Medicine I and II Firm Curriculum

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Physician Director for the rotation:
Your respective firm chief and chief resident

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ROTATION GOALS AND EDUCATIONAL PURPOSE
As with all rotations, providing exceptional patient care while learning is our primary responsibility. This is no different with the medicine service. The service has 3 specific goals.

1. Providing the highest standard of patient care.
2. To train physicians and medical students in internal medicine and the medical subspecialties
3. To raise, discuss and elucidate the important ethical, scientific, and economic issues involved in medical practice and patient care.

This rotation provides an opportunity to gain experience in diagnosis and management of patients with a variety of acute medical problems in the inpatient setting. This rotation is a core rotation for the majority of PGY1 and PGY2/3 residents.

Please see separate addendum highlighting specific objectives for this rotation (general medicine wards objectives).

ROTATION SCHEDULE AND LOGISTICS

Rotation Administrative contact: Bethany Millar

First Day Reporting Protocol:
Prior to the first day, interns and residents must receive sign-out from their colleagues who are going off service.

When: Meet your team no later than 7 AM on the first morning of the rotation.

Where:
Med I: 12200 Work room (door code: 123).
Med 2: 11200 Work room (door code: 1120*)

To Whom: You will meet your team at that time.
Required Conferences

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Required rounds/clinics:
- Daily attending rounds
- Report: see above schedule
- You may have your continuity clinic scheduled; it is your responsibility to check your clinic schedule.

Call Schedule: See monthly team assignment sheet (Color block schedule) and call schedule.

- Call is every fourth day and follows the following four day cycle:
- On call interns/residents should leave by 9:30 PM and should have at least 10 hours off before returning to work. They absolutely must leave by 11:30 PM and must have a minimum of 8 continuous hours off before returning to work. This means that if the PGY1/2 leaves at 11:30 PM, he or she cannot return to work earlier than 8:30 AM the following day.
- PGY1s will not have overnight call. PGY2/3s will generally have one overnight call during the block. Overnight call is the Saturday call: call begins at 7am on Saturday and the resident MUST leave by 11 AM on Sunday.
- Each intern/resident will be scheduled four days off in each 4-week rotation

Weekend/day off Schedule:
- PGY1s are off on Wednesdays, Thursdays or Saturdays (short and pre-call days only).
- PGY2s are off on Fridays and Sundays (short and pre-call days only).
The entire team will be present on their call and post call days during a weekend and arrangements are made for a day off during the week. Please look at your monthly team assignment sheet and call schedule for detailed days off.
ROTATION SPECIFIC INFORMATION
There are 4 Med I and 4 Med II and 1 medicine on “cardiology” firm teams, each made up of 2 PGY1s, 1 PGY2 or 3 and 1 attending with or without medical students. Additionally, teams may also have a pharmacist that rounds with the team.

Team caps: PGY-1s can admit 5 patients (inclusive of transfer patients) each on a call day. Team call day cap is 10 new patients. The PGY1 must not be assigned more than 8 new patients in a 48 hour period. Team total census cap is 20.

The bounce back rule: A patient can only be bounced back to a team if ALL members (attending, resident, and intern) have had time to fully evaluate that patient.

- This means that the patient must have been staffed by the attending
- This also means that if the intern has left the team it should not be bounced back
- Patients who are discharged on the resident’s first day of firm are NOT eligible unless evaluated by the attending prior to discharge
- Can only count the patient ONCE
- Call team still admits the patient and bounces them back to the team the next day (the resident must be there)
- We do not get bouncebacks from hospitalist unless < 48 hrs
- If a patient is bounced to a hospitalist team that patient SHOULD NOT count toward your team’s cap.

Bounce backs need to be kept and staffed by the on-call team and to be given back the following day when resident and/or attending are present. Bounce backs count as an admission for the on-call team if they could not be seen by the original team. An attending or resident needs to see new patients. The patient should only be counted once for a team’s count.

ROTATION COMPETENCY OBJECTIVES/CURRICULUM
All of the Competency Milestones are pertinent to this rotation. Areas of special focus are noted below.

Interns should be able to be able to develop a basic level of competence in the skills listed. JARs should be able to perform the skills with less supervision, at a higher level (e.g., elicit subtle physical findings), in multiple patients and in more complex patients. SARs should be almost independent in these skills, and able to deal with unexpected events and ambiguous situations.

I. Patient care
a. Gather and synthesize essential and accurate information to define each patient’s clinical problems, including performing a thorough history and physical examination
b. Synthesize data into a prioritized problem list and differential diagnosis, then develops and achieves comprehensive management plans for patients
c. Manage patients with progressive responsibility and independence
d. Monitor and follow up patients appropriately.
e. Know the indications, contraindications, & risks of some invasive procedures and competently perform some invasive procedures
f. Request and provide consultative care
g. Prioritize each day’s work (Intern for self, resident for entire team)

II. Medical Knowledge
a. Demonstrate an increasing fund of knowledge in the range of common problems encountered in inpatient internal medicine and utilize this knowledge in clinical reasoning. While on Firm the resident should become familiar with the diagnostic and therapeutic approach to patients with:
   i. Chest pain, Shortness of breath, DVT/PE, Nausea/Vomiting/Diarrhea, Fever, Mental status changes, Abdominal pain, GI bleeding, Syncope and lightheadedness, Renal failure, acute and/or chronic, Anemia, Hypertension, Diabetes mellitus, Pneumonia, Urinary tract infection, Soft tissue infections (such as cellulitis, diabetic foot infection, decubitus ulcer), and Alcohol withdrawal
b. Residents will demonstrate an increasing ability to teach others on these and other topics.
c. Knowledge of diagnostic testing and procedures

III. Interpersonal and communication skills
a. Communicate effectively with patients and caregivers
   i. Demonstrate caring and respectful behaviors with patients, families, including those who are angry and frustrated; and all members of the health care team
   ii. Counsel and educate patients and their families
   iii. Conduct supportive and respectful discussions of code status and advance directives
b. Communicate effectively with interprofessional teams
c. Facilitate the learning of students and other health care professionals
d. Appropriate utilization and completion of health records
   i. Demonstrate ability to convey clinical information accurately and concisely in oral presentations and in chart notes

IV. Professionalism
a. Demonstrate respect, compassion, and integrity
b. Demonstrate a commitment to excellence and on-going professional development
c. Have professional and respectful interactions with patients, caregivers and members of the interprofessional team

Approved by the Program Director: 5/26/15
d. Accept responsibility and follow through on tasks

e. Develop an appreciation for the ethical, cultural and socioeconomic dimensions of illness, demonstrating sensitivity and responsiveness to patients’ culture, age, gender, and disabilities

f. Residents should display initiative and leadership; be able to delegate responsibility appropriately

g. Exhibit integrity and ethical behavior in professional conduct

h. Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and other aspects of clinical care

V. Practice-based Learning and improvement

a. All interns and residents should understand their limitations of knowledge and judgment; ask for help when needed; and be self-motivated to acquire knowledge
   i. Monitor practice with a goal for improvement
   ii. Learn and improve via performance audit
   iii. JARs and SARs should learn how to use knowledge of study designs and statistical methods in the critical appraisal of clinical studies and apply to the care of patients
   iv. Use information technology to manage information and access on-line medical information

b. Accept feedback, learn from own errors and develop self-improvement plans
   i. Learn and improve via feedback

c. Learns and improves at the point of care

VI. Systems-based practice

a. Work effectively with an interprofessional team (such as with nurses, secretaries, social workers, nutritionist, interpreters, physical and occupational therapists, technicians)
   i. Residents should develop proficiency in leading the health care team, organizing and managing medical care

b. Advocate for quality patient care and assist patients in dealing with system complexities

c. Recognize system error and advocate for system improvement

d. Identify forces that impact the cost of health care and advocate for and practice cost-effective care

e. Transition patients effectively within and across the health delivery systems
   i. Understand and appreciate the importance of contacting the patient’s primary care provider at the time of admission or soon thereafter

TEACHING METHODS

I. Supervised patient care:
a. The mix of diseases: Admissions encompass a broad mix of acute general medical problems requiring hospitalization.
b. Patient characteristics: Adult population including indigent and insured patients, of both sexes and a wide range of ages.
c. Types of clinical encounters: Inpatient.
d. Procedures: When PGY1s perform procedures, they must be directly supervised (supervisor must be present from start to completion of the procedure) by an upper level resident, fellow or faculty member who is certified in that procedure. All residents are required to log their procedures in MyEvaluations and have these signed off by a supervising fellow or faculty. Residents who complete at least 5 of the following procedures (paracentesis, thoracentesis, lumbar puncture, central line placement) are considered certified and, based on this experience, may perform procedures without direct supervision by faculty or fellow. PGY-2 and 3 residents are not allowed to perform procedures for which they are not certified. Even when “certified,” residents are encouraged to seek direct supervision when performing procedures if they are uncomfortable for any reason (unusual anatomy, etc.).
e. Level of faculty supervision: Progressive, graduated responsibility for performance of the admission history and physical examination, formulation of diagnostic and therapeutic plans, writing of orders, continued inpatient care, and performance of bedside procedures, all under the supervision of attending physicians. PGY1s are directly supervised by PGY2/3s. The attending physician is ultimately responsible for the care of the patient.

II. Structured didactics and small group learning
   a. Didactic and Bedside Teaching Rounds 3-5 days/week sufficient to provide at least 4.5 hours of teaching
   b. Residents’ and Interns’ Reports
   c. Journal Club
   d. Core noon Conferences, PS/QI Conference and Global Health Conference
   e. Grand Rounds
   f. CPC

III. Independent Study
   a. Recommended resources
      i. UpToDate is recommended as a concise peer-reviewed source for on-the-spot information. Residents are encouraged to go to the original literature for more in-depth learning.
      ii. Pulmonary Embolism


iii. Community-acquired pneumonia


iv. Diabetes Mellitus

1. Standards of Medical Care in Diabetes—2015, Abridged for Primary care providers. *Diabetes Care* 2015 33(2)
http://clinical.diabetesjournals.org/content/33/2/97.full.pdf+html

http://care.diabetesjournals.org/content/37 Supp liment_1/S81.full.pdf+html?sid=3df9f30a0-0558-47ea-8c9d-95b519210d33

v. Hypertension:


vi. Hepatic Cirrhosis


vii. Alcohol withdrawal


3.
EVALUATION METHODS
House officer evaluation forms, completed by attending physician, with verbal feedback to the house officers. Peer Evaluations will be utilized. The use of the mini-CEX (clinical evaluation exercise) is encouraged during this rotation (4 CEXs per year are required). Overall, house officers will be evaluated on the ACGME milestones. The following milestone will be evaluated during this rotation:

1. Gathers and synthesizes essential and accurate history information to define each patient’s clinical problem (PC1).
2. Gathers and synthesizes essential and accurate physical exam information to define each patient’s clinical problem (PC1).
3. Develops and achieves comprehensive care plans for each patient (PC2).
4. Seeks guidance when necessary (PC2b).
5. Possesses the scientific, socioeconomic and behavioral knowledge (MK1).
6. Knowledge of diagnostic testing and procedures (MK2).
7. Identifies forces that impact the cost of health care, and advocates for, and practices cost-effective care (SBP3).
8. Learns and improves via feedback. (PBLI3)
9. Uses evidence based medicine to learn and improve at the point of care (PBLI4).
10. Has professional and respectful interactions with patients, caregivers and members of the interprofessional team (e.g. peers, consultants, nursing, ancillary professionals and support personnel) (PROF1).
11. Accepts responsibility and follows through on tasks. (PROF2)
12. Responds to each patient’s unique characteristics and needs. (PROF3)
13. Communicates effectively with patients and caregivers and is able to build a therapeutic relationship. (ICS1)
14. Communicates effectively in interprofessional teams (e.g. peers, consultants, nursing, ancillary professionals and other support personnel). (ICS2)

SUPERVISION
The attending physician is ultimately responsible for the patients and will oversee patient care. The attending will see patients on daily rounds. The attending physician will observe the interns and residents performing specific tasks of patient management such as the interview and physical examination, choice of diagnostic studies, formulation of differential diagnosis or problem lists, development of plans for short-term and long-term medical management, communication of treatment plans, invasive procedures, and discharge planning. Chart auditing for format and quality of data entry should be done, with feedback to the residents.

There is a combination of direct and indirect supervision.
A. Direct Supervision – the supervising physician is physically present with the resident and patient.
B. Indirect Supervision:

1. Direct supervision immediately available – the supervising physician is physically within the hospital.
2. Direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities.

PGY-1s: All PGY-1s receive direct supervision on medicine wards. Direct and indirect supervision is provided by an upper level resident and faculty attending.

PGY-2/3s: All PGY 2&3s receive a combination of direct and indirect supervision on the Medicine wards.

When to call the service attending:

- Anytime a patient expires
- Anytime a serious safety event occurs
- Anytime you feel you need back up
- Anytime you have significant concern about the appropriateness of an admission.
- Anytime there has been a significant change in the patient’s condition (i.e. requiring an ICU transfer).
- Anytime a patient is attempting to or has left against medical advice/elooped.