WARDS

PGY 1

GOALS: Demonstrate competence in the management of common and unusual medical problems in any adult patient, acting as the primary physician on the inpatient service. Relate in a professional, altruistic, and humanistic manner to patients, their families, and health care personnel.

OBJECTIVES: This is an experiential educational activity that involves 3-5 months rotation during the year. This is supplemented by teaching rounds, conferences, seminars, and demonstrations

Knowledge: At the end of the rotations (3-5 months) the resident should be able to:

- Demonstrate the ability to manage common and uncommon problems
- Demonstrate knowledge of the natural history, pathophysiology, clinical presentation, diagnosis and management for these clinical problems
- Show the ability to recognize when consultation is indicated
- Demonstrate knowledge of cost of medical care provided and demonstrate efficient utilization of resources
- Identify concerns and problems that patients and their families may have near the end of life
- Advance to the second year and lead a medical team

Clinical skills

- Elicit a detailed history; perform a comprehensive physical examination; formulate a meaningful and justifiable problem list or differential diagnoses; record the data in the chart
- (During the interview) Ensure patient comfort and privacy; avoid medical terms; use verbal and non-verbal cues, interpret verbal and non-verbal cues; use interpreters for non-English speaking patients; use signage for the speech or hearing disabled; use silence, maintain eye contact with patient, confront patient tactfully in case of discrepancy, ask for patient's interpretation or for clarification as needed; avoid probing against resistance, respond to questions and comments from patient; use open ended, simple direct, multiple choice, leading, or loaded questions as appropriate
- Perform symptom analysis (Location, radiation, character, severity, manner of onset, duration, frequency, aggravating and relieving factors, associated symptoms, response to therapy, course since onset)
- (On physical examination) Conduct examination in a setting with strict attention to privacy; expose only those areas of the body being examined at the appropriate time; ensure patient comfort during the examination; obtain the presence of a third person when examining performing the rectal-genital examination
- Examine patient regionally (body) as opposed to by organ; minimize changes in body positions (lying, sitting, standing, turning, and bending) of patient
- Use techniques of palpation, percussion, auscultation, and transillumination
- Measure lesions accurately

- Demonstrate ability to use sphygmomanometer, otoscope, ophthalmoscope, hammer, and tuning fork
- Outline a logical and practical management plan (diagnostic and therapeutic) through legible entries at the end of the database and in writing unambiguous orders
- Illustrate the ability to incorporate psychosocial and ethical concerns of patient and family in developing a patient management plan
- Review the chart, obtain interval history, and perform focused examination on a daily basis in providing ongoing care to established in-patient
- Write legible and meaningful daily progress notes using the SOAP format
- Illustrate an understanding of patient management through a relevant problem-based medical record including progress notes, procedure notes, and assessments
- Demonstrate ability to synthesize accessory clinical data with other database in problem solving
- Dictate a comprehensive yet succinct discharge summary in accepted format
- Enter date and time and sign all entries made by the resident
- Demonstrate a cost-effective approach to medical care
- Communicate proposed tests, management options, and expected results with patients and with their families as appropriate in a timely manner
- Demonstrate effective teaching skills with medical students, para-medical students, peers and others

Procedural skills

- Show competence in accessing venous lines for administration of medications, fluids, nutrients, and sampling of blood for analysis
- Observe, assist in performing, and/or perform procedures required by the American Board of Internal Medicine for entrance to the certifying examination. Perform the procedures (listed here) under the direct supervision of physicians who are qualified to perform the respective procedures. The minimum numbers are in parentheses abdominal paracentesis (3); arterial puncture for blood gas analysis (5); arthrocentesis of the knee joint (3); central venous line placement (5); lumbar puncture (5); thoracentesis (5); critical life saving procedures (this requirement can be met by documentation of successful training in advanced cardiac life support); breast examinations (5); rectal examinations (5); and pelvic examinations and pap smears, including wet mount (5). The resident is expected to begin to develop proficiency in performing the procedures during the first year, and should demonstrate full competency at the end of the three years of training in Internal Medicine

Attitudes

- Demonstrate ability to work with other health care providers in patient management including appropriate utilization of consulting physicians, nursing, therapists, social workers, health educators, and other ancillary staff
- Model the characteristics of unconditional positive patient regard, accessibility, affability, and continuity in clinical activities

- Model professional attitudes and behaviors of punctuality (all rounds, conferences, and scheduled events), reliability, peer support, peer evaluation, time management, and teaching
- Complete medical records in a timely manner by visiting the medical records department at least on a weekly basis
- Notify the supervising resident, program co-coordinator, chief resident, or program director in case of absences or lateness
- Maintain privacy and confidentiality; demonstrate empathy and respect for patients regardless of race, national origin, religion, sexual preferences, and social or economical status
- Respond in a timely and respectful manner to questions and concerns from patients and their families; encourage patients to ask questions, ask for clarification or interpretation as necessary
- Allow patient autonomy in selecting diagnostic tests, but guide patients in the decision making process
- Demonstrate the willingness to review own practice of medicine, admit errors, and learn from own mistakes

Teaching and education

- Attend at least 70 % of the departmental "noon" conferences
- Participate in departmental and hospital committees
- Teaching rounds
- Didactic presentations
- Work and management rounds
- Assigned reading/presentations
- Self directed study

Evaluations

- Formative by supervising resident
- Formative by attending physician
- 360^0 global evaluation
- Chart stimulated recall
- MCQ – ACP annually, Departmental 4 times per year
- Portfolio
- Mini CEX
- Summative evaluations and counseling at 5-6 month interval by the Program Director

WARDS

PGY 2 and 3

GOALS: Demonstrate competence in the management of common and unusual medical problems in any adult patient, acting as the primary physician on the inpatient service. Relate in a professional, altruistic, and humanistic manner to patients, their families, and health care personnel.

OBJECTIVES: This is an experiential educational activity that involves 3-5 months rotation during the year. This is supplemented by teaching rounds, conferences, seminars, and demonstrations

Knowledge: At the end of the rotations (3-5 months) the resident should be able to:

- Demonstrate the ability to manage common and uncommon problems
- Demonstrate knowledge of the natural history, pathophysiology, clinical presentation, diagnosis and management for these clinical problems
- Show the ability to recognize when consultation is indicated
- Demonstrate knowledge of cost of medical care provided and demonstrate efficient utilization of resources
- Identify concerns and problems that patients and their families may have near the end of life

Clinical skills

- Elicit a detailed history; perform a comprehensive physical examination; formulate a meaningful and justifiable problem list or differential diagnoses; record the data in the chart
- (During the interview) Ensure patient comfort and privacy; avoid medical terms; use verbal and non-verbal cues, interpret verbal and non-verbal cues; use interpreters for non-English speaking patients; use signage for the speech or hearing disabled; use silence, maintain eye contact with patient, confront patient tactfully in case of discrepancy, ask for patient's interpretation or for clarification as needed; avoid probing against resistance, respond to questions and comments from patient; use open ended, simple direct, multiple choice, leading, or loaded questions as appropriate
- Perform symptom analysis (Location, radiation, character, severity, manner of onset, duration, frequency, aggravating and relieving factors, associated symptoms, response to therapy, course since onset)
- (On physical examination) Conduct examination in a setting with strict attention to privacy; expose only those areas of the body being examined at the appropriate time; ensure patient comfort during the examination; obtain the presence of a third person when examining performing the rectal-genital examination
- Examine patient regionally (body) as opposed to by organ; minimize changes in body positions (lying, sitting, standing, turning, and bending) of patient
- Use techniques of palpation, percussion, auscultation, and transillumination
- Measure lesions accurately
- Demonstrate ability to use sphygmomanometer, otoscope, ophthalmoscope, hammer, and tuning fork
- Outline a logical and practical management plan (diagnostic and therapeutic) through legible entries at the end of the database and in writing unambiguous orders
- Illustrate the ability to incorporate psychosocial and ethical concerns of patient and family in developing a patient management plan
- Review the chart, obtain interval history, and perform focused examination on a daily basis in providing ongoing care to established in-patient
- Write legible and meaningful daily progress notes using the SOAP format

- Illustrate an understanding of patient management through a relevant problem-based medical record including progress notes, procedure notes, and assessments
- Demonstrate ability to synthesize accessory clinical data with other database in problem solving
- Dictate a comprehensive yet succinct discharge summary in accepted format
- Enter date and time and sign all entries made by the resident
- Demonstrate a cost-effective approach to medical care
- Communicate proposed tests, management options, and expected results with patients and with their families as appropriate in a timely manner
- Supervise first year residents and medical students in obtaining medical histories, performing physical examinations, and managing patients
- Demonstrate effective teaching skills with first year residents (interns), medical students, para-medical students, peers and others
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Procedural skills

- Show competence in accessing venous lines for administration of medications, fluids, nutrients, and sampling of blood for analysis
- Continue to develop competence in performing procedures required by the American Board of Internal Medicine for entrance to the certifying examination. The resident should observe, assist in performing, and perform procedures required by the American Board of Internal Medicine for entrance to the certifying examination. Perform the procedures listed here under the direct supervision of physicians who are qualified to perform the respective procedures. The minimum numbers are in parentheses abdominal paracentesis (3); arterial puncture for blood gas analysis (5); arthrocentesis of the knee joint (3); central venous line placement (5); lumbar puncture (5); thoracentesis (5); critical life saving procedures (this requirement can be met by documentation of successful training in advanced cardiac life support); breast examinations (5); rectal examinations (5); and pelvic examinations and pap smears, including wet mount (5). The resident is expected to begin to develop proficiency in performing the procedures during the first year, and should demonstrate full competency at the end of the three years of training in Internal Medicine

Attitudes

- Demonstrate ability to work with other health care providers in patient management including appropriate utilization of consulting physicians, nursing, therapists, social workers, health educators, and other ancillary staff
- Model the characteristics of unconditional positive patient regard, accessibility, affability, and continuity in clinical activities
- Model professional attitudes and behaviors of punctuality (all rounds, conferences, and scheduled events), reliability, peer support, peer evaluation, time management, and teaching
- Complete medical records in a timely manner by visiting the medical records department at least on a weekly basis

- Notify the supervising resident, program co-coordinator, chief resident, or program director in case of absences or lateness
- Maintain privacy and confidentiality; demonstrate empathy and respect for patients regardless of race, national origin, religion, sexual preferences, and social or economical status
- Respond in a timely and respectful manner to questions and concerns from patients and their families; encourage patients to ask questions, ask for clarification or interpretation as necessary
- Allow patient autonomy in selecting diagnostic tests, but guide patients in the decision making process
- Demonstrate the willingness to review own practice of medicine, admit errors, and learn from own mistakes

Teaching and education

- Attend at least 70 % of the departmental "noon" conferences
- Attend and actively participate in presentations and discussions at morning report at least 75 % of scheduled report
- Present cases for discussion at M & M conferences as assigned by the chief resident. These presentations may occur when on other rotations
- Present at least 2 "Resident Lectures" during the PGY 2 year. Either or both presentations may occur when on other rotations
- Participate in departmental and hospital committees

Evaluations

- Formative by supervising resident
- Formative by attending physician
- 360^0 global evaluation
- Chart stimulated recall
- MCQ – ACP annually, Departmental 4 times per year
- Portfolio
- Mini CEX ?
- Summative evaluations and counseling at 5-6 month interval by the Program Director

In-Patient General Medical Ward Rotation

All residents who are assigned to the medical wards must perform a complete, independent interview, physical examination, laboratory review and prepare a complete write-up of newly admitted hospital patients regardless of the activities of other members of the team, of the private

or team's attending physician, or patient admission status. These activities must be completed on the day of admission.

All residents newly assigned to a hospitalized patient (i.e. at the beginning of the rotation) must likewise perform a complete interview and physical examination of each assigned patient and laboratory review, and prepare a complete write up. Their written notes will be titled an "On-Service Note", dated and timed.

The Medical Interview

Obtain history that is appropriate for the setting:
Detailed for new patient; focused for follow up or continuing patient; limited for critically sick patients; tailored for employment or school

For non-communicative patients
From drivers, relatives, friends, bystanders, review of medical records

Use appropriate language and other techniques
Ensure patient comfort and privacy; avoid medical terms; use verbal and non-verbal cues, interpret verbal and non-verbal cues; use interpreters for non-English speaking patients; use signage (ask for assistance) for the speech or hearing disabled; use silence, maintain eye contact with patient, confront patient tactfully in case of discrepancy, ask for patient's interpretation or for clarification as needed; avoid probing against resistance, respond to questions and comments from patient

Use appropriate type of questions
Open ended, simple direct, multiple choice, leading, loaded

Perform symptom analysis
Location, radiation, character, severity, manner of onset, duration, frequency, aggravating and relieving factors, associated symptoms, response to therapy, course since onset

NOTE: Patients are not "poor historians"; physicians should shoulder responsibility for poor histories just as they acknowledge difficulty in performing a procedure or interpreting an x-ray… that means slowing down to listen. The doctor is the instrument of the history-taking. The definition of historian is the recorder of events, not the source of information. The patient is the source of a medical history and the physician is the historian. However, the physician must use additional or alternate sources to obtain the history as the situation dictates. Communication with the attending physician (private or assigned) is a must.

The major components of the history are:

Chief complaint – a single symptom whenever possible. This is the main reason for the patient to be in the hospital and should be in the patient's own words, providing the words convey meaningful information. They may not necessarily be the first words in response to the first question.

History of present illness – the heart of the illness. It centers around the chief complaint and is a chronological description of the history of the disease for which the patient is hospitalized (or for which the patient seeks medical care). It is a description in chronological order the origin of the illness, previous hospitalizations and evaluations, complications, medications, response to therapy, and conclude with the current symptoms. Note that in many instances symptoms that are not present are also very important. disease processes contributing to the patient's condition at the time of the examination.

Past medical history – a listing of significant diseases in the past including hospitalizations, transfusions, major accidents, and surgical procedures.

Medications – list all current and recent medications; include the dose, frequency and when last taken. It may be necessary to compare a tablet with pictures in the PDR, or to call a pharmacist.

Allergies – list if any and state type. Be sure to label chart and indicate in doctors orders "patient is allergic to???"

Family history – list all diseases that have familial basis in the patient

Social history – family situation, recreation, drugs, alcohol, home care, education level, financial resources (especially if this is an issue that will impact on medical care)

Systems review or Review of symptoms – a systematic review of each of the organ system asking general and specific questions in the effort to uncover otherwise "hidden" illnesses. Simple direct questions tends to facilitate this.

Begin the interview by addressing the patient appropriately by the last name using the title "Mr., Mrs., Ms., Dr. etc,"

Introduce yourself, "break the ice"

Use open ended questions during the interview

Use simple direct questions, multiple choice questions, leading questions, loaded questions only when necessary

Perform symptom analysis on all symptoms that are present

Be critical in history taking. For example do not accept vague or suspicious statements as gospel truth. If your patient is "allergic to penicillin", ask "in what way?"

After you have asked the patient all the questions you have, then ask "Is there anything else bothering you that I have not asked?"

End the interview by letting the patient know what your next step will be.

The Physical Examination

Instruments: *stethoscope, ophthalmoscope with attachable otoscope, pocket flashlight, reflex hammer, tuning fork (128 cps), centimeter ruler, two large straight or safety pins and a wisp of cotton, rectal glove, lubricant, hemoccult test equipment . A sphygmomanometer is necessary to check for pulsus paradoxus and auscultatory gap*

Perform physical examination that is appropriate for the setting:
Detailed for new patient; focused for follow up or continuing patient; limited for critically sick patients; tailored for employment or school

Privacy, respect, and protection:
Conduct examination in a setting with attention to strict privacy; expose only those areas of the body being examined at the appropriate time; ensure patient comfort during the examination; obtain the presence of a third person when examining performing the rectal-genital examination

Maneuvers in examinations:
The examination must be conducted in a logical manner. Examine patient regionally (body) as opposed to by organ; minimize changes in body positions (lying, sitting, standing, turning, bending) of patient; use techniques of:

- Palpation
- Percussion
- Auscultation
- Transillumination
- Measuring lesions accurately
- Ddemonstrating utility of and use sphygmomanometer, otoscope, ophthalmoscope, hammer, and tuning fork.

The examination of the female reproductive system is an integral part of the general physical examination to the patient who is not a virgin. There is no medical reason to defer the pelvic examination in the presence of menses. A rectal examination is part of a complete physical examination. Any stool present on the examination glove is inspected and tested for blood. Physical examinations are tailored to the patient. If an abnormality is found, it is studied meticulously using special maneuvers as indicated.

Complete histories and physical examinations must be done even though major problems may have been determined early. In so doing, major problems will be confirmed or rejected, new problems may be uncovered, and isolated historical facts which do not fit elsewhere may be found. Further, what was thought to be a simple problem may be more complex or involve more systems than originally suspected.

Laboratory Tests

Laboratory tests are obtained only when indicated. Tests should be ordered only when the results will influence the management of the patient. The resident must personally review and interpret:

- Peripheral blood smear
- Urine sediments
- Chest and abdominal films
- Sputum smear
- EKG
- Spirometry
- CBC
- Blood chemistry and complete metabolic panel
- ABG

The Medical Records

The medical record is also a legal document. Careful thought should go into every written note. A clear picture of the patient and his/her illness is given for the benefit of later physicians. Sentences must be complete. Abbreviations are sparingly used since they are subject to misinterpretation.

Each page must contain identifying data of the patient

Initial H & P must contain a description of the findings on the detailed (comprehensive) evaluation of the patient. This include the demographics of the patient, all components of the history, and examination of each organ system. A statement about the source of the history and the reliability of the patient must also be included.

The "present illness" is arranged chronologically by going back to the apparent beginning of the illness and tracing it up to the present. Each manifestation is fully described in terms of seven major dimensions: bodily location, quality, quantity, chronology, setting, aggravating and alleviating factors, and associated symptoms. In addition to symptoms, the description of the "present illness" includes what the patient has done about the disorder and other medical investigations. The “present illness” concludes with other pertinent negative information and risk factors if not previously stated. Clinical judgment (developed with time) will dictate how much data obtained on evaluation will be recorded.

The initial H & P must include a list of possible diagnosis (differential diagnosis) in order of likelihood. This should be followed by a short discussion as to why each diagnosis is included and what action would be taken to include or exclude each one. The list must be based on the evidence that is available. The use of computer aided programs is strongly encouraged.

Sample CC & HPI

Sample problem list

Progress note should be headed with the problem. A problem can be an unexplained symptom, an unexplained sign, an abnormal laboratory finding, or a specific diagnosis. The progress note should be organized according in the following format:

- Symptoms subjective
- Signs objective (physical findings and pertinent laboratory data)
- Differential assessment*
- Management plans (diagnostic, therapeutic)
- Education education of the patient

*Residents are encouraged to expand on the list of possible diagnoses (differential diagnosis) by indicating the reasons for including each diagnosis.

Each note must contain:

- Title – progress note, consult preliminary, cross coverage, etc.
- Date
- Time – must indicate a.m. or p.m. OR use the 24 hour clock
- Legibly written
- Factual
- Contain results of special tests or procedures and only significant laboratory results
- Legibly signed or print name and pager number

Sample progress note

Procedure note: Any procedure that is performed by a resident requires note. Such notes are entered in the chart immediately underlining its title and enclosing it, in its entirety, in a box for emphasis. These procedures include lumbar punctures, bone marrow aspiration and biopsies, thoracentesis, paracentesis, sigmoidoscopies, etc. The note includes the indication for the procedures, a careful description of the premedication, local preparation, instruments used, site, amount and description of material obtained, and studies ordered. Associated symptoms and the patient's status after the procedures must also be described.

Sample procedure note

ON-Service/Off-Service note: When a resident rotates on or off the service he/she must write a note summarizing the patient's problem and hospital course so that the highlights of the patient's illness are underscored for the oncoming resident and a smooth transfer of care will ensue. This is called the “On-Service” or “Off-Service” note. It should be brief. It should include a summary of findings on admission, hospital course (including significant laboratory results), present status, and future diagnostic and therapeutic plans. These notes are usually brief, but contain the essential points of the hospital course.

Sample note

Discharge note: The discharge note is written on the day of discharge and summarizes the course of the patient in the hospital. It should include the final diagnoses, status of the patient on

discharge, list of (or referral to orders) for medications, plans for follow up – routine and unresolved or partially resolved problems. **The discharge note is separate from the narrative/discharge summary.**

Sample discharge note

Discharge summary: The summary should be dictated on the day of discharge. The resident must visit the medical records department weekly to sign off/complete all charts. The narrative must contain the following:

- Name of resident dictating the summary
- Name of the physician in charge of the patient
- Name of the patient
- Medical record number
- Date of admission
- Date of discharge
- Summarize the admission history and physical findings
- Specify important laboratory data
- Hospital course
- Procedures and results
- Complications, if any
- Consults
- Status of patient on discharge
- Pending results of tests
- Instructions given to patient
- List medications – include dose and frequency
- Plans for follow up

Sample discharge summary

Autopsies: