, actions, indications, and contraindications of commonly used dermatologic medications.

Methods:

<table>
<thead>
<tr>
<th></th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1ST WK</td>
<td>*UNMC IM Derm Clin 10-12 (H)</td>
<td>*Derm Surg 9-11(H)</td>
<td>*Peds Derm (H) 9-Noon</td>
<td>**IM Derm (H) 9-12</td>
<td>*IM Derm (F) 1-4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*IM Derm Clinic (H &amp; MOD) 12:50-4:30</td>
<td>**IM Derm Clinic 1-4 (F &amp; MOD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2ND WK</td>
<td>*UNMC IM Derm Clin 10-12 (H)</td>
<td>*Derm Surg 9-11(H)</td>
<td>*IM Derm Clinic (F &amp; MOD) 1-4</td>
<td>**IM Derm (H) 9-12</td>
<td>*IM Derm (F) 1-4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*IM Derm Clinic (H &amp; MOD) 12:50-4:30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3RD WK</td>
<td>*UNMC IM Derm Clin 10-12 (H)</td>
<td>*Derm Surg 9-11(H)</td>
<td>*Peds Derm (H) - 9-Noon</td>
<td>**IM Derm (H) 9-12</td>
<td>*IM Derm (F) 1-4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*IM Derm Clinic (H &amp; MOD) 12:50-4:30</td>
<td>*IM Derm (F &amp; MOD) 1-4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4TH WK</td>
<td>*UNMC IM Derm Clin 10-12 (H)</td>
<td>*Derm Surg 9-11(H)</td>
<td>*IM Derm (F &amp; MOD) 1-4</td>
<td>**IM Derm (H) 9-12</td>
<td>*IM Derm (F) 1-4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*IM Derm Clinic (H &amp; MOD) 12:50-4:30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5TH WK</td>
<td>*UNMC IM Derm Clin 10-12 (H)</td>
<td>*Derm Surg 9-11(H)</td>
<td>*IM Derm (F &amp; MOD) 1-4</td>
<td>**IM Derm (H) 9-12</td>
<td>*IM Derm (F) 1-4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*IM Derm Clinic (H &amp; MOD) 12:50-4:30</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(H) = Dr. Kristie Hayes; (F) = Dr. Ramon Fusaro; (MOD) = Michelle DiBaise, PA
* ALL Students, House Officers and Residents attend this clinic
** ALL House Officers and Residents attend this clinic (Students 2nd week of month)
Implementation:


Familiarize yourself with the following topics on which you may be tested. The page numbers refer to references in Principles of Dermatology, 2nd Ed., Lookingbill & Marks:

A) Acne vulgaris - 189-194
B) Acne Rosacea - 194-195
C) Basal Cell Carcinoma - 81-84
D) Squamous Cell Carcinoma - 79-81
E) Actinic Keratosis - 77-79
F) Melanoma - 94-97
G) Psoriasis - 138-142, 287-288
H) Atopic Dermatitis - 127-130
I) Contact Dermatitis - 123-127
J) Seborrheic Dermatitis - 130-131
K) Nevi - 91-94
L) Cutaneous Fungal Infection - 17-18, 142-149
M) Alopecia - 174-283
N) Warts - 66-72
O) Cutaneous Bacterial Infection - 196-199
P) Cutaneous Viral Infection - 75-77, 149-153, 162-169
Q) Arthropod Infestation - 178-182
R) Autoimmune Bullous Disease - 169-170, 172-176
S) Skin Changes Associated with Prolonged Sun Exposure - handout
T) Seborrheic keratosis - 73-74

Evaluation:

1. Give a presentation on a dermatology patient seen in clinic or on a topic of your choice. The topic should be approved by either Dr. Hayes, Dr. Fusaro or Michelle DiBaise, PA. The presentation will occur on the last week of your rotation. The exact time will be decided upon within two weeks prior to the presentation.

2. Complete a written examination.
DESIGNER MONTH

Purpose:

Elective experiences are intended to enrich the educational experience of residents in conformity with their needs, interests, and/or future professional plans. Electives must be well-constructed, purposeful, and effective learning experiences, with written goals and objectives. The development of the Designer Month was made to allow residents an opportunity to experience aspects of medicine which otherwise would not be an option in a traditional rotation schedule.

Objectives & Methods:

The “Approval of Greater Nebraska/Designer Month Rotation” form (See Designer Figure 1) may be obtained from the Resident Coordinator and completed several months prior to the rotation. All information must be completed on this form prior to meeting with the Program Director to get approval. The form asks you to write your goals and objectives for the proposed rotation along with who will be completing your evaluation.

After receiving the Program Director’s approval, you need to get a check list (See Designer Figure 2) from the Resident Coordinator to complete. If you are doing your rotation off campus, administrative paperwork must be completed. Some of the information that will need to be obtained is a signed letter of agreement with the institution, goals and objectives for the rotation, evaluation criteria, etc. You may need to obtain a medical license from a different state if you are doing this outside of Nebraska. You will need to contact the Administrator of Graduate Medical Education at 559-4629 to ensure your malpractice insurance covers your rotation. You are responsible for getting this paperwork done before your rotation starts.

Housing for the Designer Month will be your responsibility.

Evaluation:

A written report must be submitted to the Program Director summarizing the educational experience you had. This must be turned in within two weeks of completing the rotation. An evaluation will be obtained from your primary preceptor for inclusion in your personnel file.
DEVELOPMENTAL/BEHAVIORAL

Preceptors: Cindy Ellis, M.D.; Howard Needelman, M.D.

Purpose:

The goal of this one-month rotation is to provide the resident with a background in the principles of normal childhood development and behavior and associated problems of dysfunction.

Objectives:

In accomplishing this primary goal, residents will be introduced to methods of evaluation and therapy and gain basic skills in handling psychosocial issues in pediatric populations. An integral part of this experience will be gaining an appreciation of interdisciplinary evaluation and resource availability.

Methods:

By the end of the rotation, the resident will be able to:
1. Discuss patterns of normal development and be able to perform developmental screening.
2. Initiate evaluation and management, including referral, of children and adolescents with developmental behavioral disorders.
3. Develop a clinical approach to the infant and preschooler with developmental delay.
4. Participate as a member of an interdisciplinary team in the evaluation of a child with a developmental disability.
5. Acquire a knowledge base of various developmental disabilities (i.e., ADHD, cerebral palsy, mental retardation, communication/hearing disorders, spina bifida), to allow the resident to be able to act as the primary physician of the patient with disabilities.

Implementation:

The resident will achieve the objectives of the rotation by attending clinics, completing suggested reading and assignments, and attending conferences as required by the developmental behavioral pediatrics staff.

Evaluation:

At the end of the rotation, the resident will be evaluated by a member of the developmental behavioral pediatrics staff. The resident's evaluation will be based on the degree of success in completing the objectives of the rotation.
Purpose:

The purpose of the Emergency Medicine/Critical Care rotation for pediatrics and medicine/pediatrics residents is as follows:
1. Understand the basic principles of emergency medical services for children, including the role of the primary care provider, pre-hospital care systems, and regional trauma systems;
2. Understand how to rapidly assess, resuscitate, and stabilize a critically ill or injured child in the emergency room setting;
3. Develop a logical and efficient approach to the care of emergency patients, applying principles of decision-making and problem-solving; and
4. Understand how to provide sensitive support acutely to patients and families of children and adolescents in acute illness and injury, and arrange for on-going support and/or preventive services if needed.

Objectives:

1. Develop a systematic approach to the evaluation of pediatric emergency/trauma patients.
2. Prioritize and maximize the aspects of medical intervention for the pediatric emergency/trauma patient.
3. Demonstrate communication skills and use of appropriate pain management involving the injured child and his/her parent(s).
4. Demonstrate basic skills in the area of cardiopulmonary arrest and resuscitation.
5. Diagnose and manage the following categories of pediatric emergencies/trauma:
   - Acute respiratory problems, including status asthma, acute asthma, croup, epiglottitis, foreign body aspiration, pneumonia/infections, apnea, anaphylaxis
   - Dehydration/shock from any cause
   - The child with altered level of consciousness including coma, blunt and penetrating head injuries
   - Seizures, including status epilepticus and febrile convulsions
   - The “poisoned patient” (to include general management, utilization of the “Poison Center,” and specific aspects of common poisonings (acetaminophen, salicylate, narcotic, caustics, antihistamines, TCA’s, hydrocarbons, alcohols, lead and iron)
   - Victims of major/multiple trauma, including initial assessment, triage and stabilization/intervention
   - Lacerations, including foreign body management and recognition of tendon, joint and neurovascular injuries and appropriate utilization of specialists
   - Partial and full thickness burns, electrical burns, including fluid management and referral
   - Sepsis/meningitis with respect to age differences (neonate, infant, child, adolescent), including antibiotic therapy
   - The child with fever without obvious foci of infection with respect to various ages (neonate, infant, child, adolescent)
   - The child with abdominal pain or an acute abdomen, in newborn, infant, child and adolescent ages, including pelvic inflammatory disease/STD's
   - Strains/sprains of extremities, including “Nursemaids Elbow”
• Fractures of long bones, extremities, skull and facial/nasal bones. Dislocations and emergent reductions. Splinting techniques and referral.
• Dental, maxilla/mandible injuries
• Eye injuries including foreign body, corneal abrasion, infections and penetrating trauma
• Child/sexual abuse, rape, including proper legal documentation and reporting
• Animal/insect bites, including rabies, tickborne infections, spiders and snakes
• Common skin rashes, including infections, erythema multiforme and drug reactions
• Common febrile illness in infants, children and adolescents
• The child with a foreign body (orifice)
• The child with scrotal pain or swelling (including labial swelling)
• The child with a limp
• The acutely ill diabetic (hypo/hyperglycemia and DKA)
• The child with chest pain
• The child with a headache

Methods:
With Dr. Joekel's assistance, residents should prepare a schedule about one week in advance of the rotation. You may be assigned to the Children's ED or to the St. Joseph's ED (trauma center). The expectations for the rotation are as follows; You should work a minimum of 20 shifts during the month. Fifteen shifts in the emergency department, and five shifts at Children's Urgicare. If you are working at the Children's ED for the month, you will also go to the Children's Urgicare on Dupont Circle for 5 shifts. If you are working at the St. Joseph ED, you will go to the Children's Urgicare on West Maple Street for 5 shifts. Hours of your shifts are as follows; at the ED (either Children's or St. Joseph's) you will work 4 pm to midnight during the week, and noon to midnight on the weekends. You are expected to work one half of the Saturday's and Sunday's during the month, and these shifts will be in the emergency departments of Children's or St. Joseph's only. Your 5 shifts at the Urgicare will be 5 pm to 11 pm, Monday thru Friday only. You may be asked to come in early for some of your shifts for lectures, case reviews or independent study. Some flexibility is allowed on the specific hours of work to allow for outside clinics, etc. Individual variations in the schedule are at the discretion of the attending staff and are not guaranteed. Vacation time needs to be arranged with the resident program coordinator, before ED scheduling is finalized.

When reporting to the Children's ED, report to Dr. Joekel. When reporting to St. Joseph's ED, report to Pat Pogreba, Dr. Grigsby's secretary.

You are expected to dress and conduct yourself in a professional manor. No scrubs or “on call” clothing PLEASE. You represent the Joint Residency Program, therefore we ask that you use good judgement. On those same lines, please treat the ancillary staff as you wish yourself to be treated, that is, WITH RESPECT. And, please identify yourself as Dr. ________, the pediatric resident working with Dr. so and so. This will help patients and families identify who their attending physician is. Some patients or families may ask to see the staff physician only; politely say okay and do not take it personally.

You are encouraged to see any and all patients during the rotation. However, there will be times when it is busy and the attending staff may ask you to see certain patients to expedite the flow through the ED. Please realize that this is for everyone’s benefit and not a reflection of your skills. At the St. Joseph’s ED, you are expected to see all pediatric patients, all trauma patients, and selected adult patients with
problems that are treated the same whether adult or pediatric (i.e., lacerations, sprains, simple fractures, 
STD’s, earache, sore throat, etc.). Your priority for seeing patients should be pediatric and adult trauma, 
then other pediatric patients, then selected “other patients” as coordinated by the St. Joseph’s attending 
staff. You are not expected to see “sick” adult patients with chest pain, strokes, headache, GI bleed, etc. 
that are beyond the scope of pediatric practice unless you have a special interest in those areas (and not 
at the expense of your pediatric experience).

There will be times when it is busy and the attending staff physician is ultimately responsible for your 
actions in the ED or Urgicare. Therefore NO question is too silly or trivial when it concerns patient care. 
Also, this means that we are responsible for your charting and we must edit and sign ALL your charts. 
Additionally, if a patient is to be admitted, or if the referring physician needs to be called for follow up, the 
RESIDENT physician should defer these calls to the STAFF ED physician. Resident to resident calls on 
patients/admission are allowed and encouraged.

Part of your first shift at each respective site should be as an observer. Watch how we interview patients, 
do exams, chart, discharge, etc. to get a feel of how the system works.

When seeing patients, it generally works best if you see the patient first, formulate a differential diagnosis 
and plan, then present it to the staff. Generally the staff will go along with your plan or occasionally will 
modify it. Most if not all of the staff adhere to the saying, “See one, Do one, Teach one” when it comes to 
procedures, etc.

All patients discharged need specific discharge instructions for follow up. Watch how we do it and you will 
get the hang of it. NEVER dismiss a patient without presenting/discussing with the attending staff first.

Implementation:

During the rotation, residents will be involved in formal and informal education sessions with the staff 
physicians utilizing cases seen and written “objectives” for the rotation. The success of these sessions 
will depend greatly upon the resident; our hope is that the house officer will participate eagerly in all of 
these activities and help make this an enjoyable month for all.

Most of these texts can be found in our office. PLEASE DON’T remove them from there (a surefire way to 
fail the rotation):
2. Pediatric Emergency Medicine, Concepts and Clinical Practice. Roger M. Barkin (ed.); C.V. Mosby 
   Company, 1st ed.
4. 2000 Red Book. Committee on Infectious Diseases, AAP.
9. Emergency Radiology of the Acutely Ill or Injured Child. Leonard E. Swischuk (ed.); Williams and 
   Wilkins.
10. Smith’s The Critically Ill Child. Dickerman and Lucey (Eds.); W.B. Saunders Company.
Evaluation:

The attending staff will evaluate you individually, based on the standard evaluation forms that the residency program uses. You will be evaluated on your fund of medical knowledge, your clinical and diagnostic skills, procedures, and your ability to “get along” and be a valuable member of the ED “team”. We are looking for improvement in all these areas as you gain experience while working in the ED and Urgicare centers. Additionally, you may be given a post-rotation test as a part of your evaluation. If during your rotation one or more of us feel you are having difficulty, we will attempt to alert you so you may take corrective action as soon as possible. Also, if you are having difficulty with the attending staff, or another member of the ancillary personnel, you are expected to bring this to the attention of Dr. Joekel (the Children’s resident education coordinator), or Dr. Grigsby (the St. Joseph’s Trauma Center coordinator).
UNMC
Preceptors: Kevin Corley, M.D.

Children's
Preceptors: Kevin Corley, M.D.

Purpose:
To provide house staff with exposure to patients referred to a pediatric endocrinology and diabetes practice by participating in ambulatory and inpatient evaluations of patients. This rotation provides the resident with experience in diagnostic problems of growth, pubertal development, thyroid dysfunction and adrenal disorders in both inpatient and outpatient settings. Further experiences can be gained in disturbances of carbohydrate metabolism. The house staff will be responsible for the daily care of inpatients, endocrine consultations and implementation of tolerance tests with the supervision of the staff.

Objectives:
1. The student will have the opportunity to improve his/her clinical skills in obtaining a history and performing a physical examination with specific reference to the endocrine system.
2. The student will learn to integrate clinical information into a differential diagnosis and to obtain appropriate diagnostic tests to arrive at a specific endocrine diagnosis.
3. The student will learn to manage patients with endocrine disorders using medication and diet therapy.
4. The student will learn to deal with the psychosocial and developmental issues of children having a chronic disorder, especially with issues in schooling and activities of daily living.
5. The student will be given the opportunity to review current thoughts on the pathogenesis, diagnosis, and clinical issues in endocrine diseases in diabetes using specialty review articles and other library resources.
6. The clinical experience will involve patients with a variety of endocrine disorders, including but not limited to the following:
   a. Type I insulin-dependent diabetes mellitus
   b. Short stature/growth hormone deficiency
   c. Hypothyroidism, both congenital and acquired
   d. Hyperthyroidism
   e. Congenital adrenal hyperplasia and adrenal insufficiency
   f. Panhypopituitarism
   g. Metabolic bone disease
   h. Hypoglycemia
   i. Precocious puberty

Methods:
1. House staff will manage outpatient assessment and follow-up of newly referred and returning patients with diabetes and endocrine disorders with supervision.
2. House staff will participate in inpatient evaluation on diabetes and endocrine problems.
3. House staff will participate in outreach endocrine clinics.

Implementation:
1. Outpatients seen in endocrine and diabetes clinics at NHS University Hospital and Creighton University Medical Center
2. Outpatients seen in outreach clinics
3. Inpatients and consults at NHS University Hospital, St. Joseph Hospital, and Children’s Hospital
4. A text on pediatric endocrinology is supplied with a list of required readings and discussions of endocrinology/diabetes topics

Evaluation:

1. The attending staff will complete the evaluation of the house staff based on resident performance on inpatient and outpatient assessments, as well as presentation of an endocrine topic.
2. The attending physician will review daily progress notes
FLOAT

*Preceptors:* John Walburn, M.D.

**Purpose:**

To provide coverage for fellow residents in order for them to attend mandatory continuity clinics and other educational activities.

**Objectives:**

Provide coverage in local community and hospital clinics, ICU's, and wards.

**Methods:**

In conjunction with the Chief Resident, appropriate coverage will be determined for services.

**Implementation:**

There are currently no educational goals and objectives for this rotation. Plans are being made to make this more of an educational rotation and not just a service-based rotation.

**Evaluation:**

Dr. Walburn, faculty and peers involved in coverage sites will complete an evaluation based on performance.
GASTROENTEROLOGY

Preceptors: Dean Antonson, M.D.; Thomas Attard, M.D.; Simon Horslen, M.D.; Dave Mack, M.D.; Laurel Prestridge, M.D.; Clarivet Torres, M.D.; Jon Vanderhoof, M.D.

Purpose:

The resident will: 1) become broadly familiar with gastrointestinal pathophysiology in infants, children and adolescents; 2) assist in evaluation of patients with gastrointestinal, hepatobiliary, and nutritional disorders; 3) participate in gastrointestinal procedures; and 4) gain some expertise in interpretation of gastrointestinal histopathology.

Objectives:

Residents will learn to evaluate and treat pediatric patients with common gastrointestinal problems. It is the goal of this elective that they will be able to manage common gastrointestinal disorders such as constipation, formula allergy, and abdominal pain without consultation with the pediatric gastroenterologist except in unusual cases. They will learn the appropriate time for referral for more severe or difficult gastrointestinal and hepatobiliary disorders.

Teaching rounds are performed on a daily basis. The resident will work closely with students and fellows as well as the attending.

Methods:

1. The resident will be able to construct a differential diagnosis for an infant or child presenting with the following signs and symptoms among others: chronic vomiting, acute bilious vomiting, abdominal distention, acute abdominal pain and tenderness, chronic abdominal pain, acute vomiting and diarrhea, chronic constipation with or without fecal soiling, abdominal mass on physical examination, direct hyperbilirubinemia in an infant, jaundice in an older child.

2. The resident will be able to perform the history and physical, and select the correct laboratory tests or other procedures which will support or confirm the eventual diagnosis described in #1, above.

3. The resident will be able to institute treatment for each eventual diagnosis.

4. The resident should know and understand the appropriate use of both standard and therapeautical infant formulas.

5. The resident should be able to use appropriately and effectively prokinetic drugs, H2 receptor antagonists, laxatives, and anti-inflammatory drugs.

Implementation:


Evaluation:

**Honors**  The resident demonstrates exceptional knowledge of common gastrointestinal disorders and treatment. Participation in discussions and response to questions demonstrate evidence of outside reading and good understanding. Resident actively contributes to patient discussions during rounds and clinics.

**High Pass**  The resident demonstrates interest and understanding of the goals and objectives of the elective. Participation in discussions demonstrates evidence of outside reading.

**Pass**  The resident demonstrates an interest in pediatric gastroenterology and gives evidence of outside reading. The resident attends all clinics and conferences unless excused.

**Marginal**  The resident attends all clinics and conferences unless excused. Resident expresses interest in pediatric gastroenterology, but fails to demonstrate evidence of outside reading and/or understanding.

**Fail**  The resident has more than two unexcused absences from clinics or conferences or consistently refuses to participate in discussions. The resident demonstrates no evidence of outside reading and/or understanding.
GENETICS

Preceptors: Bruce Buehler, M.D.; Ann Olney, M.D.; G. Bradley Schaefer, M.D.; Hobart Wiltse, M.D., Ph.D.

Purpose:

Congenital anomalies play a major role in all of pediatric care. The leading cause of infant mortality in the United States is the sequelae of congenital anomalies. This exceeds the death rate for prematurity, SIDs, and other common causes of infant or neonatal death. Sixty percent of all admissions to a pediatric hospital are for conditions with a genetic basis. Three percent of all newborns have a recognizable congenital anomaly. An additional 2% of children have congenital anomalies that are not detectable in the newborn period. Finally, 3% of the United States population is mentally retarded, of which 80% is due to genetic factors. Primary care physicians involved in the provision of health care for children and adolescents need a basic understanding of how to evaluate and when to refer children with genetic disorders or other congenital anomalies.

Graduate level (medical student, resident, post doctoral fellows, graduate trainees) may elect to take a four-week elective in Human Genetics as an option separate from Rehabilitation and Genetic Medicine. On this elective, they will have a variety of experiences including:

- Clinics: the Staff of Human Genetics supports a large number of genetic and interdisciplinary clinics, utilizing genetic services both at the Munroe-Meyer Institute and at community clinics.
- Laboratory exposure can be provided in the areas of both cytogenetics and molecular genetics.
- Formal lectures will be provided for pertinent topics; as well, attendance at regularly scheduled conferences will be encouraged. Regularly scheduled conferences include a weekly clinical Case Conference and a bi-weekly cytogenetics case conference.

The Genetics rotation is strictly an outpatient clinical rotation. There are no inpatient duties other than consultation. The resident will have the opportunity to rotate and observe most, if not all, of the genetics clinics and interdisciplinary clinics that the genetics staff participates in here at the Munroe-Meyer Institute, UNMC, and at all hospitals in the Omaha area. Depending on the scheduling time, the students may also have the opportunity to attend Outstate Genetics Clinics in the greater Nebraska area. There will be no pre- or post-test given.

Recommended reading list for this rotation would include:

- Jones’s book Smith’s Recognizable Patterns of Human Malformations
- Jorde’s Medical Genetics

“Mini research projects” can be designed and implemented if the student so desires to participate in a small research project during his/her time on the Genetics rotation.

Objectives:

1. Recognize the features of the more common pediatric genetic conditions/syndromes.
2. Know unique medical and neurodevelopmental issues of the more common conditions/syndromes.
3. Be able to categorize congenital anomalies as malformation, deformation, or disruption.
4. Understand the patterns of multiple congenital anomalies (syndrome, sequence anomaly, association).
5. Appreciate the psychosocial implications for families of children with congenital anomalies.
6. Recognize urgent issues in genetic medicine and be able to rapidly identify such issues and the immediate standard interventions.

Methods:

1. Clinical participation: clinics, consultations, interdisciplinary services
2. Attendance at scheduled genetic conferences:
   • Case conferences
   • Cytogenetics conferences
   • Molecular genetics conferences
3. Presentation of a selected topic at the genetics Case Conferences
4. Recommended readings
5. Individual instruction with attending

Implementation:

The resident will be oriented to MMI on the first day of the rotation. Standard information will include:
• Call schedule
• Clinic schedule
• Conference schedule
• Expectations
• Time lines

Evaluation:

• Direct observation in clinics
• Critique and assessment of presentation
• Conference attendance
• Evidence of independent readings
HEMATOLOGY/ONCOLOGY AND BMT ROTATION

Preceptors: James Harper, M.D. and attendings on service at UNMC and CMH.

Purpose:

The goal of this four week rotation is to provide the intern with the clinical experience of evaluating and treating patients with common hematologic and oncologic problems of childhood and to provide the intern with exposure to the care of children with multi-organ system disease using the BMT setting.

Objectives:

1. The intern should be able to demonstrate knowledge of:
   A. Development, structure, and function of the formed elements of the blood and blood forming organs.
   B. Mechanisms underlying abnormal increases or decreases in the formed elements of the blood.
   C. Age-related changes in the formed elements of blood
   D. Principles and techniques underlying blood transfusion
      i. Indications and rationale for RBC and platelet transfusion
      ii. Indications and rationale for leukocyte reduced blood products
      iii. Indications and rationale for CMV negative blood products
   iv. Transfusion reactions
      1. Febrile reaction
      2. Allergic/Anaphylactic reaction
      3. Acute Hemolytic reaction
      4. Delayed Hemolytic reaction
   E. Physiology of hemostasis
      i. Age-related differences
      ii. Pathophysiology and clinical presentations of Von Willebrand’s disease, hemophilia, ITP, microangiopathic processes (i.e.: HUS, HSP, DIC)
      iii. Pathophysiology of procoagulant conditions of childhood, their clinical presentations and risk factors.
         1. Sickle Cell Disease
         2. Acquired anticoagulant deficiencies
         3. Congenital anticoagulant deficiencies
   F. Characteristics of common tumors in childhood
      i. Clinical presentation of the following common childhood tumors
         \begin{tabular}{|l|l|}
         \hline
         Acute Lymphoblastic Leukemia & Brain tumors \\
         \hline
         Lymphoma & Neuroblastoma \\
         \hline
         Wilms tumor & Sarcomas \\
         \hline
         
      
      ii. Principles of investigation of childhood cancer
      iii. Basic principles underlying cancer therapy in children
      iv. Common late effects of cancer therapy
         1. Growth retardation
         2. Pubertal delay
         3. Learning disabilities
G. Bone Marrow Transplantation
   i. Common indications for HSCT
   ii. Pathophysiology, clinical presentations, and principles underlying therapy of the following common infectious complications
      1. Central line infections
      2. Fungal infections (Candida, Aspergillus)
      3. Viral infections (HSV, CMV, Varicella)

H. Social, Familial, and Personal effects of chronic hematologic conditions and cancer.

2. The intern will develop the following clinical skills:
   A. Clinical assessment of common hematologic and oncologic problems in children
      i. Neutropenic fever
      ii. Relapse of tumor
      iii. Endocrine dysfunction
      iv. Fluid imbalance
      v. Mucositis
      vi. Nausea
   B. Technical skills
      i. Technique for successful lumbar punctures
      ii. Technique for placement of a bone marrow aspirate needle
      iii. Technique for accessing portacaths and Hickman catheters
      iv. Technique for proper examination of a peripheral blood smear

3. The intern, using relevant knowledge and clinical data be able to recognize, diagnose, and manage problems in the field of hematology and oncology, including the following:
   A. Anemia
      i. Decreased production
      ii. Increased destruction
   B. Bleeding
   C. Transfusion reaction
   D. Enlargement of the liver or spleen
   E. Lymph node enlargement
   F. Abdominal mass
   G. Masses detected clinically or radiographically
   H. Abnormal increases or decreases in the formed elements of blood
   I. Pain control

Methods:

The intern will be involved in the following activities during the rotation:

1. Will be an active member of the pediatric hematology team, which includes the attendings, nurse coordinators, interns, and medical students.
   A. The intern will attain knowledge objectives by review of available pediatric hematology and oncology texts, as well as by literature review.
   B. Teaching sessions during rounds as well as in the clinic will also be used to attain these objectives.
C. Skill objectives will be obtained through observation, and practice of technical skills in the clinic and inpatient units.

2. Evaluate inpatients and outpatients in the clinic and BMT settings.
   A. Clinical evaluation and assessment skills will be developed with the attendings by participation in the clinic and on the inpatient units.

3. Complete the suggested reading as outlined at the beginning of the rotation.

4. Participate in the teaching sessions and conferences held during the rotation

Implementation:

The curriculum will be outlined to the intern in the information packet provided at orientation. Reading suggestions will be made at the orientation session with Dr. Harper at the beginning of the rotation.

Evaluation:

The intern will be evaluated by the attending. This evaluation will be based upon the intern’s performance with respect to the above objectives. Input as to the intern’s performance will be sought from the nurse coordinators, and from medical students that are under the supervision of the intern. The intern will meet with Dr. Harper, and/or the attending on service regularly to discuss his/her continuing performance relative to the objectives outlined above.

The intern’s evaluation of the curriculum/rotation will be sought at the middle and end of the rotations with respect to the learning opportunities at each site.
INFECTIOUS DISEASE

Preceptors: Archana Chaterjee, M.D.; Jose Romero, M.D.

Purpose:

Provide the house officer an opportunity to study in-depth the clinical and laboratory aspects of infections in children. Special emphasis is given to those infections and immunodeficiency states that are unique to the pediatric age patient. A minimum of 3 weeks plus one weekend on rotation must be completed to receive credit.

Objectives:

1. Discuss the etiology, pathogenesis and therapy of the common pediatric viral exanthems.
2. Discuss the etiology, pathogenesis and therapy of sepsis, by age, in pediatric patients up to age 18 years.
3. Understand the etiology, clinical presentation and treatment of common pediatric upper and lower respiratory infections.
4. Describe the common causes, etiology and management of gastroenteritis in children.
5. Be able to recognize the common congenital infections and discuss and appropriate laboratory evaluation of same.
6. Understand the common pediatric immunodeficiency disorders and list appropriate screening tests to evaluate these conditions.
7. Be able to discuss the commonly used oral and parenteral antimicrobials for children with special emphasis on pharmacology and \textit{in vitro} activity.
8. Be able to discuss the methodologies and appropriate use of common microbiologic test procedures such as throat/blood/urine/sputum/CSF cultures, minimal inhibitory concentration, etc.
9. Describe the appropriate collection methods for obtaining viral respiratory, urine, blood, etc., specimens for laboratory testing.
10. Understand the pathogenesis of hematogenous musculoskeletal infections and present an organized approach to diagnosis and therapy.
11. Discuss the relative \textit{in vitro} activities and clinical use of the common oral and intravenous antimicrobials for pediatric patients.

Methods:

The house officers are expected to work with the Pediatric Infectious Disease fellows and faculty members to see all inpatient pediatric infectious disease consults during their month of rotation, including consults on evenings and weekends when they are not on call for pediatrics. House officers will be on call no more than 2 weekends during the month, which we try to coordinate with their weekend pediatric call schedule. They will attend a number of lectures, which are included in a handout that they will receive on the first day of the rotation.

Implementation:
House officers are required to present selected cases at our weekly pediatric infectious disease conference and to prepare a discussion of at least one patient at the city-wide combined infectious disease seminar. In addition, if a particularly interesting patient or patients are seen during the month, residents are highly encouraged to write a case report for publication with the assistance of the fellow and/or faculty member.

A required reading list is provided to the house officers on the first day of the rotation. This photocopied book is provided gratis to the residents and includes a number of selected literature references in pediatric infectious disease. In addition, all house officers are required to read the entirety of Krugman's Infectious Diseases of Children, a copy of which may be borrowed from our office at the beginning of the rotation.

Evaluation:

The final evaluation for this rotation will be a composite of performance on daily rounds, weekly presentations at the Pediatric Infectious Disease Conference, and a final examination at the end of the month.
METABOLISM

Preceptors: Hobart Wiltse, M.D., Ph.D.

Purpose:

This experience should prepare the resident to consider inherited metabolic conditions in the differential diagnosis of a variety of clinical problems and make appropriate use of available diagnostic tests.

Objectives:

Cognitive Objectives

A. Identify major clinical features of the following inborn errors of metabolism, as outlined in Nelson Textbook of Pediatrics, 16th Edition, 2000, pp 328-430:
   • Phenylketonuria
   • Tyrosinemia type 1
   • Homocystinuria
   • Methyltetrahydrofolate reductase deficiency
   • Maple syrup urine disease
   •Isovaleric acidaemia
   • Biotinidase deficiency
   • Beta-ketothiolase deficiency
   • Propionic acidaemia
   • Methylmalonic acidaemia
   • Nonketotic hyperglycinemia
   • Pyridoxine dependency
   • CPS deficiency
   • OTC deficiency
   • Citrullinemia
   • Transient hyperammonemia of the newborn
   • Glutaric aciduria type 1
   • Canavan disease
   • Medium-chain acyl CoA (MCAD) deficiency
   • Long-chain 3-hydroxyacyl CoA (LCHAD) deficiency
   • Zellweger syndrome
   • X-linked adrenoleukodystrophy
   • Tay-Sachs disease
   • Gaucher disease
   • Niemann-Pick disease
   • Metachromatic leukodystrophy
   • Krabbe disease
   • Wolman disease
   • Glycogen storage disease
   • Galactosemia
   • Hereditary fructose intolerance
   • Pyruvate dehydrogenase (E₁, E₂, E₃) deficiency
• Carbohydrate-deficient glycoprotein syndrome
• Mucopolysaccharide storage disease
• Lesch-Nyhan syndrome
• Mitochondrial myopathy
• Acute intermittent porphyria
• Mitochondrial encephalomyopathy
B. Become familiar with the currently recommended management for phenylketonuria, galactosemia, urea cycle defects, fatty acid oxidation defects, and glycogen storage disease.

Experiential Objectives
A. Gain skill in diagnosing metabolic disease by utilizing the Metabolism Review 2001 handout (attached) and/or Nelson Textbook of Pediatrics for working through the following scenarios:

1. Given a newborn infant with a positive screening test for phenylketonuria, galactosemia, or biotinidase deficiency, recommend the appropriate confirmatory diagnostic steps.
2. Recommend metabolic screening procedures for a severely jaundiced infant, several days old, with what appears to be Gram-negative septicemia but still awaiting culture proof.
3. Recommend metabolic screening procedures for a neonate with fulminating liver failure.
4. Recommend metabolic screening procedures for a neonate with lethargy and hyperventilation.
5. Recommend metabolic screening procedures for a neonate with lethargy, vomiting, an increased anion gap, and neutropenia.
6. Recommend metabolic screening procedures for a neonate with myoclonic jerking, hypotonia, and secondary apnea.
7. A previously healthy 6 month-old infant presents with a hypoglycemic seizure and hepatomegaly in the course of a febrile illness with vomiting. The initial urine specimen is free of acetone. Recommend appropriate diagnostic steps.
8. A 3 month-old infant was delivered at 34 weeks because of the HELLP syndrome in the mother. The infant is now gaining poorly and is often lethargic between feedings. You find mild hepatic enlargement, fasting hypoglycemia without ketonuria, and elevation in AST and ALT. Recommend additional diagnostic steps.
9. A female patient with a long-standing history of protein aversion develops a febrile illness with vomiting and then becomes confused, combative, and progressively obtunded. Recommend appropriate diagnostic steps.
10. An infant has marked hepatomegaly and fasting hypoglycemia which is relatively asymptomatic. Recommend appropriate diagnostic steps.
11. Given a young child who presents with a hypoglycemic seizure and marked ketonuria, recommend an appropriate protocol to confirm a diagnosis of ketotic hypoglycemia.
12. Identify one or more disease states and one or more therapeutic regimens which can lead to carnitine depletion, and predict the clinical manifestations of carnitine depletion.
13. Predict the artefact that might appear in an organic acid screen of the urine of an infant whose diet contains medium-chain triglyceride.
14. A 6 month-old male infant has x-ray evidence of active rickets. Recommend test procedures which will differentiate type 1 vitamin D dependency, type 2 vitamin D dependency, x-linked hypophosphatemia, and cystinosis from each other.
15. Recognize the clinical presentation of Gaucher disease, Pompe disease, Tay-Sachs disease and Hurler's disease. Given an infant or child with a positive urine screening test for
mucopolysaccharide, recommend additional tests which would differentiate the major types of generalized mucopolysaccharidosis.

16. Given a child with any newly diagnosed lysosomal storage disease, counsel the parents regarding mode of inheritance, recurrence risk, and prognosis.

17. A newborn infant has an unusual facial appearance with prominent forehead, a large fontanelle, and cataracts. Recurring seizures are difficult to control and marked hypotonia is present. Recommend appropriate diagnostic steps.

18. An 8 year-old boy has a worsening school performance and behaviors suggestive of ADHD. His handwriting has been deteriorating. His gait is clumsy and you find his tendon reflexes increased. There is a suggestion of Addisonian pigmentation. Recommend appropriate diagnostic steps.

B. Utilize diagnostic strategies from Metabolism Review 2001 in evaluating children seen as outpatients in metabolic management clinic and in in-patient consultations.

Methods:

The resident will participate in inpatient consultations and clinic follow-up visits for children with metabolic problems. Guidance will be offered in selection of tests and use of progress notes for documentation of rationale. Regular tutorial sessions will be scheduled for purposes of didactic instruction, sharing of current articles, reviewing patient experience, and evaluating resident progress as needed.

Implementation:

Expectations will be routinely discussed in an orientation session. Standard departmental evaluative questionnaires and reports will be utilized at end of rotation. Results of the written exam will be scrutinized for indications of gaps in the educational experiences.

Evaluation:

Evaluation will be accomplished by direct observation of resident interactions with patients, resident contributions to the clinical record, and resident information-retrieval techniques. At end of rotation, the resident will be asked to complete a multiple choice exam based on the cognitive and experiential objectives outlined in sections II and III, and results will be discussed with the resident.
Preceptors: Neonatologists on service

Purpose:

The resident will be exposed to the critical care of sick and high-risk neonates and the convalescent care of recovering, growing neonates.

Objectives:

Emphasis will be placed on resuscitation of the high risk infant, recognition of signs and symptoms of neonatal illness with the formation of a differential diagnosis and treatment plan; monitoring of physiologic parameters; calculation of fluid, electrolyte and nutrition requirements; assessment of blood gases and respiratory treatment strategies. The resident will have the opportunity to participate with staff in minor procedures. Scheduling and assignment will be as per attending Neonatologist. Didactic instruction will be provided through daily rounds, conferences, and lectures. There is an average of 45 new admissions per month with an average of 24 patients per day.

Methods:

1. Residents are to attend high risk deliveries complicated by prematurity, multiple gestation, meconium staining, congenital anomalies and perinatal depression as well as routine cesarean sections. The goal is to provide students with exposure to neonatal resuscitation as outlined by the AAP and AHA.

2. Residents are expected to perform complete history and physicals including evaluation of the maternal obstetrical/medical history with subsequent development of a differential diagnosis, evaluation and treatment plan.

3. Residents will be involved in the daily evaluation, care and formulation of treatment plans of neonates in the NICU. This includes “work” rounds as well as formal rounds with the staff Neonatologist, and nursing staff.

4. The resident will be exposed to many of the neonatal problems requiring NICU care; i.e., prematurity, respiratory distress, congenital anomalies, perinatal depression, anemia, significant hyperbilirubinemia, hypoglycemia, sepsis, etc. The resident will also be exposed to some of the outcomes of neonatal intensive care.

5. The resident is to perform procedures; i.e., IV starts, intubation, catheter placement, chest tube placement, etc. performed on their patients. These will be supervised by a staff Neonatologist.

6. Residents will be members of a team communicating with referring physicians, consulting physicians and families regarding patient management.

Implementation:
1. A selective reading handout on specific topics is available in the UNMC Residency Library (UH 5160) to check out.

   - Chapter 2, Page 59-62
   - Chapter 4, Page 130-132
   - Chapter 6, Page 157-213
   - Chapter 11, Page 412-413
   - Chapter 17, Page 629-630
   - Chapter 19, Page 714-716


**Evaluation:**

A multiple choice exam of 5-10 questions during the last week of the rotation will be administered. Successful completion of the rotation will be based upon the resident's demonstrated exceptional knowledge of neonatal disorders and neonatal treatment strategies; the resident actively participates in patient discussion and management; and the resident clearly demonstrates self-study beyond requirements with appropriate application to NICU care.
NEPHROLOGY

Preceptors: Helen Lovell, M.D.; Pascale Lane, M.D.

Purpose:

The house officer will become familiar with the evaluation and management of pediatric kidney and urinary tract diseases; fluid, electrolyte, and acid-base disturbances; and hypertension.

Objectives:

The resident will become familiar with pediatric aspects of genito-urinary tract disease. Specifically: 1) medical management of congenital renal or G-U anomalies; 2) acute and chronic urinary tract infections; 3) evaluation of asymptomatic proteinuria and hematuria including urine sediment examination; 4) evaluation and therapy of hypertension; 5) medical management of acute or chronic renal failure including dialysis and 6) management of acute or chronic glomerulonephritis.

Methods:

The resident will be involved in the following activities during the rotation:
- Will be an active member of the pediatric nephrology team which will include medical students, nurse coordinator, and the attending physicians, and
- Evaluate inpatients on the consult service, as well as attend outpatient pediatric nephrology clients.

Implementation:

The resident will receive journal articles regarding common pediatric nephrology problems. Reading of pertinent sections of current pediatric textbooks is also recommended. Independent research and reading regarding nephrology patient problems will be expected.

Evaluation:

Evaluation will be based on demonstration of exceptional knowledge of pediatric nephrology and pediatrics through discussions during rounds, clinics, and consultations. Attendance and participation in rounds, clinics, and consultations unless absence is excused. Demonstration of excellence in researching, organizing, and presenting a clinical or basic science nephrology-related topic.
NEUROLOGY

Preceptors: Paul Larsen, M.D.; Janice McAllister, M.D.; Ivan Pavkovic, M.D.; Rhonda Wright, M.D.

Purpose:

The goal of this four week elective is to provide the resident with the clinical experience of evaluating children with neurological disorders, and thereby, acquire skills necessary to perform the pediatric neurologic exam and to develop a diagnostic therapeutic approach to common neurologic problems in children.

Objectives:

1. The resident should be able to outline the developmental milestones of the infant and child and how they affect the neurological exam.
2. The resident should be able to synthesize the neurological findings observed on examination and determine the anatomical location of the lesion.
3. The resident should be able to perform a neurological examination on a neonate, infant, toddler, and child.
4. The resident will be able to outline and discuss a logical approach to common pediatric neurological problems.
5. The resident should understand the proper diagnostic use of the laboratory procedures used in pediatric neurology including EEG, EMG, CT, MRI, etc.

Methods:

The resident will be involved in the following activities during the rotation:
- Will be an active member of the pediatric neurology team which will include residents in neurology, medical students, and the attending physicians, and
- Evaluate inpatients on the consult service, as well as attend outpatient pediatric neurology clients.

Implementation:

1. Complete the suggested reading, as outlined at the beginning of the rotation.
2. Participate in the teaching sessions and conferences held during the rotation.

Evaluation:

At the end of the rotation, the resident will be evaluated by the attending. This evaluation will be based upon the resident’s performance with respect to the above objectives. There will be a practical examination based on the resident’s performing a neurologic exam on a patient, and a written exam based on the required reading.
Preceptors: R. Fred Olney, M.D.

Purpose:

The purpose of the newborn nursery rotation is to give the resident experience functioning as the primary care physician for all babies admitted to the normal newborn nursery on the Pediatric service at NHS University Hospital.

Objectives:

The goals for this rotation include but are not limited to:
- Continued study of newborn medicine,
- Improvement of communication skills with mothers and staff
- Developing small group teaching techniques

Methods:

Residents will be obtaining full obstetric histories, daily physical examinations, and organizing rounds with the pediatric faculty and medical students. All calls will be taken by this resident for the nursery during the day on weekdays.

The resident will work with intensive care nursery residents with regard to various newborn situations such as newborn resuscitation and care of well and recovering premature infants. There will be exposure to a relatively high risk setting because of our level three nursery at a university hospital. Close attention will be made to follow-up care after discharge using anticipatory guidance techniques and utilizing ancillary services such as social services and visiting nurses.

Implementation:

Residents will be expected to check out “A Normal Newborn Curriculum” from the residency coordinator and read the information presented. Daily review of written notes and critiques of presentations will be done to help the resident’s performance.

Evaluation:

Residents will be evaluated on their written notes, oral presentations, and discussions based upon the reading material.
ORTHOPAEDICS

Preceptors: Paul Esposito, M.D.; Walter Huurman, M.D.; Glen Ginsburg, M.D.

Purpose:

The purpose of the Pediatric Orthopaedic elective is to provide the resident the ability to evaluate children with musculoskeletal complaints. In addition, training in the physical examination and utilization of ancillary studies to allow for a timely, appropriate diagnosis will be a priority on this rotation.

Objectives:

1. The resident will be able to obtain an accurate musculoskeletal history and differentiate abnormal musculoskeletal problems from the normal developmental milestones.

2. The resident will learn to evaluate the child physically, and accurately describe and record appropriate physical findings. Normal developmental findings will be distinguishable from abnormal developmental findings to the resident by the completion of the rotation.

3. The resident will be able to recognize the more common musculoskeletal problems that occur in children, and be taught appropriate referral patterns.

4. The resident will be taught basic radiographic interpretation and will be exposed to the preoperative, intraoperative, and postoperative basic radiographic interpretation. They will be exposed to the preoperative, intraoperative, and postoperative care of the pediatric musculoskeletal patients. This will include children with trauma as well as neuromuscular abnormalities and congenital anomalies.

5. Appropriate evaluation and recognition of traumatic, congenital, developmental and inflammatory problems will be achieved.

Methods:

1. The pediatric resident will be integrated into the pediatric orthopaedic service and will interact with orthopaedic residents as well as the orthopaedic faculty.

2. The rotation will be tailored to the resident's interests, which typically are primarily in the clinic setting, but there will be some exposure to the care of the musculoskeletal patient in the inpatient setting as well as in the operative theater.

Implementation:

Recommended text books are available in our office for the residents to utilize during the rotation. Recommended textbooks include:

- Pediatric Orthopaedics by Dennis Weiner
- Fundamentals of Pediatric Orthopaedics by Lynn T. Staheli
- Essentials of Musculoskeletal Care, published in conjunction with the American Academy of Orthopaedic Surgeons and the American Academy of Pediatrics
Evaluation:

Throughout the rotation with one-on-one interaction the resident's knowledge base will be evaluated. Satisfactory completion of this rotation will include discussions at which point the resident will have the opportunity to demonstrate their ability to obtain a musculoskeletal history and physical, as well as to outline appropriate referral patterns and treatment for patients with common pediatric orthopaedic problems.
PEDIATRIC INTENSIVE CARE UNIT (CHILDREN’S)

Preceptors: George Reynolds, M.D; Mohan Mysore, M.D., Dr. Naga Pham and Jayesh Thakker, M.D.

Purpose:

In this rotation, the resident participates as a sub-intern in the care of critically ill pediatric patients.

Objectives:

1. The resident will manage the assigned PICU patient under the supervision of the PICU attending physician and will complete the required paperwork.
2. The resident will attend all inpatient rounds, core content lectures, pediatric-cardiac catheterization conference, and other didactic sessions.
3. The resident will demonstrate mastery of specific clinical competencies.

Methods:

Residents are assigned patients whom they will follow throughout their PICU stay, managing their care with duties and responsibilities. Patients represent the full range of pediatric critical care. Diagnoses include sepsis, shock, respiratory failure, status epilepticus, status asthmaticus, and multiple pediatric trauma. In addition, the resident will be involved in the post-operative management of complex post-operative cases including congenital heart disease, general pediatric surgery, pediatric neurosurgery, and pediatric orthopedic surgery. The pediatric ICU at Children's Hospital is a 17 bed facility and cares for patients from 0-21 years of age.

Implementation:

Daily teaching conferences taught by the faculty will stress practical hands-on care. The primary goal of the rotation is to help the resident integrate his/her understanding of physiology with the bedside care of the critically ill child.

Evaluation:

1. The attending staff physician will complete the evaluation report of the resident.
2. The course director will review admission histories and physicals, daily progress notes, and procedures that the resident completes during the rotation.
PULMONARY – UNMC, CHILDREN’S, COMMUNITY

UNMC
Preceptors: John Colombo, M.D.; Paul Sammut, M.D.  
C. Gerald Judy, M.D.

Children’s
Preceptors: Mark Wilson, M.D.

Midwest Children’s Chest Physicians
Midwest Allergy and Asthma
8552 Cass Street
Preceptors: Kevin Murphy, M.D.; Jeff Nelson, M.D. and George Zieg M.D.

Purpose:
The purpose of this rotation is to give the resident a broad range of experiences with various pulmonary 
and upper respiratory problems ranging from asthma to cystic fibrosis. Experience will be obtained from 
both outpatient and inpatient exposure.

Objectives:
1. A basic understanding of pathophysiology, signs and symptoms, diagnosis and treatment of acute 
   and chronic asthma.
2. Basic understanding of pathophysiology(molecular and clinical), signs, symptoms, diagnosis, and 
   treatment of cystic fibrosis.
3. Be able to differentiate upper from lower airway obstruction based on the patient history and physical 
   examination.
5. A basic understanding of pulmonary function testing in children.

Methods:
UNMC/Midwest Children Chest Physician/Midwest Allergy and Asthma
The pediatric pulmonology clinic meets 2 half days per week. The pediatric pulmonary/allergy clinic 
meets five days a week. In these clinics the resident, under the supervision of the staff, evaluates new 
and follow-up patients with all forms of pediatric lung diseases. Approximately 40% of these patients 
have cystic fibrosis and are followed for routine care. The remainder includes a significant number of 
patients with asthma, recurrent pneumonia, chronic cough, tuberculosis, recurrent aspiration 
pneumonias and many other assorted disorders. The resident will learn to perform and interpret basic 
pulmonary function tests. The resident will learn the role, interpretation, and indications for an allergic 
evaluation in children. Inpatient rounds are made daily with the staff on patients hospitalized for cystic 
fibrosis or other pulmonary disease. Consultations are performed on other services' patients with 
pulmonary complications, including intensive care patients receiving mechanical ventilation therapy. 
Each resident will be required at the end of their rotation to present a pediatric pulmonary topic of their 
choice.
Children's Hospital

The resident will participate in the care of the hospitalized pediatric patient. The acuity of the illness, the impact on the family, and the impact on the child make the care of the patient a multi-tiered task. The resident on this rotation will assume primary responsibility for their patients, working with the attending to ensure that quality and timely care is given. The resident will continue to advance their communication, clinical problem solving and procedural skills, and become more familiar with common health problems in pediatrics.

Implementation:

Competencies residents are expected to achieve:

1. Evaluate patients from infancy through adolescence in a variety of clinical settings, establishing rapport with the patient and family in order to obtain a complete history and physical examination. Effectively communicate information to both the patient and parent, ensuring both understand the diagnosis and treatment plan and have the opportunity to ask questions. Recognize the important role of patient education in management of acute and chronic illnesses.

2. Prepare a complete written summary of the history and physical. Present a complete, well organized summary of the findings of the patient's history and physical examination, modifying the presentation to fit the situation.

3. Identify clinical problems and formulate an initial diagnostic and therapeutic plan, considering the cost, risks, benefits and limitations of laboratory tests, imaging studies, medications, consultations. Write admission orders for the hospitalized patient.

4. Effectively communicate information about the diagnosis and treatment to the patient and caregiver. Communicate with other health care workers, including consultants, nurses and social workers.

5. Interpret the results of commonly ordered laboratory tests, such as the CBC, urinalysis, and serum electrolytes, and recognize that the normal values of some tests may vary with the age of the patient. Write daily progress notes on the patients, including the interpretation.

6. Obtain up-dated information relevant to the diagnosis and treatment of the patient, performing a literature search and critical review of the literature.

7. Understand the indications for procedures such as a lumbar puncture, parenteral fluids including intravenous and intra-osseous fluids, and emergency procedures such as intubation. Provide emotional support for patients undergoing procedures. The technical aspects of the procedures should be introduced, although there is no expectation of mastery at the fourth year student level.

Suggested readings:

2. Pediatric Respiratory Disease: Diagnosis and Treatment, Hilman, W.B. Saunders, 1993.
4. Cystic Fibrosis Lung Disease: Approaching the 21st Century, A certified continuing medical education resource, Thomas M. Murphy, M.D. and Beryl J. Rosenstein, M.D., October 1995 (A copy of which Gary Beck has for distribution to medical student on the general pediatric service).
5. Seminars in Respiratory and in Critical Care Medicine: Cystic Fibrosis, Stanley B. Fiel, M.D., Volume 15; Number 5, September 1994 (For additional reading concerning cystic fibrosis).
Evaluation:

1. The attending staff physicians on service will complete resident evaluation.
2. The staff attending will review daily progress notes, and procedures that the resident completes during the rotation.
Preceptors: Larry Jung, M.D.

Purpose:
To learn the diagnosis and management of a variety of patients with rheumatic and immunologic disorders.

Objectives:
1. The trainee will have the opportunity to sharpen his/her clinical skills in obtaining a history and performing a physical examination with specific reference to the musculoskeletal system and the immune system.

2. The trainee will learn to integrate clinical information into a differential diagnosis and to obtain appropriate diagnostic tests to arrive at a specific rheumatic diagnosis. The clinical experience will involve patients with a variety of rheumatic and immunologic disorders including but not limited to the following:
   (a) Juvenile arthritis
   (b) SLE
   (c) Scleroderma
   (d) Dermatomyositis
   (e) Acute rheumatic fever
   (f) Other vasculitic disorders
   (g) Hypogammaglobulinemia
   (h) Recurrent infections
   (i) Fever of unknown origin

3. The trainee will learn to manage patients with rheumatic and immunologic disorders using medication, physical/occupational therapy, and consultation with other subspecialties.

4. The trainee will learn to deal with the psychosocial and developmental issues of children having a chronic disorder, especially with issues in schooling and activities of daily living.

5. The trainee will have an opportunity to carry out a clinical research project if desired.

Methods:
The trainee will have opportunities to diagnose and manage patients in clinics at Children’s Hospital (twice a week), and with hospital consultation services at Children’s Hospital, St. Joseph Hospital, and NHS University and Clarkson Hospitals.
Implementation:

The trainee will be given the opportunity to review current thoughts on the pathogenesis, diagnosis and clinical issues in rheumatic and immunologic disorders using specialty journals and other library resources.

Evaluation:

The trainee will be evaluated at the end of the elective based on his/her clinical performance and presentation of a selected topic.
WARDS – UNMC, CHILDREN’S

Children’s
Preceptors: Ward attendings from each service

Purpose:

Inpatient service at Children’s Hospital and NHS University Hospital gives residents the opportunity to be exposed to diverse disease processes meriting hospitalization of pediatric patients. Interns will be exposed to these disease processes and they should attempt to become comfortable with the diagnosis and management of these illnesses. Supervising residents will learn to manage the inpatient team and should function as a triage specialist, educator of both students and interns, problem solver, consultant for the interns, and liaison between attendings and the interns.

Objectives:

Interns:

1. By the end of the month, the intern should be able to recognize a sick child and initiate appropriate therapy.
2. The intern should be able to admit an ill child, obtain the appropriate history, and do a complete physical examination. With that information, the intern should develop a differential diagnosis and reasonable plan based on that diagnosis. Finally, the intern should effectively communicate that plan with the attending physician.
3. The intern should learn how to manage the day-to-day problems of a sick child in the hospital setting, including advancing or withdrawing treatment as appropriate, daily notes, and preparation for discharge.
4. The intern will spend time each day teaching peers and medical students.

Supervisors:

1. Supervising residents have the responsibility to make sure all patients admitted to the wards are triaged in a timely and appropriate manner.
2. Supervisors will spend time teaching daily as time permits. Topics should be based on areas germane to patients being treated on the floors. These sessions will include the interns as well as medical students.
3. Supervisors will see and write brief notes on all patients admitted to the floor resident teams.
4. Supervisors will coordinate attending rounds with all services at UNMC.

Methods:

Being hospitalized is a stressful and anxious experience for both children and their parents. Always introduce yourself and identify your specific role (i.e., medical student or resident physician) in the care of the patient before taking a history or examining the patient. Medical students should introduce themselves as students and not as student doctors or student physicians, as this can lead to confusion for the patients and their families. In addition, always explain to the patient (if developmentally appropriate) and the parent what you are going to be doing (e.g., performing a history and physical). Finally, remember to thank the children and their families for allowing you to care of them during your education.
It is important to remember that Children’s Hospital and NHS University Hospital are teaching hospitals and that the children and their families will encounter multiple members of the health care team including students, residents, attendings, and consultants. Though some families will be familiar with the medical hierarchy, most families will not. Therefore, it is essential that this hierarchy be explained to the families during the initial contact. This will help prevent the confusion and frustration that can develop in such a teaching environment. Either the intern or the supervisor should make the appropriate explanation to the family.

When interacting with patients and their families try to work as a team in order to reduce repetitive questions. Whenever time permits, the residents, students, and nurses should participate together in the initial assessment of each patient. This will allow each discipline to hear the same information so redundant questions are reduced. If the different disciplines are unable to participate together, then try to utilize any data already gathered so as not to ask repetitive questions. The nursing forms have information regarding diet, medicine, and allergies that, if reviewed prior to the history and physical, can reduce the number of questions asked of the families and patients. Ultimately, this teamwork will improve patient satisfaction and lead to more efficient utilization of time and resources.

Please wear clothing and shoes that are professional in nature. Residents may only wear scrubs during call after 4:30 P.M. and when post-call. Students may only wear scrubs during call; they may not wear scrubs during the day unless they stayed overnight. Students and residents who are not on call but working on the weekend may not wear scrubs into the hospital. Medical students and resident must wear their identification badges at all times while in contact with patients and their families. This will prevent the confusion that can occur when multiple people are involved in the care of the patients.

Listed below are specific duties and responsibilities for each institution.

**UNMC**

**WARD TEAM:** 1 supervisor and 1-2 intern(s)

**INTERN DAILY DUTIES:**

1. Attend morning report held three times a week. Check-out from the night before should be done prior to this.
2. Attend all conferences, which have priorities over rounds. The supervisor should help cover during conferences.
3. Admissions will be assigned by the supervisor. After notification by the nurse that the patient is on the floor, perform the H&P and discuss with the pediatric supervisor. Then, contact the attending and present the patient, your differential diagnosis, and treatment plan. Discuss the orders before writing them (unless the patient needs a STAT treatment, for example ventolin, orders may be given before discussion with the attending). The attending must be contacted within one hour of admission. If you do not feel that you will be able to do this within one hour, contact your supervisor when you are notified that the patient is on the floor.
4. H&P’s must be dictated within 24 hours of admission. If the patient is going to the OR, the H&P must be dictated before they are taken down. If there are students, they may write the H&P, but it must be READ, CORRECTED, AND CO-SIGNED by the resident.
5. The admitting resident MUST write, at minimum, a brief admitting note.
6. The resident is to write all orders (or co-sign student orders) as soon as possible after discussion with the attending. All chemotherapy orders must be co-signed.
7. When consults are obtained, call the resident on service or the attending with pertinent history, physical, and the questions that you want answered. All recommendations MUST be reviewed with the primary attending before orders are written.
8. DATED AND TIMED daily progress notes must be written on all patients and consults. Students may write notes, but resident must write their own note.
9. Round with attendings daily.
10. Follow-up on all studies ordered.
11. Respond to all pediatric codes. The floor intern is to have beeper 1863 at all times.
12. Residents should leave for continuity clinic (if at a different site) at 11:45 am. Written check-out must be given to the supervisor, who will cover during their absence and check out to the on-call person. Please contact the on-call resident before leaving clinic to answer any questions regarding your check-out sheet. If you are on-call, you MUST BE BACK BY 17:00.
13. Check-out may be at 16:30 if all work is completed and the on-call resident is available, otherwise at 17:00. Written check-out is to be given to the on-call resident. Check-out to the clinic intern is to be NO EARLIER THAN 16:30.
14. The post-call intern may check with the supervisor and if their work is completed, check-out written, and they will not be taking another admission, they may leave at 15:00. THIS IS NOT A GUARANTEE!!
15. Off service notes are to be written on standard forms on all patients in house longer than three days. These should not be more than three days old at the start of service. IF A PATIENT IS DISCHARGED WITHIN 24 HOURS OF CHANGE OF SERVICE, THE RESIDENT FROM THE PREVIOUS MONTH IS TO DO THE DISCHARGE SUMMARY.
16. Dictate discharge summary within 48 hours. Medical Records will call after 24 hours as a reminder.

WARD INTERN ON-CALL DUTIES:
1. Call is from 17:00 to 08:00 M-F and 08:00 to 08:00 on weekends. Clinic interns must not leave clinic by 16:30 to take call. The post-call intern should check-out to the ward intern prior to morning report.
2. Work-up all admissions as above.
3. Respond to all pages regarding patients on the floors or bone marrow unit that are being followed primarily by a pediatric intern or BMU PA. When a patient is seen, a brief DATED AND TIMED NOTE should be written describing the reason for the call, physical findings and action taken. If the attending or supervisor was contacted, please document this. Follow-up on call studies ordered.
4. Carry pager 1863 and respond to all pediatric codes.
5. Call supervisor for any problems or assistance.

WARD SUPERVISOR DAILY DUTIES:
1. Attend morning report three times per week.
2. Attend all conferences. Cover wards/admissions during conferences to allow the interns to attend.
3. Assign admissions and PICU transfers to the interns and assist in the work-up as needed. The supervisor should see each admit on the day of admission and write a brief admit note. If the census is high, the supervisor should admit and follow primary patients (if >10 per intern).
4. Assist the intern with admissions/procedures/problems.
5. Round daily with the intern.
6. Round and assist as needed in the bone marrow transplant unit.
7. Conduct teaching rounds with the interns and the students 1-2 afternoons a week.
8. Cover the intern service while they are at continuity clinic.
9. Carry the 1859 code pager during the day and respond to all pediatric codes.
10. Check-out with the coverage supervisor to cover during continuity clinic. If the clinic is at another hospital, check-out by 11:45 am. Written check-out for all patients that you are following primarily or are potential problems and admissions.
11. Check-out with on-call supervisor any potential problems or known admits.
12. If any problems arise, the supervisor should handle them or contact the assistant program director or one of the chief residents.
13. Meet with the assistant program director on a weekly basis to discuss the rotation.

ON-CALL SUPERVISOR DUTIES:
1. Attend morning report 3 times per week.
2. Call is from 17:00 to 08:00 M-F and 08:00 to 08:00 weekends.
3. Coverage in the PICU.
4. Assist intern in the NICU, wards, bone marrow unit.
5. See all ER consults.
6. Carry pager 1859 and respond to all pediatric codes.
7. Attend all deliveries with the intern in the NICU.
8. Write DATED AND TIMED notes with problem, physical, and treatment on patients that are seen during the night.
9. See all admissions with intern and write a brief admit note on each patient.
10. Document all patient-related calls on the “General Pediatrics Clinics Telephone Triage Form” and give to the Residency Coordinator for appropriate distribution. Please see Appendix page A14-A15 for an example of the form and instructions.

Guidelines for Discharge Summary
If the monthly floor resident took care of the patient that was discharged by someone else, the floor resident does the summary. If the floor resident admitted a patient and the next month’s resident sends him/her home, the next month resident does the summary, since they sent him/her home. If a patient is admitted and discharged in 24 hours and the floor resident never saw the patient at all, it is an easy discharge summary and the weekend resident should do the summary. If the weekend resident doesn’t seem to be able to get it done, the floor resident can work it out with them and involve the supervisor to get it done.

Children’s
PICS: The PICS is a formal pediatric teaching and patient care service. Patients admitted to the service are from numerous referral sources: local or intra/inter-state Family Physicians, Pediatricians, or Pediatric Sub-specialists or patients admitted to the hospital who do not have a physician. When requested, the PICS team will assume the care of medically complicated transfers from the PICU if the patient does not have a local physician. The PICS team will also provide general pediatric consultative services.

Daily PICS teaching rounds begin at 9:30 a.m. through approximately 11:00 a.m., Monday-Friday. Patient work rounds follow the completion of teaching rounds. Saturday and Sunday involve patient work rounds only and will generally start at 8:00 a.m.

Third year medical students are required to formally present a patient with discussion of the patient’s hospital course and diagnostic dilemma over the course of their inpatient month. This should not be a patient followed by the PICS team. A formal written summary (History and Physical/Differential Diagnosis/Discussion of the Diagnosis) of this patient is also required and may be turned into either the PICS attending or Pediatric Chief Resident at the end of the month.

Team Assignments:
**SUPERVISOR #1 (HOII) Phone 955-7954 Pager 221-8633**
*Pink Team* Intern Pagers: 221-8635 and 231-0282
Pediatric Inpatient Care Service Patients
All Family Medicine Patients
Infectious Disease Patients (when ID is primary admitting physician)
Pulmonary Patients- Dr. Wilson

**SUPERVISOR #2 (HOIII) Phone 955-7979 Pager 299-5163**
*Blue Team* Intern Pagers: 221-1546 and 299-5149
Cardiology Patients/ Cardiothoracic Surgery Patients
Boystown Pediatrics’ Patients
Midwest Allergy and Asthma/ Dr. Stokes
UNMC Patients- general pediatricians, pulmonologists, nephrologists
Rheumatology/ Allergy and Immunology Patients
Neurology Patients

**YELLOW TEAM** Intern Pagers: 221-8634 and 231-0270
Physicians Clinic Patients
Alegent Health Patients
Hematology/Oncology Patients
Endocrinology Patients
Genetics/Metabolism Patients
All Other Group Patients
When there are 3 supervisors, there will be 1 supervisor for each of the pink and white teams and a senior supervisor will oversee the blue and yellow teams. When there are 4 supervisors, there will be 1 supervisor for each team.

Call: On weekdays call is from 4:30 – 5:00 P.M. to 8:00 A.M. On weekends, call is from 8:00 A.M. to 8:00 A.M. the following day. While on call, residents must stay within the hospital building. Residents must keep their pager on and with them at all times. Residents may not take a shower during their call unless another resident is holding the pager as residents are responsible for promptly responding to any pages and immediately responding to a code.

Pageboys: The supervisors will carry the two supervisor pageboys (221-8633 and 299-5163) and mobile phones (955-7954 and 955-7979) during non-call hours during the weekdays. The interns will carry their respective team pageboys during the weekdays while not on call. The 221-8633 pageboy and the 955-7954 phone will be transferred to the intern on call and will continue to be the pageboy that the nursing staff will use to contact the on-call intern. The 299-5163 pageboy and the 955-7979 will be carried by the supervisor on call. This pageboy will serve as the pageboy that all admitting physicians will use to notify the supervisor of all admissions. All potential admitting physicians have been notified that the 299-5163 pageboy is the means of contacting the supervisor at any time.

Checkout: Checkout begins between 4:30 – 5:00 P.M. on weekdays whenever the on-call supervisor arrives. Checkout sheets are color-coded by team colors. Please write legibly on these sheets and include the patient's full name, room number, attending physician, consultants, weight, diagnoses, medications, current problems by system, anticipated problems, and a list of things to check during the call. If you are on call you should not accept illegible or incomplete checkout sheets. You may make any resident rewrite the sheets if they are unacceptable. Checkout sheets may not be reused. They must be rewritten every day including weekends.

Charting: Please date and time every order and note written. Number the orders so that they are clearly distinguishable. Students may write orders but they must be signed by a resident. When finished writing any orders, admission or otherwise, the intern should review the orders with the nurse caring for the patient. This can be done in person or by contacting the nurse on his/her phone. This will prevent any confusion regarding the orders and will initiate treatment more quickly. Any orders for a radiographic procedure must have an indication for the x-ray written after the order.

Consultation: When writing the orders for a consult, please specify A) the service and physician or group, and B) the reason for the consult. In addition, if a resident writes the order s/he is responsible for notifying the consultant of the consult and to supply the consultant with the pertinent clinical information. Please request consultation and notify the consultant as early in the day as possible to allow the consultant flexibility in planning their day.

Off-Service Notes: Off-service notes must be written at the end of each month on all patients who have been hospitalized for greater than 48 hours prior to the change of service. The off-service note should be written in sufficient detail so that the incoming residents can easily and quickly gain an understanding of the clinical course and current problems of the patient. It should include a brief summary of the history leading to admission, the hospital course to date, current medications, pending lab studies, and a summary of each organ system including problems and treatment. The off-service note should be placed in the chart, dated, timed, and signed. An off-service note does not need to be written on any patient who will be discharged on the first day of the new rotation.

Supervisor: The supervising resident, because of his/her experience, should function as a triage specialist, educator of both students and interns, problem solver, consultant for the interns, and liaison between attendings and the interns.

The supervisor should be contacted by admitting or the admitting physician (ER physician, private pediatricians, family practitioners, and subspecialists) prior to the patient's arrival to the ward. The supervisor should then have an idea of the level of the patient's illness and what treatment may need to be initiated upon arrival to the ward. The supervisor should make any arrangements for treatment prior to arrival, if needed, by contacting the nursing staff and relaying the orders to them. The supervisor should also notify the admitting intern of the admission.

The admitting nurse should page the supervisor (299-5163) when the patient arrives on the floor. The supervisor should see every patient that is admitted. Ideally, the supervisor should see the patient at the time of arrival or as soon after arrival as possible. The supervisor should assess the patient to determine the severity of illness and the need for intervention. If treatment is needed, then the supervisor should initiate it at that time in conjunction with the intern if present.
The supervisor should introduce the intern and/or medical students to the patient and parents. The supervisor can then either stay for the H&P or leave the room but review the history and physical exam after the intern completes it. The supervisor may need to obtain more history or perform parts of the physical exam if she feels it is needed to complete the assessment. Finally, the supervisor and intern should together develop an assessment, differential diagnosis, and treatment plan before the intern calls the admitting physician to discuss the case.

The supervisor should write a very brief note summarizing the relevant history, physical findings, assessment, and treatment plans. The supervisor does not need to write a note if the patient is admitted from an ambulatory clinic at Children’s such as GI or Hem/Onc and the patient has been assessed by an attending with orders or an attending note written on the chart. In addition, a supervisor note does not need to be written if the attending has come to Children’s to assess the patient during the admission.

The supervisor should decide which admissions are appropriate for medical students to lead the H&P’s. They are also responsible for reviewing the medical students' written H&P’s.

The supervisor should read about the patient’s diagnosis or problems in a general text and/or obtain journal articles for the intern and students. The supervisor should spend some time teaching the team about each patient when time permits. Education of students and interns is a primary responsibility of each supervisor. In addition, the supervisors should spend down time discussing general topics with students and interns.

The supervisors should round each weekday with two teams, one of which should be the post-call team and the other should be the team participating in teaching rounds. The supervisors should attend the Pediatric Inpatient Care Service Rounds daily. The supervisors should try to arrange their time so that each team receives equal attention during the week.

**High Census Policy**

During high census times when the maximum numbers have been reached on the inpatient service, the on-call team will still complete History and Physicals if they are able to see the patient in a timely manner (within 30 minutes of the patients arrival to the floor). The last order in the admissions orders will instruct the nurses to call all questions to the attending physician and the residents will not follow those patients until the teams are below the maximum numbers. A sticker will be placed on the outside of the chart indicating the admitting physician as the primary contact physician. The admitting nursing staff will place this sticker on the chart when the last admission order indicates that someone other than the residents are to be called for all questions and orders. When the residents are able to follow the patient due to decrease in census, the sticker will be replaced with the resident team sticker after the attending has been notified.

During high census times, when the maximum numbers have been reached on the inpatient service, only the on-call teams will complete courtesy History and Physicals. During the hours of 8 am to 5 pm Monday through Friday, the residents will not complete History and Physicals for new patients, instead the admitting physician will need to complete the History and Physical and all orders. The admitting physician will be contacted for all orders and questions from nursing staff. During high census times, the admitting physician will be contacted by the supervising resident and advised of the high census policy. The admitting physician will be given the option to admit the patient to the Pediatric Inpatient Care Service if they wish for that attending physician to take over care for this hospitalization.

If at any time the residents are unable to triage and admit a patient within 30 minutes of that patient’s arrival to the floor, the admitting physician will be contacted by the supervising resident. This situation may occur when multiple patients are being admitted at once, even if the maximum number of patients has not been reached. The admitting physician will need to personally admit their patient or admit to the Pediatric Inpatient Care Service Physician. If the combined team numbers are below the maximum, the team residents will start following these patients once the day team arrives and has communicated with the admitting physician.

If at any time the residents are called to triage a patient with a status change or worsening condition, the supervising resident will examine the patient and call the admitting physician to discuss the patients’ condition. The residents will respond to all code 4 calls and requests by nursing to assess patients with changing status. This includes all patients in Children’s Hospital, even those who are not followed by the resident teams.
**Interns:** The intern should function as the primary physician for each patient while hospitalized, under the supervision of the attending physician and supervising residents. The intern is responsible for admitting patients, making daily rounds on each patient, discussing the patient with the attending on a daily basis, arranging consultation, and discharging the patient. In addition, the intern also is an educator for the medical students.

When a patient is admitted the intern is responsible for calling the attending and discussing the case as well as the orders pertaining to the evaluation and treatment of the child. (If there is a subintern the intern may call the attending and inform the attending that a subintern did the H&P and would like to discuss the patient with the attending. The intern and supervisor should discuss the patient with the subintern before calling the attending.) The intern should write the orders in a timely manner and should review the admitting orders with the patient's nurse either in person or by phone so as to prevent confusion and to efficiently initiate treatment. The intern is responsible for writing an admit note on each and every patient. This note should minimally include a detailed history of present illness, relevant past medical history, family history, social history, and review of systems, a detailed physical exam, assessment, differential diagnosis and plan. The intern is responsible for dictating a complete H&P.

The intern is responsible for making daily rounds on each patient on his/her team and writing a daily note that summarizes the patient’s clinical course and details the work-up and treatment. The intern should review the student notes and correct/amend them as necessary. When possible the intern should round in person with the attending, but minimally should discuss each patient with the attending by phone on a daily basis. If the attending has left a note on the chart without talking to the intern, then the intern should contact the attending some time during the day to discuss the patient. The intern should discuss major orders (e.g., starting or discontinuing medications, ordering labs or x-rays, ordering consults, or discharging the patient) with the attending before proceeding. The intern may start an IV and order an IV solution at the time of admission before talking with an attending if the intern feels this is needed. Obviously, the intern can initiate any treatment or work-up in an emergency situation without talking with the attending.

**Medical Students:** The medical student’s primary responsibility is to master the pediatric H&P, participate in daily care of inpatient pediatric patients, strengthen their presentation skills and writing skills, and to develop the necessary fund of knowledge pertaining to pediatrics to fulfill the objectives of the clerkship. Patient management conference, grand rounds, and student lectures are mandatory. Noon resident lectures are recommended but not mandatory. Student teaching rounds are also mandatory.

Interns should lead the H&P unless the medical student is performing the H&P. If the student is leading it, then the intern should ask any additional questions s/he deems necessary in order to obtain missing data or to clarify information already obtained. With new students, interns should demonstrate the pediatric H&P with several patients before asking the medical students to lead an H&P. The medical students should lead H&P’s in which the patient is interesting, the patient and parents are willing to participate, and no time constraints exist with respect to the care of the patient, the parents, or the residents. If the medical student leads the H&P, then s/he should write a complete H&P including a thoughtful assessment, differential diagnosis, and plan. **The student should then review this written H&P with either the intern or supervisor.**

Medical students should not write more than one or two H&P’s while on call. This allows the students to read about the disease processes they encounter in their patients. The students should participate as active observers in other admissions.

**Implementation:**

Residents will be expected to read any information presented and expected to read about their patients from current literature and textbooks available in the libraries. Daily review of written notes and critiques of presentations will be done to help the resident’s performance.

**UNMC-Morning Report Guidelines**

* Morning report will start promptly at 7:30 a.m.
* All residents and students assigned to UNMC Rotations (Inpatient/Outpatient are expected to attend.
* Inpatient Supervising Resident will give report of patients admitted since previous morning report. This should include: age, sex, diagnosis/admitting problem.
* Outpatient Clinic Supervising Resident will assign presenting resident schedule.
Case Presentation Requirements (10 minutes):
*Chief Complaint
*HPI
*Brief Past Medical History
*Pertinent Physical Exam with vital, wt., ht., head circumference (if less that 3 years age), including percentiles
*Participants are encouraged to hold questions until the resident has completed the entire case presentation.

Case Discussion (10 minutes):
*Differential Diagnosis
*Medical Management (lab tests and results, procedures, medications)
*X-rays should be checked out and brought for review

Brief discussion of final diagnosis or suggested further investigation/evaluation (5 minutes)
Total Session Goal-30 minutes
Case Selections:
*Patient recently evaluated
*Presenting resident should have been actively involved in the diagnosis and management
*May be a common or obscure pediatric problem
*Presenting resident should have reviewed basic literature on the presenting problem and differential diagnosis
*Residents should bring pertinent x-rays for review (even if normal)

Children’s
*Morning report will start promptly at 8:00 a.m.
*All residents and students assigned to Children’s Rotations (Inpatient/Outpatient are expected to attend).
*Supervising Resident will give report of patients admitted since previous morning report. This should include: age, sex, diagnosis/admitting problem.
*Supervising resident will assign presenting resident schedule.

Case Presentation Requirements (10 minutes):
*Chief Complaint
*HPI
*Brief Past Medical History
*Pertinent Physical Exam with vital, wt., ht., head circumference (if less that 3 years age), including percentiles
*Participants are encouraged to hold questions until the resident has completed the entire case presentation.

Case Discussion (10 minutes):
*Differential Diagnosis
*Medical Management (lab tests and results, procedures, medications)
*X-rays should be checked out and brought for review

Brief discussion of final diagnosis or suggested further investigation/evaluation (5 minutes)
Total Session Goal-30 minutes
Case Selections:
*Patient recently admitted and evaluated
*Presenting resident should have been actively involved in the diagnosis and management
*May be a common or obscure pediatric problem
*Presenting resident should have reviewed basic literature on the presenting problem and differential diagnosis
*Residents should bring pertinent x-rays for review (even if normal)

Evaluation:
Residents will be evaluated on their written notes, oral presentations, and discussions based upon the reading material.