**Version date**: May 9, 2016

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

**Administrative Coordinator:**
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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.

**ROTATION SCHEDULE AND LOGISTICS**

**Rotation Administrative contact:** Bethany Millar

**First Day Reporting Protocol:**

**When:** Meet the on-call team at 8 PM  
**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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<td>AM</td>
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<td>8:00 Grand rounds</td>
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<td>7:30 PM Night Report</td>
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**Required rounds/clinics/presentations:**
- Daily presentation rounds of the admissions
- Night report at 7:30 PM every other Thursday in the 11100 conference room. Schedule to be emailed out separately.

**Call Schedule:** See monthly team assignment sheet and call schedule.

**Med I**
- **PGY1:** Tuesday through Sunday 8PM to completion of presentation the following morning (usually by 8 AM).
  - PGY1’s day off is Monday night
- **PGY2/3:** Monday through Friday and Sunday 8PM to completion of presentation the following morning (usually by 8 AM).
  - PGY2/3’s day off is Saturday night
- You will be scheduled four days off in each 4-week rotation

**Med II**
- **PGY1:** Monday, Wednesday through Sunday 8PM to completion of presentation the following morning (usually by 8 AM).
  - PGY1’s day off is Tuesday night
- **PGY2/3:** Monday through Friday and Sunday 8PM to completion of presentation the following morning (usually by 8 AM).
  - PGY2/3’s day off is Saturday night
- You will be scheduled four days off in each 4-week rotation

**ROTATION SPECIFIC INFORMATION**
There is one Med I and one Med II Night float team, made up of 1 PGY1 and 1 PGY2/3.

Team caps: Med 1 and Med 2 night float teams will admit 5 patients at maximum, but may admit fewer patients.
- If the day team caps then night float team will admit 4 patients with the following priority: 2 forward fill patients, 2 short call patients.
• If the day team does not cap, then the night float team will admit 5 patients in the following priority: 2 forward fill patients, up to 3 back fill patients, the remaining patients as short call patients (with a total of 5 admissions).

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

I. Patient care
   a. Gather accurate information about patients, including performing a thorough history and physical examination on new patients and a focused evaluation on cross-coverage patients
   b. Synthesize data into a prioritized problem list and differential diagnosis, then formulate diagnostic and therapeutic plans
   c. Monitor and follow up patients appropriately
   d. Prioritize each day’s work (Intern for self, resident for entire team)
   e. Know the indications, contraindications, and risks of some invasive procedures and competently perform some invasive procedures

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 Night Float the resident should become familiar with the diagnostic and therapeutic approach to patients with:
      i. Chest pain
      ii. Shortness of breath
      iii. Fever
      iv. Mental status changes
      v. Abdominal pain
      vi. GI bleeding
      vii. Syncope and lightheadedness
      viii. Renal failure, acute and/or chronic
      ix. Anemia
      x. Hypertension and hypertensive urgency
      xi. Diabetes mellitus
      xii. Pneumonia
      xiii. Urinary tract infection
      xiv. Soft tissue infections (such as cellulitis, diabetic foot infection, decubitus ulcer)
      xv. Alcohol withdrawal
   b. Residents will demonstrate an increasing ability to teach others

III. Interpersonal and communication skills
a. Demonstrate caring and respectful behaviors with patients, families, including those who are angry and frustrated; and all members of the health care team
b. 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. 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
d. Develop an appreciation for the ethical, cultural and socioeconomic dimensions of illness, demonstrating sensitivity and responsiveness to patients’ culture, age, gender, and disabilities
e. Residents should display initiative and leadership; be able to delegate responsibility appropriately

V. Practice-based Learning and improvement
a. All interns and residents should understands his or her limitations of knowledge and judgment; ask for help when needed; and be self-motivated to acquire knowledge
b. Accept feedback, learn from own errors and develop self-improvement plans
c. Use information technology to manage information and access on-line medical information
d. JARs and SARs should learn how to use knowledge of study designs and statistical methods to the critical appraisal of clinical studies and apply to the care of patients

VI. Systems-based practice
a. Work effectively with others (such as nurses, secretaries, interpreters, technicians) as a member of a health care team
b. Advocate for quality patient care and assist patients in dealing with system complexities
c. Residents should develop proficiency in leading the health care team, organizing and managing medical care
d. Learn the cost-effective use of diagnostic and therapeutic technology

TEACHING METHODS
I. Supervised patient care:
   a. Admissions encompass a broad mix of acute general medical problems requiring hospitalization, including indigent and insured patients, of both sexes and a wide range of ages
   b. types of clinical encounters: Inpatient
   c. 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.).

d. 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. 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.

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. Develops and achieves comprehensive care plans for each patient (PC2).
2. Seeks guidance when necessary (PC2b).
3. Manages patients with progressive responsibility and independence (PC3).
4. Accepts responsibility and follows through on tasks (PROF2).
5. Accepts the responsibilities expected of a physician professional (PROF2b).

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 I and II night float. 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 I and II night float.

**When to call the service attending:**

- Anytime a patient expires
- Anytime a serious safety event occurs
- 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/eloped.
- Anytime an invasive procedure (other than a typical bedside procedure) is considered or ordered
- Anytime there is significant uncertainty
- Anytime you feel you need back up or have a question