



2007 – 2008 edition

**Internal Medicine Residency Program**  
Naval Medical Center, Portsmouth, Virginia

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## INTRODUCTION

The Naval Hospital has had an intern orientation (lasting for 2 weeks before actually starting internship) for years. To my knowledge, however, the Internal Medicine department has not had a formal RESIDENT orientation for the “new” junior and senior residents. This would imply that it is not a big deal to progress from the intern level to junior resident, or from junior to senior resident. Although it may not involve as much anxiety as going from 4<sup>th</sup> year medical student to “physician”, there are still many new responsibilities and expectations, which can generate anxiety initially, and consternation later when told that you’re not living up to standards which weren’t clear to you. While by no means all-inclusive, this manual will hopefully be a resource for you as you enter the next level of training in Internal Medicine. The orientation will cover much of what is written, but I recommend perusing each page at least once. I’ve included as much as I can remember about each subject in terms of “most commonly asked questions/points of confusion”, and much of the material is included because you asked for it on the survey distributed earlier this year.

### **June 2007**

In our ongoing attempt to adapt the residency to the strains of work-hour restrictions and staff deployments, as well as our continued ambitions to improve the clinical and academic experience of the house staff, many aspects of the the residency, and in turn, the resident manual, have undergone revision. These include the change to a two-resident call system and elimination of the night float, the addition of a dedicated oncology ward team, the movement of all staff lectures to Thursday afternoons for a dedicated ½ day of academics and the addition of a 3<sup>rd</sup> year ICU rotation. Please use this manual as a roadmap to help navigate these changes and as a starting point for refining the program even further.

*David Furman, Chief of Residents 2007-2008*

### **June 2006**

This year signals new changes in the curriculum which hold great promise for even better training. There is a restructuring of Geriatrics and Ambulatory Medicine. Perhaps the most exciting is the creation of a standing Hematology-Oncology Ward Team. In the past this manual has helped to provide guidance during the ever-changing circumstances of residency. My goal was to make clear the expectations for the residents in regard to individual rotation goals as well as the overall goals of the program. My hope is that you will find this manual informative and user-friendly while at the same time using it to maximize your experience as a resident.

*James Fletcher, Chief of Residents 2006-2007*

### **June 2005**

As you can see, this manual has had many contributors and even more changes through the years. My hope was to make this patchwork quilt user-friendly for you, both concise and organized, while updating nearly every section. Make sure you review the presentation expectations, watch responsibilities (again!), admissions, dictation access, and board procedure sections, which have had greater upheaval.

*Karen Bullock, Chief of Residents 2005-2006*

### **June 2004**

Several additions and clarifications have been included in this year's manual. Clarification of the expectations for morning report, changes to the on-call responsibilities due to the use of the float system, required patient safety information, RRC requirements, policy for leave, due process, and the impaired resident have been included. You will find that the residency is always changing. I have tried to answer questions here instead of dictate policy. I hope this will assist you during this year.

*Anthony Nations, Chief of Residents 2004-2005*

### **June 2003**

The call system is still in flux as we attempt to find the system which works best for us and complies with the new RRC regulations. I have left some of the details of the system out, as it is still subject to change, but the basic roles of the various on-call designations are described. Other changes in the manual include some modifications of the morning report format, the addition of senior board review and intern morning report, changes in the Journal Club format, and some notes on professionalism.

*Ben Fischer, Chief of Residents 2003-2004*

### **June 2002**

This year includes the new "away" rotations offered at DePaul Hospital as well as the Washington Hospital Center. There are also some changes in the requirements for Grand Rounds, as well as some clarification of paperwork responsibilities. I hope that this year's edition clears up some confusion and will answer more "nuts and bolts" questions.

*Dan Rakowski, Chief of Residents 2002-2003*

### **June 2001**

In this year's manual we included the program requirements for graduation (#'s of procedures, etc), a summary of ancillary clinics the internal medicine clinic offers, as well as subtle changes in the morning report and journal club formats. I hope this serves as a useful resource even as the NMCP continues to evolve.

*Daniel Seidensticker, Chief of Residents 2001-2002*

### **June 2000**

Since moving into Charette, the normal routine of patient care has changed in many ways. I have updated the manual based on observations over the past year. Parts have been rearranged and, at times, rewritten for better flow. New items include the Observation Unit and closed ICU. I hope this manual continues to be a valuable resource.

*Art Pemberton, Chief of Residents 2000-2001*

### **June 1999**

Now that we have moved into the Charette Medical Center, I have made the appropriate changes in the resident manual. This manual served as wonderful resource for me during my residency, and I hope it serves in the same capacity for you.

*Meg Perusse Oberman, Chief of Residents 1999-2000*

**June 1997**

Enclosed you will find a revised resident manual. Hopefully this will assist you with your transition to PGY-2 and 3 residents. Notable changes are increases in the NAR hours, morning report, intern night float and resident academic responsibilities.

*Richard Scranton, Chief of Residents 1997-1998*

**May 1996**

This manual is intended to cover the theory as well as the “nuts and bolts” of our residency program. I hope that it will serve as a valuable resource for you this upcoming year. This update will cover some of the changes necessitated by the NAR, etc. As above, any suggestions for improving this manual for future years are appreciated.

*Kevin Sumption, Chief of Residents 1996-1997*

**May 1995**

This resident’s manual was developed by Lisa Inouye, Chief Resident 1993-1994. It has served as an incredible resource for many of us through out the year. With Lisa’s permission, I have updated a few items and added some others. Hopefully, we have covered the major resident responsibilities and guidelines for clinics/lectures/call etc. Any suggestions you have for future years’ manual, just let me know.

*Margaret MacKrell Gaglione, Chief of Residents 1995-1996*

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## ACADEMIC CONFERENCES

### **Morning Report**

#### **GOALS**

1. Learning
2. Evaluating Performance
  - a. The Watch: Patient management, complications, and consultations
  - b. Presentations
  - c. Professional development
3. Quality Assurance
  - a. Review admissions
  - b. Discuss adverse outcomes
  - c. Discuss administrative issues
4. Role Modeling
  - a. Set standard of professionalism for the department
  - b. Demonstrate appropriate communication and behavior for medical meetings
  - c. Model the thought process and approach to evaluating patients

In general, Morning Report is designed for two purposes: **Education** and **Evaluation**.

Utilizing our faculty as a resource, this hour should be educational, stimulating, and nonthreatening. The ultimate goal is to foster a culture of professionalism, scholarship, and respect, as the way we present ourselves in AM report sets the tone for the department. Given that we are a training program, the faculty has both legal and ethical responsibilities with respect to supervising and evaluating residents. Morning report offers the opportunity for providing immediate feedback to residents regarding their management of patients. This is said with the hope that positive feedback is also given, that any negative feedback should be constructive and completely impersonal, and with the clear understanding that many things appear more clearly in retrospect than at 0300 in the ED.

In addition to being a forum for discussing challenging or interesting new admissions, the morning report is also an opportunity to broaden the clinical exposure of each individual member of the house staff. Our inpatient service is dwarfed by the huge number of outpatients who pass through our various clinics and with that volume comes a variety of clinical syndromes, phenomena and pathology that often never requires hospitalization, but is part of the internal medicine residency curriculum. Consequently, residents are encouraged to bring their outpatient elective experiences with them to morning report to share with their fellow house staff.

#### **FORMAT**

1. Morning report is a daily conference which is held under the direction of the Chief of Residents. Attendance is mandatory unless involved in direct and urgent patient care.
  - a. Residents are expected to be seated by 0730 and are encouraged to sit as a group in the front to foster a climate of collegiality.
  - b. The back row of the conference room is reserved for staff physicians.
  - c. Our goal will be a teaching exercise and the discussion of at least ONE CASE per day.

- d. The COR will direct the session by summarizing salient points on the board, addressing questions to the residents and faculty for comment, and leading other creative components.
- e. The COR will encourage resident participation and staff opinion when necessary. **VOLUNTARY** resident participation is **STRONGLY FAVORED**.
- f. Each division should try to have at least one faculty representative in attendance every day.

**2. Senior Residents:**

- a. Are responsible to briefly present codes and watch consults.
- b. Share presentation of deaths and overnight complications (i.e. unit transfers) with the junior resident.
- c. Will be encouraged to assume teaching roles in morning report. The COR will ask senior residents to contribute to the discussion in areas in which individual residents have particular interest or in which they have demonstrated expertise.

**3. Junior Residents:**

- a. Are primarily responsible for presentations at morning report.
- b. One or two residents will be scheduled to present on each day. The first scheduled resident will generally be the NAR and will present a recent admission. The second presenter will in most cases be one of the ward residents, who should be prepared to discuss a patient on his or her team who has not been previously presented. The resident should be prepared to discuss not only the initial admitting evaluation but also the ensuing hospital course.
- c. Familiarity with medical literature relevant to cases is encouraged.
- d. The COR will notify residents in advance, whenever possible, and help “frame” cases if needed.
- e. In general, each ward resident and the CCU resident should have at least one patient on their service whom they are prepared to present should the need arise.

**4. Residents on Elective rotations:**

- a. May also be scheduled to present.
- b. Present subspecialty cases, either inpatient or outpatient, which raise clinical points of interest relevant to the general internist.
- c. The COR will choose the subspecialty areas to be presented each month.
- d. The subspecialty faculty are encouraged to count this presentation as taking the place of an assigned lecture.
- e. As such, you will also be expected to present a review of relevant literature associated with the topic (not as extensive as in a resident lecture or grand rounds).

5. The residents and interns not presenting are responsible for summarizing the case and answering questions. The goal is not to threaten, but instead to foster an environment of teaching and learning.

6. The admitting resident is expected to be able to competently discuss any patient that was admitted during their watch.

7. **Wednesday mornings** will feature Intern Report, Junior Procedure Review, and Senior Board Review, subject to change upon consensus agreement of the residents.

The purpose of intern morning report is the same as described for the residents. It will allow the COR to focus the sessions to the intern level and increase the involvement of interns, both allowing the interns to gain more from the session as well as allowing assessment of their skills, knowledge base, clinical reasoning, etc. Generally speaking intern morning reports is conducted with few or no staff attendings other than the COR. This is in order to maintain a relaxed, non-threatening environment and encourage maximal participation.

8. The topic schedule will vary according to the COR and PD. At this point, **Mondays** will be Grand Rounds or resident lectures when designated, two **Thursdays** a month will feature Cardiology Teaching Rounds, and **Fridays** will include visiting professors and on the final Friday of each month, Jeopardy, reviewing material from the month's Thursday lectures.

### **SENIOR RESIDENT BOARD REVIEW**

Senior residents and a selected enthusiastic faculty member will meet...

When: Wednesday mornings during intern morning report

Why: For review sessions based on the MKSAP sample questions.

Where: In the Nephrology conference room.

Goals: With the goal of clarifying your understanding of clinical entities you know and to supplement learning in those areas in which you are relatively inexperienced.

Who will present: According to the schedule listed on the DFFM54 drive in the Call and Academic Folder.

Who should attend: You, unless your patient or intern actively needs you (same caveat as AM Report).

The more you put into it, the more you will get out of it. Staff have expressed concerns that they were being asked to “spoon feed” residents – your motivation will dispel those concerns. Be an active learner in this process!

### **MORNING REPORT CASE EXPECTATIONS**

#### *Overview*

- Make a convincing case for the important problems, differential, and plan.
- Make it structured, organized, and targeted;  
it should take about **5 minutes**.

#### *Opening Statement*

- Brief statement of the chief complaint.
- Include pointed and relevant historical information.
- **Brief** statement if/why pt cannot give reliable history, and briefly name other information source.

### *Present Illness*

- The “syndrome” or differential you considered should guide what you include.
- Be chronologically organized and clear without analyzing.
- Remember OPQRST: (Onset, Provoke/Palliate, Quality, Region/Radiation, associated Symptoms, Timing).
- Translate history into descriptive terms to guide your HPI (without leaping to a diagnosis): insidious/abrupt, unilateral/bilateral, constant/intermittent.
- Translate history into appropriate medical terminology: “felt very ill” (malaise); “achy all over” (myalgias); “felt like vomiting but didn’t” (nausea); “short of breath walking up the stairs (exertional dyspnea); “felt like a knife stabbing” (lancinating). Note that these are still descriptive terms, not diagnoses.
- Include elements of past history (with supporting studies and therapeutic interventions), meds, FH, SH (including psychosocial factors) **that specifically contribute to the Present Illness**.
- *Pertinent ROS*- positives and negatives to make the listener understand your DDX.
- Only include ER course if it significantly affects/alters triage or immediate treatment decisions prior to coming to your care. Report facts and events, not ER diagnoses.

### *Other History*

- Important PMH (with supporting history/data).
- Exclude minor diagnoses without impact on current care.
- Important meds with doses of relevant ones.
- Allergies.
- Focused FH/SH/ROS.
- **Avoid repetition.** If you mentioned it in the HPI, do not repeat in PMH.

### *Physical Exam*

- Always include general appearance, body habitus (BMI if appropriate) and specific vitals.
- Include pertinent elements of exam and any abnormal findings; remainder may be noted as “noncontributory”.

### *Labs/Data*

- Include pertinent or otherwise significant labs/studies.
- Know baseline Hgb and/or Cr as appropriate.

### *Synthesis*

Assess and synthesize, do not regurgitate. The summary should reflect your synthesized, coherent impression using medical language that you are comfortable using.

- Use descriptive terms: (some more: uni/bilateral, proximal/distal, lg/sm joint, insidious/escalating)
- Demonstrate your thinking about the patient-specific differential dx.
- If multiple issues, weave together or discuss lesser issues in problem list.
- First sentence of synthesis should include patient description (age category\*, gender, race if pertinent, previous state of health).
- \*Age category suggestions: 18-25 “young adult”, 25-45 “adult”, 45-65 “middle-aged”, >65 “elderly”.

- Presentation description (using descriptive identifiers, eg acute, subacute, chronic, progressive, fluctuating, static, etc., of the most important and relevant history (HPI-PMH-Other) and data (PE-lab-rad))
- The 3<sup>rd</sup> or 4<sup>th</sup> sentence in the summary is reserved for introducing the differential diagnosis. Begin with *most likely* diagnosis followed by other considerations. At this point a more lengthy explanation can be launched or encouraged by the audience.
- Remember, the summary is the lead into the differential diagnosis and reflects your unique and independent analysis of the case. We are asking for your opinion, so don't be afraid to give it.

*Items to avoid*

- “Vital signs stable”: a faux pas in Internal Medicine.
- “Neuro exam non focal”; this implies a detailed exam was performed, and often a detailed exam is not required. Therefore, only report on the part of the exam that was performed.
- “Normocephalic/Atraumatic” ; NC is a pediatric term. AT should only be noted if pertinent.
- “PERRLA” (pronounced “pearl-a”): Abbreviations should not be spoken like a word. If you must note pupils, say “pupils equal, round and reactive to light and accommodation”. This also should only be noted if pertinent.
- “History as above”—there is an “above” in written but not oral presentations.
- Trade names for medications.
- Patient names.

## Resident Formal Presentations

### GRAND ROUNDS

1. Goals
  - a. Improve knowledge and understanding of disease and medical decision-making
  - b. Improve presentation skills
2. Requirement
  - a. **One presentation each year for PGY-2 and PGY-3 residents.**
  - b. Usually done the month following a ward month.
  - c. May request or may be required to complete another presentation.
  - d. Scheduled by the COR at the beginning of the academic year.
  - e. All will occur at Morning Report, tentatively Mondays.
  - f. M & M or CPC format may be used for meeting this objective as appropriate.
3. Format
  - a. Case-based, similar to morning report presentations, based on a ward team patient.
  - b. Focus is on presentation skills--- not simply putting everything on slides.
  - c. Grand Rounds should last 30-45 minutes to allow time for questions.
4. What we want
  - a. **Diagnostic dilemma** or **therapeutic controversy** is the desired basis for presentation. “Fascinoma” is acceptable IF general diagnostic principles can be gleaned from case discussion.
  - b. Clinical questions that arose during the care of the patient are encouraged, along with how the question was answered (literature search, specialist consultation, etc.)
  - c. Extended discussion of general pathophysiology (review of coagulation cascade, minimal change disease, life cycle of *Aedes aegypti*= excessive daytime sleepiness) is discouraged unless it bears specific relevance to a clinical question.
  - d. Evaluation will be based on achieving the skills described in July’s “How to Give a Talk” Series.
  - e. Evaluation forms should be completed by two faculty members for your “File”.

### RESIDENT LECTURE

1. Goals
  - a. Demonstrate ability to organize and synthesize original literature
  - b. Develop the knowledge base of a topic through research and reading.
  - c. Improve presentation skills (Powerpoint AND Delivery)
2. Requirement
  - a. **One presentation per year for PGY-2 and PGY-3 residents.**
  - b. Scheduled by the COR at the beginning of the academic year.
  - c. **PGY-2 lectures will be done as a Noon Lecture; PGY-3 lectures will occur during AM Report.**
3. Format Requirements
  - a. **Handouts** are appropriate and encouraged for juniors, **required** for seniors.
  - b. The resident is expected to inform the attendings from the appropriate division that they are giving a lecture in their subspecialty.
  - c. Lectures should also last 30-45 minutes to allow time for questions.

d. Evaluation will be the same as for Grand Rounds.

4. Topic

a. Resident lectures must be approved by the COR in advance to avoid duplicating a previously scheduled faculty topic.

b. Pick something you are interested in if you want us to be! You will be more passionate, retain the knowledge, like being the “Resident (or Department) Expert”, and have it on hand for the future.

That being said, it should still be of use to the general internist.

**CLINICAL PEER REVIEW CONFERENCE (previously referred to as “MORBIDITY & MORTALITY”)**

1. Goals

a. Review patients who have experienced an adverse event or outcome in order to improve the care provided by all internists.

b. Familiarize learners with the processes of error evaluation and management.

2. Format

a. A member of the housestaff who had no involvement in the case will be asked in advance to review the medical record to collect the basic facts of the case and the pertinent event. They are then encourage to contact individuals involved to get first hand accounts and to fill in “gaps in the medical record’s account.

b. The case will be presented objectively by this individual. This is to be a brief summary of the pertinent facts and events. **No powerpoint.**

c. The objective is to promote discussion of pivotal points in the management of the patient, thus, the resident’s goal should be to frame those aspects of the case.

d. Cases will be supplemented by selections of standard cases from the AHRQ (Agency for Healthcare Research and Quality).

e. The COR, APD or PD will moderate the exchange of ideas.

3. Expectation

a. This will be done in a **scholarly, nonmalignant manner** with the understanding that we are all human and capable of making mistakes.

b. We want have at least one of either an M&M or CPC per month.

**CLINICAL PATHOLOGY / AUTOPSY CONFERENCE**

1. Goals

a. Review the gross pathology and histology of patients who recently died or were given tissue specific diagnoses while on the medicine service.

b. Specific attention will be paid to the cause(s) of death, the role of therapeutic management, and the accuracy of diagnosis.

2. Format

a. The resident who cared for the patient will be asked to give a brief summation of the patient’s history and hospital course, as well as discuss the events surrounding the patient’s death (if indicated).

b. The presenting resident will provide a literature review and discussion on the pertinent topic, paying special attention to those historical features that are germane to the diagnosis.

- c. **It is highly encouraged to involve a pathologist to assist with the discussion!**
- d. May be held in the Pathology Conference Room or Autopsy Suite.

## **JOURNAL CLUB**

1. Goals
  - a. Foster the idea of continuing education through group participation.
  - b. Assist with developing the skills necessary to critically review the literature and present the information gained in such a fashion that others will benefit.
  - c. Collegiality
2. Format
  - a. Once a month: Date will vary but usually be the last Thursday of the month. Occuring as the lunch time event on the Thursday academic half-day schedule
  - b. Most commonly will be held in the pediatric conference room.
  - d. Again, being part of the academic Thursday schedule, these are mandatory.
3. Expectations
  - a. Presentations will be literature-based.
  - b. The consult senior resident (or junior if there is no senior that month) will be responsible for the article(s) for that month's journal club. The selection of articles should be based on a clinical question which the resident sought to answer by reviewing the literature or on a recently released high profile article which may have applicability to general medicine patients.
  - c. Articles (2, max 3) should be discussed with the COR ahead of time and copies or links to articles will be provided to each resident.
  - d. The resident responsible for that month's articles should be prepared to introduce and summarize the articles, but will not necessarily be expected to be the primary discussant.
  - e. The format of the journal club will evolve over the course of the year.
  - f. During the first several months, we will present the methodology to critical reading. This approach should be used when reviewing articles for the JC.

## **THURSDAY ACADEMIC LECTURES**

Begin each week at 1215 in the IM Conference Room and...

- Are mandatory unless post-call, involved in admitting a new patient or in acute patient care. Given by attendings from our department or guest attendings from other specialties (Derm, Uro, Psych).
- Last 45-60 minutes.
- The topics are based on the curriculum, incorporating both specialty topics and integrative areas (ethics, geriatrics, primary care, adolescent medicine, etc.).

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## ACADEMIC RESPONSIBILITIES

These are the minimum academic requirements for graduation. Note that this does not include all requirements:

1. Scholarly activity (research or case vignette)
2. One resident lecture per year
3. One or more grand rounds per year
4. One Journal Club session leadership
5. New Innovations procedure log (plus any old procedure log sheets)
6. Procedure sign off sheet
7. CEX and GTA
8. Mini-CEXs
9. All rotation evaluations and annual program evaluation
10. All charts dictated
11. C-1 Status.

### **SCHOLARLY ACTIVITY**

The ACGME states that “each resident must demonstrate some form of acceptable scholarly activity. Scholarly activities may include original research, comprehensive case reports, or review of assigned clinical and research topics.”

At a minimum, each resident is required to write and submit a case report to the Associates’ Subsection at the regional and national meetings of the American College of Physicians to complete their residency training. These case reports should be a review of the case, a thorough literature review and discussion, and in a format that is acceptable for publication or submission for presentation. Preparing two case reports per three years of residency is strongly encouraged. Research projects abound within our department, both large and small. Talk to the Research coordinator, Dr. John Smith (GI), about potential projects.

Our residents have performed extremely well, winning several awards at the Navy, state, and national levels of the ACP over the past several years.

### **PROCEDURES**

- Are primarily logged in New Innovations now ([www.new-innov.com](http://www.new-innov.com)).
- Can be entered in the pocket size logbook you received as an intern if on away rotations--and turned in quarterly. If you choose to use the log book you **MUST** ensure all signatures are included. Non signed procedures will not be counted. You **MUST** tally all procedures as you submit them.
- Have a minimum required number for certification/clinical privileges (see reference list).
- Should be documented **as you perform them** by the supervising attending.
- Should be signed off in the main procedure sign-off sheet for your file when the required number is complete. If not signed off on the master procedure sign-off sheet you cannot supervise others.
- You should maintain your log of major procedures, like LP, thoracenteses, paracenteses, central lines, even after you have enough to be “signed off”. Your credentialing at year’s end includes documentation on number of certain procedures accomplished.

**This sign-off sheet must be completed prior to graduation.**

- Should be accompanied by an appropriately detailed chart note, including consent and post procedure imaging.

Note that CXR, ECG etc. do not need a log for every one interpreted, but you should keep some record of these and other procedures done on the wards or get your ward attending to document a summary at the end of the month, since you may not complete all the CXR or ECG readings necessary for certification on your pulmonary or cardiology rotation, for example. You are responsible for showing your documentation to the specialist for each procedure in order to get final approval and signature.

Certification in the following procedures is required for graduation from the Internal Medicine Residency Program:

<b><u>Procedure:</u></b>	<b><u>Method of certification:</u></b>
BLS	
ACLS	Successful completion of course
ATLS	
Venous blood sampling	
Bladder catheterization	
Nasogastric intubation	During intern year - direct observation of 3 procedures each by supervising resident.
Arterial blood sampling	5 directly observed <sup>1</sup>
Arterial line placement	5 directly observed <sup>2</sup>
Lumbar puncture	5 directly observed
Paracentesis	3 directly observed
Knee arthrocentesis	3 directly observed
Thoracentesis	5 directly observed <sup>3</sup>
Central line placement	5 directly observed
Treadmill exercise testing	5 directly/15 indirectly observed <sup>4</sup>
CXR interpretation	see procedure log section of curriculum
ECG interpretation	see procedure log section of curriculum
Urinalysis interpretation	see procedure log section of curriculum
Peripheral smear int.	see procedure log section of curriculum
Wet mount vaginal dis. int.	see procedure log section of curriculum
Gram stain interpretation	see procedure log section of curriculum
Breast examination	
Female pelvic examination	Successful completion of CEX and standardized patient exercises
Male genital examination	
Rectal examination	

The following procedures are considered optional. Trainees interested in General Internal Medicine or expecting assignment in an isolated location will receive priority for procedures with limited availability.

<b><u>Procedure:</u></b>	<b><u>Method of Certification:</u></b>
Flexible sigmoidoscopy	20 directly observed
PA catheter placement	5 directly/5 indirectly observed
Endotracheal intubation	10 directly observed
Bone marrow aspiration/biopsy	5 directly observed
Liver biopsy	10 directly observed
Pleural biopsy	10 directly observed
Spirometry	20 directly observed
Skin (punch) biopsy	3 directly observed
Temporary pacemaker placement	5 indirectly/5 directly observed
Pericardiocentesis	5 indirectly/5 directly observed
Elective cardioversion	5 directly observed
Malaria smear interpretation	5 documented
Arthrocentesis (other than knee)	3 directly observed

**1 Directly observed** - observed by a senior resident or staff who is certified or credentialed in the particular procedure.

**2** The performance of 5 arterial line placements can substitute for and be counted toward 5 arterial blood sampling.

**3** The initial 5 treadmills should be directly observed by a certified resident or credentialed staff; the remaining 15 should be discussed/reviewed with the supervising resident or staff.

## **CLINICAL COMPETENCY COMMITTEE**

There is a clinical competency committee comprised of the Program Director, Associate Program Directors, and representatives from several Internal Medicine divisions, which meets on a regular basis to discuss individual performances of residents and interns. Such a committee is required for all Internal Medicine Residency programs to maintain accreditation. On occasion, trainees may be asked to attend one of these meetings. The Chief of Residents attends to represent resident perspectives.

## **EVALUATIONS**

1. Monthly evaluations of you by the attending of the rotation—*required for credit*.

2. Monthly evaluations by you of the rotation/attending—*required for credit*.

3. Mid-monthly evaluation and feedback by the attending.

**If you do not receive a mid-month evaluation by your attending you are strongly encouraged to ask for one** so that you will have an opportunity to address any areas for improvement before the end of a rotation.

4. Quarterly brief review by Clinical Competency Committee.

5. Twice-yearly appointment with the Program Director.

6. Fitreps done by the Program Director.

7. All monthly evals are completed in New Innovations ([www.new-innov.com](http://www.new-innov.com)) .

8. All evals are based on the 6 ACGME core competencies:

    Patient Care

    Medical Knowledge

    Interpersonal and Communication Skills

    Professionalism

    Practice Based Learning

### Systems Based Practice.

9. Evaluations are to be weighted to reflect competencies specific to the resident's individual level of training, based on year-specific goals established by the program.

### **GRIEVANCE AND APPEAL**

#### *Procedure for evaluation grievances:*

1. Submit a memo to the Head, Clinical Competency Committee, briefly describing the grievance with the evaluation.
2. Discuss with the COR and PD.
3. The memo will be attached to the evaluation and discussed at the Clinical Competency Committee.
4. Results will depend on the individual situation.

#### *Procedure for appealing a failed rotation, probation, or other disciplinary action:*

See the GME instructions, NAVMEDCEN 5420.2F, available on the intranet.

### **YOUR FILE**

Every resident has a file in the Internal Medicine office. Your resident evaluations, certification requirements, letters of appreciation, etc. all go into this file which you can review at any time. Check it periodically.

[BACK TO TOC](#)

**THE WATCH**  
**(aka “Call”, for civilians)**

In an attempt to give “standard of care” attention to each patient, meet the RRC work-hour guidelines, and set an environment for maximal resident learning, the inpatient medical service has undergone many watch schedule changes.

The COR will outline the current Watch Bill, aka Call Schedule and guidelines and provide a copy in the **Call and Academic Schedule (07-08) folder on the DFFM54 drive**. Any changes will be reviewed with all residents and updated on the drive.

**Setting the Watch**

<b>HOURS</b>	<u>MON-THU</u> 1630-0700	<u>SAT</u> 0800-0800
	<u>FRI</u> 1230-0800	<u>SUN</u> 0800-0700

**SIGN-OUTS**

1. Occur at the beginning of watch hours for daytime house staff (time varies– see “Watch Hours” above) and briefly with the NAR/DAR/Senior/Float Intern at 1900 on weeknights.

**SHOW UP ON TIME !**

2. Location: Ward 4H Day Room or “Intern Work Room” between Wards 4H and 4J.

3. Residents responsible for coming to sign-outs in addition to those on call that night are those on wards, CCU, consults, and the DAR.

4. Residents are to sign out in the following order:

CCU\* → Post call wards\* → other wards\* → DAR → consults\*

\* If an attending is covering sign-outs, he/she goes first. Seniors are also given priority when time allows.

5. What to sign out:

a. Patients in Step Down Unit and CCU

b. Patients in DNR status (as well as their specific accepted interventions: mask, transfer to ICU, etc.)

c. TBA patients (To Be Aware)

1) Potential transfers or codes

2) Other problems (threatening AMA, VIP’s)

d. All residents provide names/pagers of their attendings, as well as any interns on call that night.

e. DAR signs out consults waiting in ED, any patients in the OBS unit, and any incoming transfers from other facilities.

6. How to sign out:

a. As is standard throughout the command, **signouts are to follow the SBAR (Situation, Background, Assessment, Recommendation) format advocated by JCAHO.**

## **MORNING TURNOVER**

Overnight Residents (NAR/SROC) will present patients to the accepting ON CALL IM ward team resident/attending\*:

1. Weekdays at 0700 prior to AM Report in the IM Conference Room
2. Weekends at 0730 prior to setting the watch in the 4H Day Room.
3. Presentations should be brief, directed, and in “resident-speak”:  
e.g. “This next patient is a 25 year old active duty E6 no PMH with her first pyelo-pressure’s stable, no failure. She wasn’t tolerating PO after OBS 24 hours and still looked dry, so we continued with IV phenergan q6 and kept the NS at 125/hr. She got cultured and IV Levaquin since she wasn’t eating- first dose given in the ER. Yes, the Urine HCG was negative. Any questions?”

\*DAR is responsible for presenting patients admitted on previous day to current ON CALL IM ward team

## **Who’s Who**

### **NIGHT ADMITTING RESIDENT (NAR)**

1. The NAR works 5 nights per week, Sunday through Thursday, from 1900-0700. NAR will attend AM report.
2. Continuity clinic is held on Friday AM.
3. The NAR is responsible for evaluating consults from the ED as well as accepting stable patients from other facilities. They should arrange with the overnight Senior (SROC), who is to evaluate patients transferred from other facilities. This arrangement may change depending on the number of patients in the ED who have already been identified as needing medicine consultation.
4. Carries the Junior code pager and responds to codes when they are called. *This always takes priority over consult/admission responsibilities to the ED.* Given that all code calls are disseminated by the ED dispatch corpsmen, the ED will be aware and understand when you are emergently pulled away.
4. If the NAR becomes inundated with consults (i.e. 2 or more behind) it is his/her responsibility to contact the senior for assistance. *If there are more than 4 patients waiting to be seen by the medicine (and cardiology) service, then the Jeopardy resident for that night should be called.*
5. Feedback on patient evaluations will be provided.
6. NAR does not work weekday holidays unless designated by the COR.
7. Typically a Junior resident rotation.

### **DAY ADMITTING RESIDENT (DAR)**

1. Also a junior rotation, in which one works Monday-Thursday from **0700 sharp (to free the NAR for AM Report)**-1900.
2. A guest Junior or Senior covers the ED on Friday 0700-1230 until the watch is set.
3. Continuity clinic is Friday AM.
4. Responsibilities are the same as the NAR but at a more palatable hour.
5. Daytime transfers are to be admitted by the Ward Resident for the receiving team, unless otherwise worked out between that resident and the DAR.
6. Back-up can be accessed by paging the COR who will recruit a senior or junior on elective/consults to help in the ED.

7. DAR does not work weekday holidays unless designated by the COR.

*\*\*\*The two above rotations are otherwise Call Free.\*\*\**

### **JUNIOR RESIDENT WEEKEND/HOLIDAY WATCH RESPONSIBILITIES (NO DAR/NAR)**

1. Carries the IM Admission consult pager(s) (#)
2. Carries the code pager and assists the senior at codes  
Note: Respond to Cardiac Arrest tests (twice daily) within 5 minutes or they report your name to the C.O. !
3. The admitting resident is responsible for making sure that the intern understands the patient's illness and the plan. The intern should be encouraged to make an independent assessment, and in some circumstances it is reasonable and appropriate to have interns see the patient in the ER prior to a full assessment by the resident.  
Criteria for getting interns involved in the ER include:
  - a. Resident has multiple consults pending.
  - b. "Sure admissions" are waiting to be seen.
  - c. There is a trusted intern on duty who is not currently overloaded with floor responsibilities.

Note: The routine practice of using interns to do the work for residents is not appropriate. If the intern is involved in the ER, the resident must closely supervise and is still responsible for writing a RAN.

4. On-call residents are responsible for all IM patients admitted to the hospital (regardless of to which service) and under their care during the watch.
5. It is the responsibility of the admitting resident to inform the resident accepting the patient (ward resident) of each admission.
9. Do **NOT** see in-house consults or answer panic values...just give them the senior's pager number (3606).  
As you can see, you have enough to do already!

### **SENIOR RESIDENT WATCH RESPONSIBILITIES**

1. Carry the Code pager (and respond promptly to tests). **\*\*The Senior Medicine Resident On Call is the medical officer in charge of codes for the watch (including the work day); make sure you introduce yourself as such when you respond!\*\***
2. Carry the Consult pager (#8799).
  - a. Consults may come from the surgical services, OB/GYN, or Psychiatry to address Internal Medicine problems that have arisen in their patients.
  - b. After evaluating the patient and developing a plan, discuss the case with the Consult attending. They want to be made aware of **all** watch consults (unless you're told otherwise).
  - c. Remember to maintain the role of the consultant. Do not write your recommendations down on the order sheets unless the home team says it's fine.
  - d. Usually the consult service does not round in the ICU.
3. Floor Coverage:           In this capacity they should:

- a. Check on all patients signed out to the watch as TBA.
  - b. Serve as back-up to the interns for cross-cover questions and crashes.
    - 1) The intern will call you with varying levels of panic.
    - 2) Listen, reassure the intern, and go evaluate the patient.
    - 3) If the NAR is swamped in the ED and patients are looking bad on the floors, call the Jeopardy resident in to assist with the ED. *Priority is always acute issues with patients already admitted to the medicine services.*
  - c. Serve as **first backup call for any CCU or SDU patients, and write brief, nightly notes.**
  - d. Evaluate/ write RANs on direct transfer patients if the NAR is unable to see them themselves.
4. Save the Day in the ER for the juniors until the admission back-log is cleared.
  5. Address Panic values
    - a. From all subspecialty clinics.
    - b. Find out who ordered it, and from what clinic.
    - c. Check previous labs, to see if they always have that abnl value (a glc of >400, a plt count of 15,000). Usually, though, it's the better part of valor to **call the attending** that ordered the test.
    - d. If not clear who the attending is, and you think the patient should be rechecked, use the ADT command on the CHCS system to get the patient's phone # and discuss the situation with the patient.
    - e. When all else fails, notify the attending by email.
  5. Check on patients from the Consult Service that were checked out, especially on weekends.
  6. On weekend days where the CCU resident is off (Saturday or Sunday), it is the responsibility of the Senior resident on call to round with the CCU attending on the new patients at 0700 or another time at the discretion of the attending. If the patient requires an EST before discharge, the resident is required to perform them. If the resident is not yet signed off on EST's, the CCU attending will remain in house to supervise the test.
  7. **Death pronouncements**
    - a. See the patient expeditiously after nurse calls you. Check pupils, pulse, listen to heart, check reflexes.
    - b. Write death note: e.g. "called to see this 89 yo patient with end stage COPD by nursing staff. Pupils fixed and dilated. No spontaneous respirations, no heart sounds auscultated over 5 minutes. DTR's absent. Patient wished to be DNR. Pt pronounced dead at 2235. OOD, Chaplain, family, attending aware/ present. Permission for postmortem obtained from family."
    - c. Fill out VSL/death form. The cause of death should somehow relate to the primary illness, if appropriate. Avoid vague and meaningless phrases like "cardiac/respiratory arrest". A credentialed staff physician must sign the actual death certificate, but the decedent affairs office takes care of that the next day.
    - d. Call the family and the ward attending. Check to make sure nursing staff called the chaplain and OOD. **The OOD has the autopsy consent forms.**
    - e. When the family arrives, respectfully request for a postmortem exam. Be assertive. The family can specify if they don't want the person's head (or whatever) to be touched; (but know that even if the head is included, the face is not cut so open-casket funeral is still possible).

- f. The nurses will make the patient look as peaceful as possible for the family, but remember if there's any chance of getting a post, **nothing** is removed until that decision is made (IV's, Foley catheter, NG tubes—all stay in).
  - g. A death summary needs to be dictated, using the same method as a discharge summary. **It is the responsibility of the ward resident that cared for the deceased to dictate this, NOT the resident that pronounced the patient** (unless it is the same resident).
8. Be aware of:
- a. ICU, SDU and CCU admissions
  - b. The number of patients admitted; the interns should not admit more than five patients per intern during a 24 hour period.
  - c. Admissions to discuss with the COR.
  - d. Excessive admissions.
- \*\*At any time, if the senior resident feels that patient safety is in jeopardy due to excessive admissions or due to patient severity of illness, then the attending shall be notified and consideration given to closing the service.\*\*
9. Notify the Department Head for:
- a. Any impending/ potential disasters or other things, i.e., VIP admissions, someone vandalized the conference room, etc.
  - b. Patients that are detained against their will.
10. Realize that we have staff support but **as the SR you are the Internist in house**. Anesthesia staff are in house. Surgery chiefs in their 5<sup>th</sup> year of residency are in house. YOU are the Internist and CAPT Cole's representative.

### **JEOPARDY RESIDENT**

1. Each day a resident (junior or senior) will be designated as "Jeopardy"
2. This is essentially "home call" – keep your pager on and within earshot at all times during that period (0700-0700)
3. Jeopardy resident will be called in if:
  - a. NAR/SROC have more than 4 patients awaiting evaluation in the ED
  - b. There are acute patient situations on the wards requiring SROC attention and ED is backed up
  - c. NAR or SROC are unable to perform their call duties due to illness, injury or other unexpected situation.
    - If junior Jeopardy resident would be filling in for SROC, call COR before calling Jeopardy resident – another senior will need to be called in.
4. If called in, Jeopardy resident is to remain "in house" until told by SROC that (s)he may go
5. It is strongly recommended that the Jeopardy resident call the DAR before leaving for the day – if the ED is significantly backed up at that time, it is in the Jeopardy resident's best interest to stay and help eliminate the backlog, rather than risk being called back in once home.
6. It goes without saying, that the Jeopardy resident must remain in a state acceptable for hospital work (e.g. no EtOH) and must remain able to get to NMCP within 30 minutes (traffic permitting).

## Life in the ER CONSULTS

1. Receive consults from ED: staff, resident or intern. **Caveat:** The ED intern should have talked to ED staff **before** talking to you.
2. Evaluate patients expeditiously; you never know when you'll get three more consults!
3. Maintain open communication with the ED residents and staff. If you are backed up or waiting for bed management, or otherwise delayed in dispositioning a patient, let them know.
4. Write all consults on progress note paper (SF 509) or type on accepted SF 509 Templates (or dictate).
5. See Command Policy: *Role of Consulting Services in the Emergency Medicine Department* in the Appendix section of this manual

## SENDING PATIENTS HOME

1. Call the attending on call: there must be an attending of record listed for everyone you recommend discharging home.  
IM= ward attending  
Cards= cardiology staff  
Specific= subspecialist (e.g. discuss Crohn's flare with the GI doc)
2. Document the name of the specialist in the note and **PROVIDE A COPY OF NOTE TO THE ATTENDING OF RECORD.**
3. Ensure adequate follow-up—not necessarily (but sometimes) with you, or the IMC (routine c/s only).
  - a. Having the patient's phone # may be very helpful.
  - b. For patients *not seen in our clinic* who require a one time IMC follow-up: Place an Internal Medicine consult describing the patient in CHCS and they will be called within 24-48 hours for their appt by IMC staff. State that you evaluated them in the ED. (**This is generally limited to active duty with operational PCMs**).
  - c. If arranging a walk in f/u with yourself, send an email to Ms. Sarah Montague or RN Tracy DiGennaro specifying the time, date, pt name and ss#. Include LCDR Eifert and Dr. Reed on the string so that they can track these things. Clinic admin staff will set up the appointment.
  - d. For patients *seen in our clinic*, you should call Ms. Montague to set up a specific time and physician (PCM if possible), or send the email above, or have the patient call.
4. Note time of disposition.

## THE OBSERVATION UNIT (affectionately known as "OBS")

- Started in mid 1999, but rarely available during the past 2 years due to "nursing shortages in the ED."
  - Consists of 3 beds in the ED
  - Managed by the ED.
  - Designed for use by Internal Medicine, Surgical Services, Pediatrics.
  - The goal is to save the hospital's money by holding patients in the ED for a maximum of 23 hours rather than admitting them to a ward.
1. Criteria for admission

- a. The patient must be one you would have admitted. If they can go home, send them home!
  - b. The patient must be stable.
  - c. There must be clearly defined goals for admission and discharge.
  - d. Admission must be for no longer than 23 hours. **If the patient fails to meet discharge criteria within 23 hours then they must be admitted.**
  - e. The patient must be from the ED. On occasion, if you have transferred a patient to be evaluated by you or the ED, the ED staff may allow you to utilize the OBS unit if you feel it is appropriate. **Patients that are direct admits from other facilities are not to be placed in the OBS unit.**
2. How to place a patient in the OBS unit
- a. Find out if there are OBS beds (with an OBS RN) available.
  - b. **Discuss the case with the Ward Attending.** If he/she agrees that OBS placement is appropriate, then talk with an ED Attending.
  - c. Agree on goals for admission and criteria for discharge or admission. For instance, for a case of pyelonephritis, discharge criteria would be: ability to tolerate PO, normal pulse and blood pressure. Admission criteria would be: inability to tolerate PO, abnormal vitals at 23 hours, worsening condition, etc.
  - d. Agree with the ED resident on orders. The ED resident **should** write them since the patient still belongs to the ED (but this does not really happen).
  - e. Do NOT write an H&P or RAN, unless you already have. Use your consult note and update it on the Progress Notes. Keep in mind: This is an extension of an outpatient note, NOT an inpatient admission chart. BREVITY is expected.
  - f. Sign your consult note with your name and admission pager number. Also note the name of the attending with whom you spoke.
  - g. **At the change of watch, the new on-call person is expected to reassess and write a BRIEF note.**
  - h. If the patient ultimately needs floor admission, use the regular admission protocol. The initial consult note becomes the RAN. There is no need to recall the Ward Attending if the patient is admitted.
  - i. If the patient meets discharge criteria from OBS, **again discuss this with the Ward Attending who was initially called**, then write a quick note, including followup plans if indicated, and the ED will discharge them.
3. Typical Diagnoses (across the services) and No-No's
- a. Abdominal pain of uncertain etiology, alcohol intoxication, allergic reaction, bleeding after minor surgery, mild-moderate COPD, cellulitis, mild-moderate CHF, chest pain in a LOW risk patient, croup, DVT who needs LMWH training, dehydration, envenomation, mild overdose, pyelonephritis, seizure, mild trauma.
  - b. The OBS unit is NOT for:
    - i. Holding area awaiting available in-house beds.
    - ii. ICU/SDU/telemetry overflow (Patients remain in the ED area for this, or are diverted to another facility).
    - iii. Expediting workup for patients who will be in house over 24 hours.
    - iv. Pre-op workup.
    - v. Holding patient to delay testing until a more convenient time.
    - vi. Complex patients with multiple issues. These patients should essentially be on auto-pilot. If they will require a lot of attention from the resident

over the 23 hours, they should probably be admitted. The ER resident does not have time to run a mini ward team in the ER.

4. “Bed and Tread”

Patients who need treadmill testing will be escorted by the ED nurse to the Cardiology clinic where the test will be performed by the Cardiology resident or Cardiology clinic RN.

5. **Again, do not forget to sign out the OBS patients to the next resident in the ED!**

### **CAN'T WE ALL JUST GET ALONG?**

The working relationship with the ER is one that by definition is difficult. The two departments have fundamentally different ways of approaching patients, and many conflicts arise because we expect ER docs to be internists or they expect us to be ER docs. The keys to harmonious interaction with the ER are mutual understanding and good communication. Some dynamics to be cognizant of while working in the “cube:”

1. Internists admit patients from many sources (ED, clinic, inter-hospital transfers, etc. )  
The ED is one of the avenues for admission/evaluation by an internist. Everybody gets frustrated working in the ER. In the darkest hours down in the ER, it is critical to remind yourself of why you went into medicine in the first place. You are there to take care of people – staying true to that purpose is a test of your professionalism. Fight the inevitable tendency to simple self-preservation instincts in the setting of ongoing assault by consult after consult. When you're feeling that way, take a deep breath, remember your purpose, retract your claws, and take care of people.
2. Dispositioning vs. Taking Care of People: the crux of the difference between ER and IM. Effectively taking care of groups of people requires striking a balance between these two sometimes competing objectives. You will need to learn to balance them. Your goal in the ER is to determine level of care required (home, floor, tele, SDU, ICU) and lay out a plan of care for the first 24 hours of the hospital stay.
  - a. You are not a one person ward team in the ER and you need to resist the temptation to complete the entire work up prior to admitting.
  - b. Any lab, study, or procedure which will alter immediate management decisions or determine level of care required should be done in the ER. Others can be postponed. Don't compromise the care of your patients but don't unnecessarily bog down the flow of patients.
3. Understand your role. Our job as internists is to use our reasoning skills in relentless fashion until we have fully evaluated a situation. We are the puzzle solvers and the people best prepared by training and temperament to deal with complex situations. Take pride in this skill. Don't expect that ER docs will be internists. Anticipate getting “I don't know what's going on” consults. Of course we all know that there is a spectrum of clinical competence amongst the ER residents and staff – as there is in our own department. You will get some poorly thought through consults, but that will not be the majority. The appropriate point at which the internist's job starts and the ER doc's job ends is a moving target affected by many variables. At a departmental level we have ongoing communication to define this (360 Evaluations), and on an individual effort it should be worked out in a collaborative atmosphere between you and the ER residents/staff on call.

## HOW TO ADMIT PATIENTS

### General Considerations

1. Determine the level of care and appropriate service (4H/4J/3B/SDU/CCU).
2. **Call Bed Management** at #3-1509 with the desired location.
  - a. They will ask for the Name, SSN, Age, Diagnosis, Attending of Record, and your pager #.
  - b. Tell them if your patient needs telemetry, line of sight, respiratory or other isolation, needs to be close to nursing station, etc.
    - i. All rule-out TB patients should be isolated until smears are negative.
    - ii. Other conditions requiring isolation include suspected Meningococcal meningitis and Varicella pneumonia or Varicella in an immunocompromised patient.

An essential reference on isolation procedures is: Garner, JS. Guideline for Isolation Precautions in Hospitals. *Infection control and Hospital Epidemiology*. Jan 1996: 54-80.
  - c. Let them do their job to find the bed! They will page you back when complete or with questions.
3. Call the Attending for all cardiology and SDU admissions, or with any concerns. **You do not have to call the IM ward attending for routine admissions.**
4. Write admission orders, skeleton orders at least, to speed movement out of the ER
5. Call the Intern and discuss the case with her/him; be available for questions related to management.
6. Write the RAN (you were multitasking, anyway, right?) See the section on RAN writing under the WARDS chapter.
7. Call the Senior if admitting to SDU/CCU (only the *Unit Cards* players).

### TELEMETRY

1. Available on 4H in limited quantity for primarily non-cardiac indications (e.g. TIA/mild stroke, lytes).
2. Ward 3B is generally reserved for stable cardiac patients or those patients from other services that need monitoring.
3. You only need permission from a cardiologist to admit to 3B if your IM admission will take up the last available telemetry bed.
4. **Patients who require telemetry must be escorted to 3B by an ACLS certified physician or nurse.** It would behoove you to accompany those patients that “warrant” physician escort.

### STEP-DOWN UNIT (3C)

1. Call the Attending. They will guide you...plus they have to know about it anyway.
2. Call the Senior Resident. They will also guide you ... **plus they have to know about it, anyway.**
3. Tell the appropriate ED nurse—they have to do their paperwork, give report, and get the portable monitors and O2, etc, set up.
4. Call the ward intern to come escort the patient to SDU; try to get them involved early. **Pts on a monitor must have an ACLS certified physician or nurse to watch the monitor during transport.**

5. If needed, especially if it's an Active Duty patient, fill out a SL/VSL slip (sick list/very sick list). This ensures that the patient's command and family are notified—do this even if the family is aware.
6. It is **REQUIRED** to call the SDU yourself and let the charge nurse know what your special concerns are. If they give you a hard time about putting a pt in the SDU, stick to your guns – **DO NOT SEND THE PT TO A LESSER LEVEL OF CARE**. Call the senior resident (or staff) to assist you if this becomes a problem.

### **ICU- A CLOSED SYSTEM (3D)**

1. The ED should determine whether a patient needs intensive care or not.
2. In the event that the ED attending has decided the patient needs ICU care, the ED will call the ICU resident who will admit the patient. As the IM resident, you may be called on for assistance.
3. If you are called to admit a patient and determine that they need ICU care, you should arrange with the ICU resident to turn over care to the ICU team.

### **Cardiac ICU- A RARE EVENT (also 3D)**

1. Call the SROC. They can help you determine if the patient needs ICU or just telemetry, and help with other decisions.
2. Call the cardiologist on call. **Have a plan.**
3. Call Bed Management and the ICU and inform them that a **Cardia ICU admission** is coming.
4. Tell the ED charge nurse.
5. Call the CCU intern to come pick the patient up for monitoring escort.

**Note:** the ICU team does **not** cover CCU patients even though they are located on the same ward, but it is important for them to be aware of the patient, as they will likely be the first responders if the patient becomes unstable.

### **WHEN A WARD TEAM CAPS**

1. See RRC Requirements for 24 hour admission quotas.
2. The admitting **resident** should write or dictate the H and P as well as initial admitting orders. In the progress note section of the chart put "RAN: see H and P."
3. The ward intern is still responsible for evaluating the patient – this just abates extra paperwork on busy nights.
4. If the admitting team has three interns, the extra patients can be turned over to the "off" intern the following day. If the team has two interns or other circumstances exist, the patient may be turned over to the next day's call team.
5. The COR will help with patient delegation.

### **Outside Calls and Transfers**

You will get called from many, many places during the watch. Most times the referring physician or IDC will want you to accept a patient. Occasionally, an outside physician may call for your opinion on a patient's management. Be wary of "curb-side" consults. If you have any doubt about the patient or the management ask to have the patient transferred to you (if stable). Call the Senior if you have questions.

### **Locales of Notoriety:**

- |                    |                  |                   |
|--------------------|------------------|-------------------|
| a. TriCare Clinics | e. Ships in port | i. Camp Lejeune*  |
| b. Sewell's Point  | f. Civilian ED's | j. Cherry Point*  |
| c. Boone Clinic    | g. Fort Eustis   | k. Fleet Liaison  |
| d. Oceana          | h. Langley AFB   | (* = call Senior) |

## THE TRANSFER CENTER

1. Basics
  - a. Co-located within Dispatch in the ED.
  - b. The access number being marketed is **953-NAVY (953-6289)**.
  - c. There will be 5 FTE (including Corpsmen) available to man the phone 24/7/365.
2. Plan of Action
  - a. The Communicator within the Transfer Center will be the first point of contact for all outside transfer requests for service.
  - b. The Communicator will do three things upon receipt of patient information:
    - i. Verify DOD eligibility for care.
    - ii. Verify bed status (new intranet electronic real-time bed tracking mechanism).
    - iii. Page the appropriate service for call-back to the referring physician.
3. Our Response
  - a. **The paged individual (staff or resident – division-specific) will have 10 minutes to call back the referring physician.**
  - b. Once the case is discussed between the sending and accepting physicians, the following two decisions are possible:
    - i. Agree to accept the patient – accepting physician then calls the Transfer Center back, and the Transfer Center makes transport arrangements.
    - ii. Agree to not accept the patient – non-accepting physician calls the Transfer Center back with this information, which will then be provided to both the Healthcare Business Operations Office and the Front Office the next business day.
      1. **SEND AN EMAIL (Outlook OK) to the Chief of Medicine and COR immediately. Page the COR to initiate our Chain of Command for information if anticipate problems.**
  - c. If we fail to return the call in 10 minutes, the **staff ED attending** will call the referring physician back and make the decision to accept or not (default: accept).

## TO ACCEPT OR NOT TO ACCEPT

1. NO
  - a. No beds available for current incoming patient needs (Tele, Cardiac, StepDown)- i.e., if you have patients in our ED who will need those beds. This is a primary concern with the new system and we are told that the system should account for ER census.
  - b. Not Stable for transfer
    - i. Ask the Senior's opinion if you're not sure.
    - ii. If you have not accepted a patient because they are unstable, make sure the outside physician knows that their hospital will be contacted for transfer

once the patient is stable. Do not give them full rein to do the work-up at their institution.

- c. **Not Active Duty or Tricare Prime Send the email to the Department Head and the COR**, as all AD/Prime patients at other facilities are reviewed weekly and “recaptured” if stable at that time.
  - 1. Not a TriCare beneficiary (thus not eligible for care)- will be checked for you by the Center.
    - a. You can check this by using CHCS
    - b. ADT/MRG- Hit enter until you get to the final screen that lists their enrollment/PCM.
  - 2. Patients seen in our clinics are usually eligible.
- d. **If you refuse to accept a transfer, for any reason, you must:**
  - i. **Send an outlook email to COR explaining the general circumstances (please exclude pt identifiers)**
  - ii. **Generate a new AHLTA Telcon for the patient to officially document the encounter and circumstances. Designate the Telcon for cosignature by the Chief of Medicine.**

**Caveat:** *If there are few patients on the ward teams, and a Tricare Standard or >65 year old non-Tricare Prime patient (with Medicare) who really loves NMCP, is an interesting case, etc., is presented from the TC we may accept them—but we are under no obligation at this time.*

#### 1) YES- IM WARD TEAMS

- a. The TC will find a bed.
- b. ER evaluation
  - i. **You may accept patients for “ER Evaluation” who are in other ERs if you think they may not warrant admission- at the discretion of the ER Attending.** The ED will see this patient and only consult you if appropriate. (This is a recent change; don’t abuse it.)
  - ii. You may ask to evaluate a patient in the ED transferred from another ER to determine level of care. This should not take more than 5 minutes.
  - iii. Direct Inpatient Transfers do not stop in the ED.
- c. When in doubt, transfer the patient into a **higher** level of care. By law, patients **cannot be transferred from a higher level of care at one facility to a lower level at another.** (ICU patients need to be transferred to the ICU.)

#### 2) YES- CARDIOLOGY

- a. If you accept a cardiac patient, assure yourself that the patient is stable. Patients should be free of chest pain prior to transfer. If there are any questions, call the Senior.
- b. Again, **call the Cardiology Attending**; currently, they like to know about ALL admissions/transfers.

#### 3) PROFESSIONALISM

In the same way that you are guaranteed to dislike the ER, you will resent the people who are trying to transfer patients to you. This is another test of your professionalism. Remember that you are representing our department, our hospital, and the Navy when

speaking with outside facilities. Be firm and get a good story, but be empathetic and recognize the limitations of places like Eustis and Langley. Keep in mind that you may well be on the other end of that line someday at a small Navy hospital without telemetry capability or subspecialty support. Do unto others as you would have done unto you, and beware the karmic boomerang. It will come around to get you.

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## **INPATIENT ROTATIONS**

### **Ward Medicine**

Ward months are the toughest months of residency but definitely the most rewarding in terms of the quality of hands-on learning and team-building. A major goal for the ward resident to achieve is the efficient organization of the workday for the team, being the primary teacher and manager for both interns and medical students. Experiment with different formats for running your ward team. This is your time!

### **THE FOUNDATION**

1. Each resident will do **six months of wards over the second and third years** per RRC guidelines. This includes our current Onc ward and CCU rotation.
2. There will be 4 ward teams, each consisting of an Attending, a Junior or Senior Resident, 2 to 4 Interns, and several medical students.

### **GOALS**

1. To provide comprehensive patient care.
2. To develop the resident's knowledge base of inpatient medicine.
3. To improve procedural and technical skills.
4. To enhance skills in:
  - a. Managing an inpatient team.
    - i. Prioritization and efficiency during rounds.
    - ii. Serving as teacher and role model for interns and medical students.
    - iii. Learning to work with the attending.
  - b. Developing professionalism in working relationships among colleagues.

### **ADMISSIONS- THE LATEST VERSION OF THE CALL SCHEDULE**

1. Accepting Hours are from 1800 the day prior to Call through 1800 the day of Call.
2. Long Call
  - a. Every fourth day for a 24 hour period.
  - b. Take initial turnover admissions the AM of their call day as previously described.
3. Short Call
  - a. Every fourth day on weekdays (non-holiday routine), including Fridays.
  - b. The team opposite the On Call Team (W2 if W4 is Long Call).
  - c. Take the first 2-3 patients of the day (one patient per intern) starting the AM of the Long Call team.
4. Who/How/What.
  - a. You are directly responsible for the evaluation and management of inpatients admitted to your service.

- b. Accept admissions from the admitting ED resident, staff physicians with admitting privileges, or patients transferred out of the ICU to the Internal Medicine Service.
  - c. Completely evaluate each patient and write the resident's admitting note (RAN). *The RAN should not duplicate the intern's history and physical, but should include pertinent findings and a detailed assessment and plan.* A problem list based on pathophysiologic correlates should be developed and the differential diagnosis should reflect synthesis of the database and some review of the literature.
  - d. Contact the responsible intern or student as soon as possible so that he/she may be involved in the patient's care in a timely fashion. The resident is expected to discuss the patient with the intern after the intern has seen the patient.
  - e. Review the admitting history/physical written by the intern or student within 24 hours. Co-sign and date student notes at the time of review. Review the orders written by the interns and sign the orders written by the students.
  - f. Provide timely feedback to interns and students, both positive and constructive.
5. Bouncebacks
- a. If a patient is readmitted within the 30 days of a **ward resident's** rotation, that patient is readmitted to the same team, **unless** that resident's team is post-call or the residents agree to transfer care the day after. The resident will accept the patient at the latest the next day. This allows for continuity of care by the **resident** only; i.e. patients do not bounce to interns if the ward resident has left for the next rotation.
6. Admission controversies (like 0700 admissions) should be resolved at the **ward resident** level. If there is a problem, the COR or the ward attending should be called.

## DISCHARGES

### Every patient needs adequate follow up.

1. Your Continuity Clinic
  - a. You will want to take many patients into your own clinic who have interesting or complicated problems; however, the policy and constraints of the IMC are such that we can rarely do this. Exceptions include patients that are already TCPrime to other branch clinics.
  - b. Talk to the clinic manager: LCDR Eifert, who will discuss with LCDR Reed and CAPT Cole.
  - c. After January, only those house staff who are staying the next year should accept patients into their clinics.
2. Ward Follow-up clinic – **ONLY FOR PTS WHO DO NOT HAVE THEIR OWN PCM OR WILL BE UNABLE TO SEE THEIR PCM IN A TIMELY MANNER!**
  - a. Occurs on your pre-call day, once a week (excepting Thursdays and Fridays), starting at 1300.
  - b. 15 minute appointments to *address the focused admit problem only.*
  - c. Your continuity clinic for the week will occur afterwards (usually 3 patients).
  - d. Patients should arrive by 1300.
  - e. To schedule, interns should:
    1. send a CHCS Mail message to Ms. Sarah Montague for booking with name/last 4 SSN, and date.

2. enter a CHCS consult request for IM, specifying that pt was an inpatient and needs follow-up visit
3. Resident Responsibility
    1. Interns should facilitate discharges.
    2. Exceptions include:
      - a. Resident must initiate/dictate all medical boards on active duty personnel. See the section on Boards.A
      - b. All active duty patient dispositions should be reviewed to ensure accuracy.
        - i. Remember to tell your AD patients that we can only recommend that con-leave be given; it is up to the command to approve/disapprove it.
        - ii. Have all your active duty patients report to their command upon discharge.
      - c. If an AI/SUBI (4<sup>th</sup> year medical student) cared for the patient, YOU must dictate the summary.
  4. Discharge Planning Team
    1. Comprised of social workers, floor nursing supervisors, a QA representative, and a dietician.
    2. **Meet with the residents daily from 0845-0900 for disposition/plan for individual patients.**
      - a. Be prepared to discuss all your ward patients at each meeting. Often you will only need to state that a patient doesn't need any assistance, and then go on to the next one.
      - b. Remember, nurses and staff often have a much better idea of the patients functional status/needs.

#### DAY-TO-DAY EXPECTATIONS

1. Work rounds
 

There are no hard-set rules for how work rounds should be run – it is up to each resident to determine their own style and what works best for them and their team. Here are some general guidelines:

  - a. Should be completed prior to AM Report (especially for SDU patients) and orders written in an organized, timely fashion.
  - b. During these rounds, the resident should evaluate each patient and direct patient management and treatment through the intern/student assigned to the patient.
  - c. **Bedside teaching rounds are encouraged;** limit card-flip rounds except as necessary. Bedside teaching is an often-neglected pillar of medical training. It provides opportunity for the resident to directly observe the interactions between intern/student and patient and provide a basis for feedback. Also, it allows students and interns to observe the resident as a role model for physical examination skills and patient rapport.
  - d. A regular review of X-rays, EKG's, and laboratory data should be accomplished as a team.
  - e. Frequent MAR rounds are strongly encouraged.
  - f. Again, attendance at teaching rounds and morning report and academic conferences is mandatory except during true emergencies.

## 2. Teaching Rounds

- a. **Generally occur daily from 0900-1030 (+)** and as policy are protected from unnecessary interruptions (routine pages from nursing, etc.).

## 3. Paperwork

- a. *Notes*- Write your own periodic progress notes on critically ill patients and when necessary on other patients.
- a. Review progress notes written by the intern/student to ensure accurate reflection of patient status. Only PGY-2+ residents can cosign 4<sup>th</sup> year Medical Student notes, orders, etc., and dictate discharge summaries of acting interns.
- b. *Sick/ Deaths* Pronounce patients at time of death and write death note. Ensure proper notification of family members.
- c. Ensure that interns carry out the responsibilities outlined in the intern ward notes section.
- d. "Pink Sheets" – JCAHO requirement. Be sure top portion is filled out with general treatment goals (e.g. treat cellulitis) and that bottom portion is initialled each day
- e. H&P
  - i. to be completed by intern unless intern "capped" for that call cycle. **Short forms should ONLY be used for admissions for procedures or blood transfusion, or chemotherapy lasting less than 48 hours- not for patients admitted with medical illness!** (See exception for Cardiology.)
  - ii. Should reflect appropriate age-related aspects of patient care, especially for our adolescent and geriatric patients.
    1. Adolescent patient charts should have documentation regarding patient's use of birth control, menstrual history, sexual history especially history of STD's and unprotected intercourse, smoking, drug and EtOH use, and school performance.
    2. Histories taken on geriatric patients should note immunization status, mental status, drug and EtOH use, sexual function, and tobacco use.
- f. *DNR orders* (Blue Sheets)- Are to be written by the resident and co-signed by the attending staff within 24 hours.
  - i. Progress note should be written to identify discussion/signing of DNR.
    1. Notes should reflect whether the patient's condition is reversible or irreversible, the physical condition of the patient, the patient's mental status, and the prognosis.
    2. The note should mention that the patient understands the relevant fact regarding his/her condition, whether or not a living will exists, and whether the patient's family is aware of patient's requests.
- g. *Patient transfers*- Patients to be transferred to another institution should be accompanied with a **stat narrative summary** of this hospitalization, a photocopy of the chart, and pertinent xray and laboratory results. Before transfer, document in our chart the name of the accepting physician and the condition of the patient on transfer.
- h. **Remember to date and time, stamp and sign everything!**

## OTHER POINTS

1. Communicate with the patient's primary/specialist physicians.
  - a. When a patient is admitted, check to see if they have an internist or subspecialist from this department caring for them.
  - b. If so, let them know (email)!
  - c. It is also courteous to touch base with them before discharge and discuss any issues such as results pending, and followup. Sometimes that physician can see the patient soon after discharge, so the patient doesn't need a ward follow up appointment.
  - d. Be sure that discharge summary is copied into AHLTA (unless dictated)
2. Evaluations
  - a. Promptly submit (within 5 working days) evaluations on interns and students as requested in New Innovations.
  - b. Meet with interns and medical student at midway point and at conclusion of rotation.
    - i. Substandard performance should be *promptly* discussed with the intern or student and the ward attending to attempt correction.
    - ii. Keep in mind that constructive criticism is often more valuable than non-specific praise.
3. Your day off!
  - a. The resident is to get the equivalent of one 24-hour time period every 7 days out of the hospital. Arrange with your attending a schedule at the beginning of the month. See RRC Requirements.
  - b. The attending is responsible for going to sign-outs for you, and doing work rounds with the interns. Be sure to sign out adequately to him/her so they know what to check and be aware of.
4. Ward Orientation
  - a. At the beginning of each ward month (early in the year), all of the ward residents and interns will attend a meeting held at AM Report that will to help answer common questions.
  - b. It is customary that each resident will meet with their interns at the start of their time together to go over expectations, rules, and any particular "pearls" the resident may have for successful work months.
5. Names and Ranks – It is strongly encouraged that **active duty personnel will be addressed by their title**. Specifically enlisted personnel will not be addressed as "Mr. or Ms." Officers may be addressed by this or their rank. Learn the enlisted rates.
6. Staff Problems. If there's a problem with a nurse, corpsman, lab or x-ray tech, take their name **and ask to speak to their supervisor** and allow the supervisor to handle the problem. Do not skip links in the chain of command. If you have a problem with another physician in our department or another, contact the COR.

## **Inpatient Cardiology / CCU**

### **THE FOUNDATION**

1. Each PGY-3 will complete one month of Inpatient Cardiology. This counts as an RRC “ward” month.
2. Location: Wards 3B (Progressive Care Unit) and 3D (CCU=part of the ICU)
  - a. Note that patients from **any** service can be housed in the PCU for telemetry. Either the Internal Medicine or Cardiology **consult** services may monitor surgical patients in conjunction with the surgical home team here.
  - b. Our CT Surgery department now routinely uses the PCU for pre and post CABG patients.
  - c. The ICU team does not routinely round on CCU patients in the unit.
3. The Team:
  - a. Cardiology attending - attendings change every Wednesday.
  - b. 1 senior IM resident
  - c. 1 ER resident (most months)
    - i. Rounds with team
    - ii. Takes call approx 6 times during the month
    - iii. Main responsibility is ER consultation
  - d. 3-4 interns
  - e. Cardiology NP (CDR Cliff Pyne) – helps with intern call periodically, but does not round with the team
4. The team receives new patients daily, 24-7.

### **DAY-TO-DAY EXPECTATIONS**

1. Work Rounds occur prior to AM Report and are similar in format to Ward Medicine.
  - a. Telemetry events should be reviewed before rounds by the intern.
  - b. **ECGs are obtained on arrival and every morning and must have an interpretation with stamp, date, and signature before rounds.** (Put the ECG’s in the chart in chronological order.)  
**\*\*Old ECGs** are available on the new MuseWeb on Intranet/Cardiology. The logon and password are MuseWeb and Muse!Web, respectively. \*\*
2. Teaching Rounds occur after AM Report. Be prepared to handle all non-cardiac patient decisions.
3. Paperwork and general principles are the same as for wards, except:
  - a. Short Form H/Ps may be used for low-risk cardiac patients expected to be <48 hour admits.
  - b. Document in the H/P the extent of the patient’s known CAD or ACS risk factors: If hx CABG/PCI, when? Which vessels? Acquire copies of old cath reports, echocardiograms, or other pertinent documents via patient release of info and fax from other hospitals.
  - c. Double check MARs and discharge meds; lots of changes are made in regimens.Note: don’t give SL NTG to patients with non-cardiac CP unless you note the reason.
  - d. Everyone should have a PA/LAT CXR unless unstable (then portable).
  - e. Follow-up at discharge for patients with cardiac disease/ post-procedure can be arranged by calling the cardiology clinic, usually with the attending of record that week or with whoever performed the procedure.
4. Your day off!

Generally you can arrange with the ER resident to split the weekend rounding responsibilities, allowing you each one weekend day off. Check with your attending for specifics on when to round.

## **PROCEDURES- HOW TO GET THEM DONE**

Arrange as soon as possible and observe/participate in as many as possible. This is a great time to get lines, PA catheters, etc.

Much of this work will be done by your interns.

### 1. ESTs

- a. Have the PCU Nurse or HM prepare the patient for EST in the EST room.
- b. Note the EST results in the chart and on the TDF: Which protocol duration of test, reason stopped, symptoms, BP response, EKG changes, final interpretation.
- c. Place copy of the EST summary in outpatient chart and complete EST in the inpatient chart.
- d. Make sure the cardiologist reviews the EST and signs it.

### 2. Echocardiograms

- a. For regular Echos, tube a copy of the consult to the cardiology clinic (29) and order in CHCS for department documentation.
- b. Make sure you indicate they are an inpatient and whether they will need a Stress Echo (what kind). This usually is organized by the staff/attending anyway since they proctor the stress echos.

### 3. MPIs

- a. No matter what time of day, enter a CHCS Consult for Cardiology stress test and Nuclear Medicine myocardial imaging so both beans are counted.
- b. Alert the Cardiac Nurse (usually Justine Reyes-Ford- via CHCS or pager) in charge of procedures who will perform the exercise EKG/ drug provocation part of the study.
- c. These tests are performed in Nuclear Medicine on the 1<sup>st</sup> floor.
- d. There are no MPIs done on Wednesdays. To get patients out of the house, we do stress echos if appropriate.
- e. Patients have to be NPO after midnight to avoid GI interference with the imaging.
- f. If the patient is admitted after hours the night before the test, the intern should call the nuclear medicine duty tech so that a dose of thallium/technitium can be ordered (number posted in PCU).

### 4. Catheterizations

- a. PRE-Cath
  - 1) Charts should indicate reason for catheterization, have a full and complete H&P (esp note vascular exam and rectal), labs, CXR interpretation and EKG when patient goes to the lab.
  - 2) Watch catheterization if at all possible. Consent will be done by the attending.
  - 3) Many caths are now admissions from the outpatient clinic with 23:59 hour stays if stented. They will likely have H/P from clinic.
- b. POST-Cath Groin checks occur 6 hours after: check groin for pulse, hematoma, and pulsatile mass.

## **ICU Basics**

The Resident Review Committee (RRC) requires at least 3 months of critical care experience. This involves an ICU month as an intern, as a junior and again as a senior.

1. The ICU is a “**closed**” service. In other words, if a patient on the medicine ward requires transfer to the ICU, that patient is then transferred to the ICU service; **The Medicine teams no longer follow patients in the ICU. This is also true for patients in the ICU as “SDU Overflow.”** Once the patient no longer requires ICU treatment, they are transferred back to the Medicine service. If the transfer back to Medicine occurs within the same month of transfer to the unit (while the same Medicine resident is on the team), the patient will bounce back to that team. We do care for our patients in the SDU.
2. Surgery manages their own patients in the ICU.
3. ICU Orientation will provide specifics on daily practices, which usually begin at 0800 with radiology rounds.
4. Note that ICU residents will have their own academic schedule and are not required to attend AM Report, etc.

## **ONCOLOGY WARD**

This is a new rotation which began in late 2006

### **THE FOUNDATION**

1. Each senior resident will complete 1 month on the inpatient oncology service. This counts as a “ward” month for RRC calculation.
2. This is a dedicated oncology service, managing acute oncologic issues (e.g. neutropenic fevers) and ongoing inpatient chemotherapy administrations.
3. Generally speaking the oncology team manages hematology patients only when there is a complex case (e.g. porphyria, TTP, etc.) or when the patient is followed outpatient by one of our staff hematologists.

### **Expectations**

1. The team:
  - i. Oncology attending – changes each week
  - ii. 1 Senior IM resident
  - iii. 1 IM Intern
  - iv. Ward 4J Discharge planner, Chaplain, Nurses
2. The routine
  - i. Teaching rounds begin approx 1000 each day, usually involving the entire team.
  - ii. As in the CCU, resident should be prepared to handle all non-oncologic issues involved in the patient’s care (though oncologists tend to be more “hands-on” with this than cardiologists).
  - iii. Similar to CCU, the Oncology service admits 24hrs/day, 7 days a week
  - iv. Anticipate daily teaching from the Oncology staff, and hopefully multiple opportunities for procedures (thoracenteses, paracenteses, LPs, bone marrow biopsies)
  - v. As with cardiology, arrange with intern for one weekend day off, each.

## **WHAT YOUR INTERNS SHOULD DO**

### **Daily Tasks – In General**

1. Perform and transcribe (or dictate) an admission history and physical within 24 hours of admission. This should be the most complete evaluation and should include a diagnostic impression, differential diagnosis, and initial plan of evaluation and treatment—not just a list of tasks to accomplish for the patient.
2. Formulate a problem list for each patient, which should be reviewed daily and updated.
3. Evaluate each patient daily prior to morning rounds, and in conjunction with the ward resident/ attending, formulate an appropriate plan of management
4. Write orders and daily progress notes in the patient’s chart. The problem oriented approach (SOAP note) is recommended. Daily SOAP notes should reflect the assessment/plan for each active problem. **Note: PGY-1 residents can and must co-sign MS3 notes but not MS4 notes. The PGY-2 or –3 resident must co-sign MS4 notes.**
5. Complete the transdisciplinary form at the time of the patient’s discharge and complete the discharge summary. This is particularly important as the end of rotation approaches. *Delinquent charts (>30 days) are a category I JCAHO violation. Thus, the delinquent list is sent directly to the Deputy Commander, and could result in being removed from clinical duties, leave withheld or other consequences, until the chart is dictated or otherwise completed. If they don’t do it, you will.*
6. Write an off-service note or dictate an interim summary at the end of the rotation to ease the transition of the oncoming team as they get to know their patients.
7. Attend all medical conferences (with you).

### **HISTORY AND PHYSICAL SPECIFICS (to ensure they happen)**

1. Sign, date, and time each side of paper written on, whether or not it has a block for your signature.
2. Include the vital signs on the physical (include height/weight).
3. **Rectal, breast, and bimanual pelvic exams are not to be “deferred,” if they are clinically indicated.** Patients may refuse and this should be noted on the H and P. Only one member of the team needs to perform this exam.
4. Ask about screening and immunizations.
5. Be sure to include an impression of the active problems and an initial diagnostic and/or therapeutic plan.
6. Do not leave blanks. For instance, do not leave empty stick figures for hemograms or chemistries or “CXR”, in anticipation of completing at a later date. Two problems arise with this widespread practice. First, more often than not, the blanks remain and the note is obviously incomplete. Second, if the blanks are filled at a later date, the impression and plan which was formulated without all of the apparently available information may be nonsensical. For example if you leave the CXR: blank and later you note pneumonia, your plan may well not reflect this problem. It then appears that either you do not care or do not know that it is worthy of comment. It is entirely correct to note that tests results are pending, “CXR: pending”, as long as you later in a subsequent note, record the results.
7. Be careful of overuse of “cut and paste” labs and studies. Though arguably a time saver, this practice may increase the likelihood of overlooking important data.

### **ORDERS**

1. Should identify the responsible physicians (attending/resident/intern) by name, position, and pager.

2. Interns may **not** countersign medical students orders. This is command policy. **Read what you are signing.** Students should be allowed to write orders ONLY to become more familiar with dosing, abbreviations, etc. This is obviously a learning process, and in no way should be used to “save time” for the team, since the PGY-1 resident must be present when the orders are written.
3. Verbal orders are to be kept at a minimum. They are not for convenience, but only when it is impossible to be physically present. Additionally, verbal orders are taken at the discretion of the nursing staff.

## **CHARTING**

1. No blanks.
2. Remember that the patient’s charts are legal documents. “Chart wars” are inappropriate.
3. Sign and date every entry
4. Document everything. Remember the adage “if it isn’t documented, it didn’t happen.”
5. Be on the lookout for BANNED ABBREVIATIONS – it is the resident’s responsibility to remind the interns about this and ensure that banned abbreviations stay out of the charts.

## **Changing Tides and Efficiency Theory**

The academic and pragmatic practice of inpatient medicine has changed dramatically in the past decade.

- Extended home health services and rising inpatient costs have *reduced length of stay*.
- More aggressive outpatient management means the patients admitted are often “sicker” or *more severely ill*.
- Computer availability and the push toward a more electronic medical record has allowed printed lab data and especially *handwritten lab flow sheets to be eliminated* from medical record requirements.
- Patient safety issues and the push toward EMR *discourages handwritten orders and notes* because of the variability in legibility and potential for error.
- The work hours restrictions has *reduced the time of work rounds* and teaching rounds, since less time is available to do the same amount of work.
- The increased pressure of time restrictions has forced corner cutting in many aspects of daily inpatient work, and there has been suboptimal guidance as to how to manage time and data.

**Consequences** of all these factors:

- Work rounds are not as productive because data hasn’t been gathered, so disposition and management decisions are deferred, delaying patient care or discharge.
- Intern physical exam findings are not verified during work rounds by residents.
- Trends in labs or abnormalities unrelated to the primary reason for hospitalization are missed.
- Opportunities for honing time and team management are missed.
- Presentation skills which are important to medical decision-making are not being honed.
- Implicit expectations were lost as emphasis shifted from primarily patient care and education to patient care and education plus work hours.

Given all of the above, the following have been developed as expectations for ward residents. These expectations are intended to help hone your time management and team management skills. Because everyone has different styles of managing and of learning, some may find these expectations concrete or rigid.

- You should see most patients every single day, and if possible see with the intern. You cannot rely on intern physical exam findings and assessments.
- You should be able to rely on interns reporting other items of a “SOAP” presentation, such as vitals, I/O’s, labs, etc. You must expect organized presentations from interns and provide feedback to improve them.
- You should be able to plan for the different days (on call, short call, etc.) and adjust schedules accordingly. If on long call, the “old patients” should be examined, discussed and a plan made as early as possible so that you can spend your time on the new incoming patients. One example of a skill that should be “carried over” from last generation is “work rounds management”—teams were through rounding (which included the whole team briefly at the bedside of nearly every patient) by the time morning report started, whether they had 6 patients or 16 patients—residents expected the interns to provide succinct presentations but still have any data available, and the resident would usually examine just one or a few things at bedside (check margins if cellulitis, lungs/ankles if CHF, palpate abdomen if pancreatitis), and then discuss the plan and move on. If a patient was not seen by the resident on work rounds, the resident would still see the patient at some point that day, providing an opportunity to check what the intern has told the patient or what the patient understands about their care.
- You should have a system to have everything you need to know about a patient at your fingertips. At first you’ll need a lot of space because you’ll record everything, but with experience you’ll determine when you need the nit-pickiest of data and when you don’t. Examples of nitpicky data include: CHF patient who got Lasix (what time, what dose/route, and how much urine output?); septic patients (when bld cx was drawn, results, when antibiotics were started or changed, what day of therapy it is), uncontrolled diabetic patients (when did the change in sliding scale start, what were the glucose readings), pain patients (when was the incremental dose changed on the PCA, total dose for 24hours, last BM) All of this type of data can and should be kept on one card or one sheet of paper, so trends can be tracked and you don’t have to search multiple papers for data. Interns should know this for their own patients; you must know for all.

## **GERIATRICS AT LAKE TAYLOR (WITH EVMS)**

### **Basics**

Location: Lake Taylor Transitional Care Hospital, Norfolk, VA (near Military Highway)

### **Expectations**

1. This is a multi-tiered medical rehabilitation facility that includes 2 floors of “Sub-acute” care patients, including several on long-term mechanical ventilation, and 3 wards of rehab patients. We serve as part of a Geriatrics team from EVMS, led by their geriatric attendings and fellows.
2. The team includes an attending, you, and usually another resident and one or two students from EVMS. You will do the work of intern and resident.
3. Your hours are generally from 0800 to 1700 (subject to variation) Monday to Friday. The morning will be team rounding and the afternoons include visits to other assisted living facilities, didactics at EVMS (one afternoon each week), or further work at Lake Taylor, including longterm care “recerts,” admitting new patients and completing discharge paperwork.

4. Each resident will be expected to carry the service's pager for 1-2 weeks (home call – telephone responses only – we do not go in – if they're that sick, then have the nurse send the pt to the ER).. NMCP call will be limited to a rare Friday PM, if at all.
5. Leave during this rotation is preferably avoided, though is negotiable in cases of need to travel for interviews, househunting, etc.; please ask at least a month in advance.
6. Residents are required to round with the attending 2 of the 4 weekends.
7. The contact is Ms. Madeline Dunstan, the Education Coordinator for EVMS Geriatric's Glennan Center: 889-5432. The staff physician contact is Dr. Marissa Galicia-Castillo.

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## PATIENT SAFETY

Medical error is a multifactorial issue for which physicians carry a significant responsibility. The following document is a required part of ward orientation.

### **Introduction**

It is estimated that from 44,000 to 180,000 patients die per year in the U.S. from medical errors, many of which are preventable. Physicians receive little if any training in the area of error prevention. "Process Improvement" & "Quality Management" were avoided by physicians because the work seemed tedious and unfulfilling. Lack of clinician participation has slowed the reduction in medical errors. Our system depends on your ability to recognize patient safety issues.

### **Objectives**

1. To provide a framework to understand the important contributions, positive and negative, you make toward the safety of patients.
2. To provide some basic tools to minimize error.
3. To inform you of systems to assess and prevent errors.

### **Medical Errors**

Errors in patient care can be defined as *the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim*. Why use such a generic definition? This terminology is used to keep the following important points in mind:

- Most errors are multifactorial.
- Most errors can be traced to a problem with a system, not an individual.
- Personalizing/individualizing errors displaces focus, encourages blaming and suppresses discussion.

Prevent errors by applying two essential concepts:

Write orders conscientiously. Ensure it is the right:

- 1. patient      2. medication      3. dosage      4. time      5. route**

This may seem simple but nationwide the majority of house staff errors involve one of the 5 "rights".

**Use your team effectively.** They will have valuable input into the reality of the patient's care. Your team members are:

### *Nurse*

- Know who your patient's nurses are.
- Make sure you are discussing the same patient; they care for multiple patients, too.
- Let them know what is planned.

### *Pharmacist*

- Write legibly, with approved abbreviations, i.e. no JCAHO banned abbreviations.

### *Discharge Planners*

- Communicate early.

### *Patient*

- Communicate issues and changes in language they can understand.
- Elicit concerns.
- Involve them in decision making.

## **Dealing with Errors**

“To Err is Human”. *Error is inevitable*. Physicians don't handle errors well because the stakes are high. Physicians tend to see error as a black mark on their performance and if the error is a near-miss may avoid reporting it. These types of errors are likely to recur because the system that allowed them isn't getting feedback to “fix holes in the safety net”. There are two processes you need to be aware of for helping to reduce error in our hospital:

### **1 – Quality of Care Review (QCR)**

This is our early warning system to identify areas with potential for error or suboptimal patient care. They can be initiated by anyone involved with the process and routed by chain of command to the Healthcare Excellence Office. See the QCR form for which types of issues require QCRs.

#### Guidelines for completing a QCR:

1. Tell the attending.
2. Provide facts and information.
3. Avoid speculation, assumptions or assigning blame.
4. Do not put in the medical record or write about it in the record. The QCR is exempt from disclosure with only specific legal exceptions. Do not make copies.
5. Route to the Risk Management Coordinator within 24 hours of the discovery of the event.

### **2 – Sentinel Event**

This is a Joint Commission for the Accreditation of Healthcare Organizations (JCAHO)-defined term and JCAHO regulated process. This process is initiated for an “unexpected occurrence involving death or serious physical or psychological injury, or risk thereof”. If the patient dies or has a permanent loss of function or is a specific JCAHO defined event (e.g. hemolytic transfusion reaction, surgery on wrong body part) the event is reported to JCAHO.

Virtually every step of every process in medical care has potential for error. While we must not halt patient care to over-scrutinize every step, it is our responsibility as physicians to be vigilant, attentive, thoughtful, and deliberate in the processes of care that we work in.

*Start out with the conviction that absolute truth is hard to reach in matters relating to our fellow creatures, healthy or diseased, that slips in observation are inevitable even with the best trained faculties, that errors in judgment must occur in the practice of an art which consists largely in balancing probabilities—start, I say, with*

*this attitude of mind...You will draw from your errors the very lessons which may enable you to avoid their repetition.*

*-William Osler, 1892*

*NOV 2002. Patient Safety Document for GMEC. Direct feedback to: L.S. Inouye, MD MPH, FACP, Internal Medicine*

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## **RRC REQUIREMENTS, as of July 2003**

Message from the Program Director on RRC admission and work hour restrictions:

The passages below are taken directly from the Internal Medicine RRC.

Read them carefully, as you must be very familiar with them.

### **INPATIENT ADMISSION / ROTATION TEAM STATS**

1. A first-year resident must not be assigned more than *five new patients per admitting day*; an additional two patients may be assigned if they are in-house transfers from the medical services.
2. A first-year resident must not be assigned more than **eight** new patients in a 48-hour period.
3. A first-year resident must not be responsible for the *ongoing care of more than 12 patients*.
4. The program must demonstrate a minimum of 210 admissions per year to the medical teaching services for each first-year resident.
5. When supervising more than one first-year resident, the supervising resident must not be responsible for the supervision or admission of *more than 10 new patients and 4 transfer patients per admitting day or more than 16 new patients in a 48-hour period*.
6. When supervising one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 16 patients.
7. When supervising more than one first-year resident, the supervising resident must not be responsible for the ongoing care of *more than 24 patients*.
8. There must be a resident on-call schedule and detailed check-out and check-in procedures, so residents will learn to work in teams and effectively transmit necessary clinical information to ensure safe and proper care of patients.
9. The on-call system must include a plan for backup to ensure that patient care is not jeopardized during or following assigned periods of duty.

### **DUTY HOURS**

1. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
2. Duty hours must be limited to **80 hours per week**, averaged over a four week period, inclusive of all in-house call activities.
3. Residents must be provided with **1 day in 7 free** from all educational and clinical responsibilities, averaged over a four week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
4. Adequate time for rest and personal activities must be provided. This should consist of a **10-hour time period provided between all daily duty periods**, and after in-house call.

### **ON CALL**

1. The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24 hour period. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

2. In-house call must occur no more frequently than **every third night**.
3. Continuous on-site duty, including in-house call, must not exceed **24 consecutive hours**. Residents may remain on duty for **up to 6 additional hours** to participate in didactic activities, transfer care of patients, conduct outpatient continuity clinics and maintain continuity of medical and surgical care.
4. No new patients may be accepted after 24 continuous hours on duty. A new patient is defined as any patient for whom the resident has not previously provided care.
5. At-home call (pager call) is defined as call taken from outside the assigned institution. (Wishful thinking...we are Internal Medicine and will probably not adopt at home call any time soon.)
  - a. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
  - b. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
  - c. The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

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## MISCELLANEOUS POLICIES

### **DUE PROCESS**

1. If you feel you have been treated unfairly...in an evaluation or probationary situation, there are clear mechanisms for due process available. For details, see the *Internal Medicine Residency Policy and Procedures Manual*.
2. **The chain of command should be used unless it interferes with due process**; that chain is: COR, Chair Clinical Competency Committee, Program Director, Director of Medical Education.

### **THE IMPAIRED RESIDENT**

1. Definition. An impaired physician is one who cannot practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair the ability to practice.
2. If you are concerned about a colleague...**you are required to report this** to your program director or the Chief of Medicine.
3. If you are concerned about yourself...be aware that your program director will not report you to a formal board if you enter treatment voluntarily. Help is available! For further details, see the Internal Medicine Residency Policy and Procedures Manual.

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## LICENSURE

1. A state license is required to practice as a GMO or to be a resident. You must comply with all regulations by the State Board of Medicine of the State where your license is issued, and while practicing in the state of Virginia there may be state-specific requirements.
2. One important requirement is to **AVOID** prescribing controlled substances to family members. This is not a Virginia law, but it **IS** a Navy law. This includes **ALL** schedules, from schedule I to even schedule IV (Lomotil). There is a board at NMCP that oversees all CHCS prescriptions, and they will discover any family prescriptions that are not allowed. You will usually get one warning, though further transgressions will result in full charges brought.

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## TAKING LEAVE For the Good of the Navy

### REGULAR LEAVE

1. *How Much Can I take?*

Interns are allowed 14 days. PGY-2/3 Residents are allowed up to 21 days of leave per year.

2. *When?*

Only in special circumstances can you take leave during a ward month, DAR, NAR, CCU, and ICU. Depending on timing, circumstances, there is a possibility your leave will not be granted. So if you are planning a big trip, please schedule it well in advance with the COR and your attending. **No more than ten consecutive days of leave will be approved without special agreement with the COR. You must complete at least 15 days on the rotation for that rotation to count towards graduation.** Abbreviated rotations are approved on a case by case basis by the program director.

3. *How?*

To take leave, you must:

- a. Complete a leave chit and sign it.
- b. Have your surrogate designated on the leave chit.
- c. Turn in the leave request early enough so that the call and clinic schedules can be adjusted appropriately.
- d. Have it signed and approved by the attending of whatever service you will be on.
- e. Have the COR and IM Clinic coordinator (Dr. Reed) sign the chit, which will then be routed up the chain.
- f. Turn in your leave papers at the end of your leave.

4. The COR will attempt to make your schedule at the beginning of the year in order to accommodate known dates when you will require leave. In the event of wanting non-emergency leave during a month in which leave is not generally permitted (as above) **you will need to work out your own coverage.** Those cases will be adjudicated on a case by case basis, but do not expect the COR to arrange coverage for you.

5. A Surrogate is a Must! This person will answer all of your telephone consults and review any of your patients' lab results while you are away. Your surrogate is responsible to answer these consults and address the labs as if they were his own patients.

## **MATERNITY/PATERNITY LEAVE**

This will be on a case-by-case basis, but in general, maternity leave consists of 6 weeks after the baby is born. Any special needs pre-delivery will be dealt with as needed. Paternity leave usually consists of one week, again, done on a case-by-case basis, and is considered *regular leave*.

## **TAD (Temporary Additional Duty)**

This occurs when you are on assignment either as a representative of the command or completing a “mission” for the command. For residents, WHC and any government sponsored travel to a conference (for example, ACP) requires TAD paperwork to be completed. Forms are available through Ms. Shipley. Please complete this paperwork at least one month prior to your departure so that your itinerary and orders can be processed.

**If you are flying to some place on TAD orders, do NOT buy your own airline ticket. The government travel office will make all of the arrangements for you based on your requested dates from the TAD paperwork.**

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## **TECHNOLOGY**

### **DIGITAL RADIOLOGY (Synapse)**

Radiology has now become totally digital, and very rarely prints any films. All studies, from basic CXRs to MRI can be viewed via the Synapse system either on dedicated monitors or via the Synapse program installed on most hospital computers. For login information and passwords contact the PACS administrator at 31162.

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## **DICTATIONS / REPORTS**

All dictations are on the **SoftMed** (VoiceScript) system

This includes radiology reports, H/P completed by interns and residents, as well as medical boards. Our STAT in house transfer summaries also utilize this system, and are routed via the identifier you use to tag the study.

**There is one Access Number: 953-9211**

### **LOGGING-ON**

1. Call above number.
2. “Welcome to VoiceScript. Enter User ID.”  
(This is provided for you at <http://intranet.mar.med.navy.mil/issw/systems/softmed.asp>)  
Enter your number and press the # Key.
3. “To Dictate...Press 1.”(Obviously to dictate, use this one and proceed.)  
“Held Jobs...Press 2.”

- “Main Menu...Press 0.” (Use this for Radiology Reports.)
- 4. “To Dictate ...again”  
“To Review...Press 2.” (Radiology Reports)
- 5. “To Search for a Job...Press 1” (Radiology)
- 6. Enter 11 digit patient ID and press #.
- 7. **Key= For “work type”, hit the # button again to play the report.**
- 8. To go to next study, enter #01.

Please see the guidance from SoftMed for further questions:

[https://intranet.mar.med.navy.mil/issw/docs/SOFTMED\\_LISTEN\\_LINE.doc](https://intranet.mar.med.navy.mil/issw/docs/SOFTMED_LISTEN_LINE.doc)

**\*\*If you need a priority transcription of a study that is on the listen line, please call Transcription at 953-1177 and the transcribers will facilitate this.\*\***

#### TEMPLATE

1. Your complete name
2. The type of report
3. The facility you are dictating from= NMCP
4. The Patient’s full name - Please spell
5. The Patient’s full Social Security Number
6. The Patient’s Date of Birth

For Example: “This is Dr. Sam Brown, that’s spelled S-A-M B-R-O-W-N, L-T, M-C, U-S-N-R from NMC Portsmouth dictating a Discharge Summary on Wieslawski, Stanley, that’s spelled W-I-E-S-L-A-W-S-K-I, first name S-T-A-N-L-E-Y. His Social Security Number is 1-2-3 dash 4-5 dash 6-7-8-9. His Date of Birth is 0-6 dash 1-1 dash 2-6...”

7. Hospital Register Number
8. Status (AD, Retired, Dependent and Service)
8. Attending/ Resident
9. Ward
10. The Patient’s Date of Admission, Surgery, etc..
11. The Patient’s Date of Discharge (if applicable)
12. Date of Dictation
13. Admission Diagnosis
14. HPI
15. PMH/ROS
16. PE, including Vitals
17. Labs
18. Hospital Course
19. Procedures with Dates
20. Discharge Diagnoses

21. Condition at Discharge
22. Instructions to Patient (Meds, Activity, Diet, Follow-up)
23. Disposition (Home, Duty, Medical Board, Limited Duty, Morgue/Death, Transfer)
24. Dictated by.... (NAME, RANK, MC, USN/USNR).
25. Approved by.... (NAME, RANK, MC, USN/USNR), Attending Physician.
26. Please send a copy to ... (Primary Care Physician) located at...

Death summaries are dictated in a similar format.

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## MEDICAL BOARDS

Medical boards serve to report upon the present state of health of any member of the Armed Forces and as an administrative board by which the convening authority or higher authority obtains a considered clinical opinion regarding the physical status of service personnel. Members do not have a right to demand a medical board since their need is determined by the medical officer or higher authority, generally under the conditions outlined below.

### REFERENCES

1. Chapter 18 - Manual of the Medical Department (MANMED) **\*\*UPDATED 2004-2005\*\***
2. Disability Evaluation Manual
3. Secretary of the Navy Instruction 1850.3

**Questions and Help - Supervisor, Medical Board Section (Ext. 5576) = Ms. Mitchell**

### WHEN YOU SHOULD REFER A CASE TO A MEDICAL BOARD

1. A medical board is required whenever a medical recommendation includes assignment limitations, when separation from the Naval Service is recommended for medical reasons, or when a report is requested by higher authority. In addition, a medical board should be written to document any condition which may affect an officer's opportunity for promotion. A medical board is mandatory in the following situations:
  - a. When a member is temporarily unable to perform full duty but return to full duty is anticipated and it is desired to follow the patient for a short period of time before final disposition is made, i.e., "limited duty."
  - b. When a member refuses reasonable medical, dental, or surgical treatment and the member's ability to perform full duty is suspect.
  - c. When a member's condition requires referral to the Physical Evaluation Board (PEB) for a determination of fitness for duty.
  - d. When continued military service would probably result in an inordinate amount of hospitalization or other close medical supervision; or would be likely to aggravate the existing condition.
  - e. When a member's condition includes the presence of mental incompetence or incapability to manage personal or financial affairs.
  - f. When a member's condition is such as to require permanent assignment limitations; i.e., specific geographic assignment, etc.

g. When in the opinion of the cognizant medical officer a service member has suffered from a significant illness or injury which may impact on future service, even though the member may now appear to be fit for full duty.

h. And, when a member of the Naval Reserve or Marine Corps Reserve contracts disease or becomes ill in line of duty while on active duty or performing inactive duty training specified as 30 days or less, if the member requires hospitalization, transportation, and subsistence which may extend beyond 10 weeks after the member is released from active duty.

(1) In the case of such reservists, limited duty is not an option.

(2) Inactive reservists who have achieved the maximum benefit of immediate active medical care, but require an additional period of rehabilitation or observation to determine the extent of recovery or who may require additional treatment at a later time, will be so identified in the narrative summary of the report. Also include in the board report the medically recommended period of rehabilitation or observation, or estimated date of future additional care.

2. Further guidance concerning various categories of cases where referral to a medical board may be appropriate, or is required are outlined in Articles 18-12 through 18-20 of the Manual of the Medical Department.

#### **FITNESS FOR DUTY AND CRITERIA FOR RETENTION ON ACTIVE DUTY**

1. The Navy Department's retention criteria and determination of fitness for active duty is that a member is unfit because of physical disability when he is unable because of disease or injury to perform the duties of his grade, rank, or rating. The fact that a member is about to retire and has a physical disability does not entitle the member to a medical board and disability retirement. Again the overriding factor is whether the disability renders the member incapable of performing his/her duties. Members may make application to the Veterans Administration for disability benefits for service-incurred disabilities which do not render them unfit for duty after retirement or separation.

2. The fact that a member did not meet enlistment, appointment or commissioning standards upon entry into the service has no bearing on the determination of fitness for duty. Once a member has entered the service, physical disability and fitness for duty is determined by his/her ability or inability to perform the duties of his/her rank, grade, or rating.

3. In regard to fitness for duty, it is very important that the medical board clearly indicate the patient's current status, prognosis, and a description of impairment of duty. Do not assume that a diagnosis unsupported by a clear history of impairment of duty will always be sufficient to justify a recommendation of unfitness. Certain conditions (seizure disorder, insulin dependent diabetes, etc.) need little justification; however, other conditions are less obviously unfitting.

4. In determining unfitness, it must also be kept in mind that all Navy personnel must be fit to serve aboard ships. The deck of a ship is an unstable platform with many ladders to be negotiated. In addition, members are deployed for long periods of time, many times without medical supervision. A member may be fit for duty ashore; however, if he is permanently unfit for duty at sea the member is unfit for duty.

## TYPES OF MEDICAL BOARDS

### 1. Limited Duty (LIMDU) Board **\*\*\*NOW FOR TWO 6 MONTH TERMS ONLY\*\*\***

a. Used to restrict or change an individual's duty assignments or duty station for a period of time. Must be done for a minimum/maximum of six months. There should be reasonable expectation that the member will be fit for full duty (FFFD) upon completion of the period of limited duty. If it is not anticipated that the member will be FFFD, the case should be referred to the Physical Evaluation Board.

b. A member placed on limited duty must be re-evaluated two months prior to expiration of the limited duty period. (The Naval Military Personnel Command establishes a Projected Rotation Date "PRD" when ordering personnel to limited duty, with the expectation that all treatment and evaluation will have been completed and the member rendered FFFD worldwide or recommended for further limited duty or separation by expiration of the PRD.) In the case of enlisted members, a first period of 6 months limited duty is approved by the hospital Commanding Officer without reference to higher authority.

c. At re-evaluation following an initial 6 months of limited duty, you may extend limited duty up to an additional 6 months validating the original diagnosis, documenting progress of the condition, establishing the date (month) of expected return to full duty, and prescribing specific limitations and the plan for further therapy, while again completing the 6100/5. Remember, this is for a total of 12 months. 3<sup>RD</sup> periods require PEB dictation if condition is the same as for 1st and/or 2<sup>nd</sup> periods; if a different condition, then an abbreviated form may be used. **The member must be directed to report to Medical Boards for administrative processing.**

d. The form required for both terms of LIMDU is the "Abbreviated Medical Evaluation Board Report" (NAVMED 6100/5) found on the intranet at *E-forms central* <https://webapps.mar.med.navy.mil/forms/> . You can also access them individually via these links:

6100/5:

[https://webapps.mar.med.navy.mil/userdata/forms/pdfs/6100\\_5.pdf](https://webapps.mar.med.navy.mil/userdata/forms/pdfs/6100_5.pdf)

6100/6:

[https://webapps.mar.med.navy.mil/userdata/forms/pdfs/6100\\_6.pdf](https://webapps.mar.med.navy.mil/userdata/forms/pdfs/6100_6.pdf)

You can fill these out electronically via the computer or print them and hand write.

**In other words, dictation is not required for the first 12 months of LIMDU for Navy and Marine Corps enlisted OR officers; All Coast Guard, Army, Air Force and National Guard boards (LIMDU or PEB) must still be dictated.**

e. To return any member to full duty, a "Return of a Patient to Medically Unrestricted Duty from Limited Duty" form (NAVMED 6100/6) must be used and a Health Record entry (SF-600) is made. **This is a new requirement.** Members have no procedural right to rebut return to full duty.

f. A complete board must be dictated in all other cases.

## **2. EPTE (Existed Prior to Entry) Discharge Medical Board**

a. Used whenever a member is determined to be unfit to perform the duties of his grade, rate, or rating and the disability is considered to have existed prior to his entrance on active duty, and not to have been aggravated while on active duty. Enlisted members may be discharged from the service if the member agrees and waives his right to a hearing before the Physical Evaluation Board. If the member does not waive rights or if the member has three or more years continuous active service, the board must be referred to the Physical Evaluation Board via Commander, Naval Medical Command, for final determination.

NOTE: Members who are considered unfit due to an EPTE non-aggravated physical disability should not be offered surgical correction unless the member enlisted under the Medical Remedial Defect Program. If the member waives his right to a hearing before the PEB, the medical board may be approved by the Commanding Officer and discharge effected.

b. In considering whether a condition is aggravated by service for PEB cases and EPTE physical disabilities, a disease or injury which clearly had its inception prior to service will be considered aggravated when the disability undergoes an increase in severity during the service unless the increase in severity is clearly shown to have been due to the natural progress of the disease or injury based on accepted medical principles.

## **3. Permanent Limited Duty Medical Board - (Limited duty to complete 20 years service, an L-5 Board)**

a. Used for members who have 16 or more years continuous active duty who are considered to be permanently unfit for full duty but who are fit to perform limited duty.

b. A permanent limited duty board should only be done when the member has a physical disability which renders him permanently unfit to perform his duties. (If the member is only temporarily unfit for full duty a six month limited duty board should be done.)

c. This type of board requires Naval Medical Command and Naval Military Personnel Command/CMC approval.

## **4. Medical Board for Referral to the Physical Evaluation Board**

a. The Physical Evaluation Board is located in Arlington, Virginia, and serves to determine a member's fitness for duty and in case of disability, the percentage disability provided. A medical board for referral to the PEB is used for members who in the opinion of the clinician are permanently unfit for further active duty due to disabilities incurred on or aggravated while on active duty. A medical board for referral to the PEB should be done **as soon as it is determined:**

- 1) that a member will not be fit for full duty within a reasonable period of time.
- 2) that the member has a condition which is expected to render him unfit in the near future.
- 3) that the member will require an inordinate amount of hospitalization or close medical supervision.
- 4) or when continued military service would be likely to aggravate the existing condition.

b. It is mandatory in PEB cases that all conditions and abnormalities be recorded in the medical board. Once the patient has been found unfit by the PEB, all physical disabilities are ratable for compensation purposes. In addition, it is likely the medical board report will be used in lieu of a separation physical exam and should therefore cover all appropriate key areas, including annual screening.

### **OUTPATIENT MEDICAL BOARDS**

It is not necessary to admit a patient to accomplish a medical board. All of the various boards outlined above may be accomplished on an outpatient basis. If an outpatient board is to be accomplished, the following procedures must be followed:

1. Send the patient to the **Medical Board Branch**, Patient Administration Department, with a completed NAVHOSP Form 61 IO/ 1, Notification of Outpatient Medical Board, stating that an outpatient medical board is being accomplished.
  - a. The Medical Board Branch will advise the patient's command that a medical board is being accomplished and will effect transfer from shipboard duty if necessary.
  - b. The medical board is to be dictated at the time it is determined to be required. Under no circumstance should the patient be allowed to bypass check-out via the Medical Board Branch as doing so will ensure the patient is unknown to them and administratively lost.

### **DO'S AND DON'T'S IN DICTATING BOARDS**

1. Do not place a member on limited duty unless there is a reasonable expectation that the member will be fit for full duty at the end of limited duty.
2. Do not place a member on limited duty if the member is on shore duty unless there is a need to change his/her assignment to prevent assignment to sea.
3. Do not place a member on limited duty for minor conditions that requires follow-up outpatient treatment unless the condition renders the member unfit.
4. Do not place a member on limited duty to completed 20 years service unless the member is permanently unfit for duty and has completed 16 years of service.
5. Do not place a member on limited duty if the member is permanently unfit, will require extensive further medical treatment or further service will likely aggravate the condition. These cases should be referred to PEB.
6. Do not allow the desires of the patient to affect the proper medical board disposition. A patient with cancer which has metastasized is unfit and should be referred to the PEB.
7. Do not state affirmatively that the-member is unfit. State, "It is the opinion of the medical board that the member's medical condition interferes with the reasonable performance of assigned duties, and on that basis is referred to the Physical Evaluation Board for fitness for duty determination." It is the role of the Physical Evaluation Board to determine fitness.
8. Include all physical disabilities in the board especially if being referred to the PEB.
9. Make a definite statement after each diagnosis whether the condition DNEPTE (did not exist prior to enlistment); EPTE, Service Aggravated; or EPTE, Not Service Aggravated.
10. Include limitations (physical or geographical) in the board for patients being placed on limited duty.
11. Medical boards going to the Physical Evaluation Board (PEB) must be completed and accepted by the PEB 30 days from dictation.

## **SAMPLE MEDICAL BOARD FORMAT**

It is suggested that this format be used in dictating medical boards:

### Introduction for Medical Board on an Inpatient

This \_\_\_\_\_ year old (fe)male, (rank)/(service), was admitted to the Naval Medical Center, Portsmouth, Virginia on (date) with the diagnoses of \_\_\_\_\_.

OR

This \_\_\_\_\_ year old (fe)male, (rank)/(service), was admitted to the sick list at (name of facility) on (date) with the diagnosis(es) of \_\_\_\_\_. He was subsequently transferred to the Naval Medical Center, Portsmouth, Virginia and admitted on (date) for further treatment, evaluation and disposition.

### Introduction for Medical Board on Outpatient

This \_\_\_\_\_ year old (fe)male, (rank)/(service), was seen as an outpatient at the Naval Medical Center, Portsmouth, Virginia for evaluation of/with complaints of \_\_\_\_\_.

### Introduction for Re-Evaluation Boards

Wording should be the same as described above concerning the particular cases, i.e. inpatient/outpatient. State that this is a re-evaluation. Invite attention to previous medical boards. **It is not necessary to repeat the contents of any previous boards.** Attention may not be invited to a Narrative Summary of a previous hospitalization; it must be summarized for inclusion in the present board, if pertinent.

### Present Illness

All pertinent data concerning each complaint, symptom, disease, injury, or disability presented by the member which causes or is alleged to cause impairment of health should be noted to include pertinent, concise, and chronological history with pertinent negatives. Specify the extent to which the symptoms disable the patient, i.e. angina after running five miles, climbing one flight of stairs, or walking across room. Remember illness causes symptoms that cause disability, and the purpose of the medical board is to document clinical evaluation of ability to perform active duty.

### Past History, Family History and Review of Systems

Present only significant facts. If non-contributory to findings of medical board, so state. Such findings may be significant, however, if the board establishes more than one diagnosis, e.g. primary diagnosis may be Arteriosclerotic Heart Diseases with Myocardial Infarction, but, ROS revealed history of arthritic symptoms that also produce a significant disability. The medical board should include history of all physical disabilities which are ratable for compensation purposes. Even if referral to the PEB is not planned, such conditions should be noted even if not

specifically evaluated. Minor conditions, present for years without impairment of performance of duty, may be ratable once a finding of unfitness is made. Family history may be significant if diagnosis of board is only poorly supported by objective evidence.

### Physical Examination

Comment on vital signs - either say they are normal, or if abnormal record them. At minimum you should also include a neurological exam, exam of heart and lungs, check for hernia and of testes in males, also pelvic exam and PAP for females. If patient is obese, record weight and height. If patient is diabetic, record weight and height. If a patient shows evidence of hypertension, even if by history, record blood pressure. Give only pertinent negative and all positive findings. You should say, "results of physical examination were unremarkable except as noted in the medical board." or "within normal limits with the following exceptions". Describe range of motion of all significant body locations. Give specific description of any defects, deformities or abnormalities, i.e. cuts, abrasions, scars, etc.

### Laboratory Studies and Radiological Findings

Describe pertinent abnormal studies which document the diagnosis/diagnoses the medical board is going to establish. If all laboratory tests were within normal limits so state in one sentence. Note specific values on all abnormal findings. Serial studies are frequently more meaningful to the reader if described in the COURSE OF TREATMENT. Postprandial and HS blood sugars are most informative for diabetic control. Do not report GTT in patients with established diabetes. Note the findings of all abnormal X-rays. If normal, so state. Do not dictate that the results of tests are pending, as the board cannot be processed until results are received.

### Course and Treatment

Do not mention patient was admitted to such and such a ward. State briefly what medical or surgical treatment was administered and with what result. List consultations with their conclusions only in this paragraph. Also list ward procedures such as colonoscopy in this paragraph with findings thereof. Do not apologize or make excuses for treatment or diagnostic studies. Simply state that "The patient was given Digoxin 0.25 mg. q.d., following which he experienced improvement in his exercise tolerance." For diabetic and obese patients, give the type of diet on which the patient was placed. Note any instructions which were given to the patient, such as required medications, e.g. insulin, dilantin, (specific dosage and directions), physical therapy, etc.

### Present Status

**This is the most important part of the medical board for administrative purposes.** Here, a report of the pertinent positive and negative physical findings should be described in detail. If there has been a marked change since admission/last evaluation, this report may be more detailed to permit assessment of change by future examiners who may not have seen the patient before. When pertinent, changes in patient weight should be recorded. State the prognosis (when pertinent) and the recommendations of the board concerning the disposition. This paragraph should be a concise but precise statement of the patient's limitations, i.e. "The patient experiences angina on moderate exertion such as mowing his lawn." Arthritic deformities should be precisely described and the measured limitations of motion noted. The limitations may be

administrative and not medical: state this if it is appropriate, i.e. “The patient is limited in that a period of observation is required to ensure eradication of the tuberculous infection.” The limitations should be described at the time the patient appears before the board, not 6 months previously or 6 years in the future. Ensure that you describe how and to what extent the patient’s condition has prevented him from performing the duties of his rate.

### Diagnosis/Diagnoses

Diagnosis/diagnoses should be listed in the order of their importance and should conform with the International Classification of Diseases, Ninth Revision, (ICD-9) Volumes I and II. Ensure that all diagnoses described in the board are listed and make a statement as to whether the condition is DNEPTE; EPTE, Service Aggravated; or DNEPTE, Not Service Aggravated.

### Opinions and Recommendations

In closing your dictation include your recommendations and opinions in one of the following forms:

#### 1. ***For Six Months Limited Duty***

“It is the opinion of the board that the patient is not fit for full duty, but is fit for a period of limited duty. It is recommended that he/she be returned to a period of 6 months limited duty (+/-“ashore”) during which time he/she should not (specify what he/she can and can’t do in layman’s terms).”

#### 2. ***For Limited Duty to Complete 20 Years Active Service***

(Use only for members with over 16 years service when it is not expected that the condition will improve.) “It is the opinion of the board that the patient is not fit for full duty, but is fit for limited duty. It is recommended that he/she be returned to limited duty to complete 20 years active service during which time he/she should not (specify what he/she can and cannot do in layman’s terms).

#### 3. ***For Full Duty***

“It is the opinion of the board that the patient is fit for return to full duty.”

#### 4. ***For EPTE Discharge***

“It is the opinion of the board that patient is not fit for active duty due to a physical disability which was neither incurred in nor aggravated by a period of active service and should be discharged from the Naval Service/Marine Corps.”

#### 5. ***For Physical Evaluation Board***

“It is the opinion of the medical board that the member’s medical condition interferes with the reasonable performance of assigned duties, and on that basis the member is referred to the Physical Evaluation Board for fitness for duty determination.”

#### 6. ***For VA Transfer***

“It is the opinion of the board that the patient is not fit for full duty, nor likely to become fit, and should be referred to the Physical Evaluation Board. Further short/long term hospitalization is

indicated. It is recommended that he/she be transferred to a Veterans Administration Hospital near his/her home.” (For psychiatric patients or those involving brain traumas) “It is the opinion of the board that the patient is/is not mentally competent and capable of handling his/her own affairs.) Competency determination must be made by a psychiatrist.”

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## **INTERNAL MEDICINE CLINIC**

This is the opportunity to care for YOUR own patients and develop the other side of an internist: outpatient care. Our colleagues, through the results of many graduating resident surveys nationwide, suggest that training programs effect great skills in inpatient/ hospitalist care but dismally prepare residents for the bulk of their future practice in the office/ clinic arena. Thus, your training ground of clinic participation and involvement, providing medical care to active duty and retired sailors and their dependents, is essential to a successful career while in the Navy and afterwards. As such, high priority is placed on professionalism in scheduling, attendance, and follow-through via telephone consults. We hope that this will be a challenging and rewarding experience for you.

### **CLINIC TEAMS**

1. Each of the four teams will consist of 2-3 attendings, 5-6 PGY-1 residents and 4-6 PGY-2 and PGY-3 residents.
2. The attendings of your team will be your point of contact when you have questions regarding a patient **outside** of your normal clinic time and for all telephone contacts.
3. The assigned clinic preceptor should be the person you first contact for questions regarding management of patients seen at scheduled clinic time.

### **OUR PATIENTS**

#### **Tricare Prime**

Tricare Prime is the Navy's "Managed Care" Program. Dependents of active duty do not pay an enrollment fee, but retirees and their dependents (under the age of 65) pay an annual enrollment fee (\$460 for a family, \$230 for an individual). When individuals/families sign up for Tricare Prime, they are assigned to a clinic and a primary care manager within that clinic. We are a TRICARE Prime clinic site. Individuals/Families who are enrolled receive the highest priority for appts. second only to active duty service members. If a TRICARE Prime enrollee cannot be seen at NMCP, they are scheduled to see a civilian physician for a minimal fee (\$12).

Beneficiaries over the age of 65 are not eligible to sign up for TRICARE Prime. However, once they have completed paperwork for both Medicare parts A and B, they are eligible for TRICARE FOR LIFE, which supplements Medicare so that nearly all out-of-pocket costs are paid when these patients see a civilian physician. We also receive consults from other TRICARE Prime Clinic sites to see a patient. These patients should be seen and once the initial question(s) addressed, referred back to their referring TRICARE Prime Physician/Primary Care Manager.

#### **TRICARE Service Center**

This is also a contract service, but separate from TRICARE Prime. Most appointments and consults to other departments are scheduled by this scheduling service, regardless of whether the patient is active duty, TRICARE prime or retiree over age 65. Our established patients make followup appts at the front desk or the waiting room phone prior to leaving clinic. If appointments are not yet available then the patient is instructed to call the service center at a future date.

## OUR HOURS

1. Monday – Friday 0800-1630: Corps staff and secretarial staff available to service phone calls and appts.

2. Resident Clinic Basics

- a. The clinic schedule is on the dffm54 server in the “Internal Medicine Clinic” folder.
- b. 0830-1200 and 1300-1630 are the scheduled hours of resident clinics. Resident clinics will be structured in 35 minute intervals from 0830-1130 and 1300-1600.
- c. Should a physician require assistance beyond this time, there will be a staff attending, RN, and corpsman available. Residents can hold an extra clinic on Friday afternoon (1430-1530) if a patient needs to be seen. If you wish to do this, please contact LCDR Eifert (our clinic manager).
- d. Clinic schedules and patient appointments are made 30-45 days (4-6 weeks) in advance. Any changes in your rotation schedule will affect your clinic schedule; **you MUST notify LCDR Eifert as soon as possible of any and all changes (may use email group G.Clinsched)**. Leave and TAD requests need to be routed through Dr. Sharon Reed as soon as possible so that we can block or cancel your clinic as necessary. Requests to cancel or reschedule clinics need to be approved by LCDR Eifert before talking with Ms. Montague. Try to give them an alternative clinic date whenever possible; it makes rescheduling much easier and patients tend to be more receptive.
- e. There may be one "hold slot" at the end of the clinic. If you do not use this spot for one of your patients, it may open up on the day of your clinic and may be filled by the attending or at the discretion of the RNs. This gives you some flexibility when trying to arrange needed and prompt follow-up for unstable patients. Any of the paraprofessional staff can help you book this hold slot. You may also send an e-mail message to Ms. Montague.

3. The clinic days for the PGY-II's and PGY-III's will depend on the rotation schedule:

GI/Nephro	Mon AM/Wed PM	Consults	Mon/Wed AM
ID	Mon AM/Tues PM	DAR, NAR	Fri AM
Rheum, Allergy	Mon/Wed PM	Geriatrics	Mon PM
Neuro	Mon PM/Wed AM	Onc Ward	Wed PM
Pulmonary	Mon PM/ Tues AM	ICU:Res	No clinic
Derm/Rads/Path	Tues/Thurs AM	CCU Res	No clinic

4. Residents are highly encouraged to discuss any patient with the staff preceptor. PGY-2/3 residents must discuss new patients (new to the clinic) with the staff preceptor. The new PGY-II's are to briefly review follow-ups, especially to determine appropriate intervals for return visits. Don't hesitate to ask if you're uncertain; outpatient Medicine is sometimes more difficult than you think.

5. Clinic Patient Population. The mix of patients that you will see in the clinic will include active duty, dependents of active duty, TRICARE prime patients, and retirees/dependents over the age of 65. Each doctor has been assigned a group of patients based on their level of experience and the number of clinic slots available. Your clinic patients will consist of patients reassigned from a prior doctor, new patients from consults or new patients you bring in from the

wards. Interns will start out the year with 15-30 patients, PGY-2's with around 30-60 patients and PGY-3's with 60-90 patients.

6. If you must have an unscheduled patient come to the clinic, you must make sure that you **call the RN staff (usually LCDR Eifert)** as soon as possible so that they can pull the patient's shadow file and generate a SF600.

### **WARD FOLLOW-UP CLINIC**

1. See Ward Medicine/ Discharges.
2. **Scheduling** - Have your team interns call/E-mail Ms. Montague with the patient's name, SS#, and date you wish patient to be seen *before* the patient is discharged from the hospital. If the patient is discharged over the weekend, have your intern place a consult to the IM clinic stating the need for ward follow up, which team resident, which date, etc.
3. **Supervision:** All notes written by the students and interns must be cosigned by the ward resident, and will be further reviewed by either the ward attending or the clinic preceptor.

### **DESIGNATING A LEAVE SURROGATE VIA CHCS**

On the first screen, enter "USR"

Then enter, "PRF"

Star "Enter/Edit Surrogate"

Enter surrogate's name for both new results and tel cons.

Remember to take them off when you return:

USR-PRF-Enter/Edit Surrogate

Put cursor on surrogate's name

Hit enter

Hit Delete

Type Y ('ok to delete...')

Hit enter

**\*\*\*Ask the person who you are going to designate as surrogate before routing your leave chit and before you go to avoid confusion and conflicts. Choose your surrogate from your team if possible.\*\*\***

### **TELEPHONE CONSULTS**

- Your patients will call the clinic (953-2277) for medication refills and with questions.
- The support staff will take a message and place a phone consult to you in AHLTA. Staff have been instructed not to give out physicians' pager numbers or offer to page doctors for patients. If they feel a patient's message is important they will check with the staff attending before paging the doctor.
- These telephone consults must be answered within **24-48 hours**. If there is an emergency, the staff will refer the patient to the emergency room or have the attending of the day take the call.
- **All Telephone Consults must be designated for cosignature by your team attending** (see the team list on the first page). The attending physician is responsible for every patient interaction, including those by telephone. It is also an easy way to

get some feedback on documentation, advice on management and for the clinic and attending to get RVU credit.

- If your patient is calling in for a medication renewal, the staff will give you the drug, dose, and pharmacy where the patient wishes to pick up the medicine. There is no need to call the patient back for medication renewals unless the staff places such a instruction on the telephone consult; simply fill the medicine to the appropriate pharmacy within *one-two days*.
- See the next section on medication renewals/refills for more instructions.
- You must list a **diagnosis** for each telephone consult.
- **If you call a patient, generate a telephone consult yourself** so that you get credit for a visit as well as have documentation of the conversation. Again, make sure that you designate these for cosignature by your attending. The staff should not be asked to return phone calls.
- Remember to **designate a surrogate** for telephone consults and lab results when you are on leave or TAD.
- **Adequate documentation is essential with telephone consults!** The telephone consult is a medicolegal document and is considered part of the medical record. Thus, informal or vague language describing the information passed to patients is discouraged. Be sure to document the following:
  1. Appropriate **background** of the question or clinical complaint
  2. Documentation of **problem list** (see below) or important underlying medical problems
  3. Adequate **“screening”** (example, for patient with dysuria, noting if there is any back pain, fevers, rigors)
  4. Appropriate **management** plan, including **follow-up** (i.e. follow up in 2 weeks at regularly scheduled appointment) and **contingency** (i.e. if pain continues greater than 5 days to call the clinic again).

#### **Checking Telephone Consults as Surrogate**

- There is no means within AHLTA for you to designate someone else as your telephone consult surrogate. Instead it is the surrogate’s responsibility to set their AHLTA Telephone Consults screen to display pending consults for themselves and for the person for whom they are covering.
- On the Telephone Consults screen click “change selections” button, then, under “providers” click on “selected providers” and choose the resident who’s consults you’ll be checking. Until you change this back, AHLTA will display this persons telephone consults each time you log in.

#### **HOW PATIENTS MAKE APPOINTMENTS**

At the end of the patient visit, patients are instructed by both the physician and support staff when they are scheduled to return. Patients are referred to the phone in the waiting room, which is a direct line to the TRICARE Service Center (TSC, 1-866-856-4584) one month prior to the appointed time to be given an appt

All our appointments are considered **routine** appointments; Patients that need to be seen the same day will be seen by the attending of the day unless their physician has an opening to see the patient. If you feel a patient needs to be seen in the Internal Medicine Clinic within a semi-urgent time frame, you may either see the patient yourself on a walk-in basis or talk with the staff attending. **Do not instruct a patient to walk into the IMC when you have not made arrangements for them to be seen by a physician.**

You may also see when a patient is next scheduled for an appointment thru CHCS. On the first order screen, type in **DPA** (Display Patient Appts.), Patient's name and whether you want future or past appts.. This may be helpful for making sure patients have follow-up in other clinics (PGY2-3 have access to DPA, if you don't have this key, call MID).

### **CHCS DESKTOP**

This has made it easier for the doctors to view their schedules and keep track of patients (see below). An open slot, however, does not mean that you can schedule a patient to come at that time without first going through LCDR Eifert. Please let the support staff know if you want to schedule an "hold slot" patient so that they may book the patient and pull charts etc.

To access desktop and create a patient list:

- enter DSK on the first screen
- enter "+" at the action prompt
- enter "clim" at the patient source prompt
- enter "baaa" at the clinic prompt
- choose "1" for IMC
- enter desired dates (t- #days for back, t+# for forward days)
- to save at the end, type "A" for all, or enter only those numbers you wish saved.

### **AHLTA APPOINTMENT VIEW**

The easiest way to view your upcoming appointments is via the "Appointments" tab in AHLTA. Simple change the date range to include the date(s) in question in order to see patients scheduled.

### **"CONVENIENCE" FILES**

The IMC maintains its own shadow file system. The charts are filed alphabetically and according to beneficiary status. These shadow files are not legal documents. There should not be anything in the shadow file which is not in the original patient record (e.g. EKG). This is a JCAHO requirement. Please review your files on a regular basis. Make sure that there is an updated PPIP (Put Prevention into Practice form) or 2276 in the patients record.

**These are not to leave the clinic.** If you wish to remove the shadow file, to bring to your desk in the GME Offices, for example, you must let LCDR Eifert know which shadow files you have taken. Also, remember to keep these files in your footlocker or cabinet at your desk, rather than on the desk itself, per HIPAA requirements.

**Only active duty patients not assigned to NMCP should leave with their medical record in hand to return to their sick call clinic files.**

## **MEDICATION REFILLS/RENEWALS**

We know that medications for chronic conditions will be continued indefinitely; however, our patients don't always know which meds are indefinitely continued and which are limited to a single course. Also, the pharmacy system requires that we distinguish between renewals and refills. A *renewal* is basically a "new prescription", a new order to the pharmacy. A *refill* is attached to a prescription and so the pharmacy recognizes that this is not to be treated as a "new" prescription. Notable points:

- NMCP Main pharmacy does only "new" prescriptions (including renewals), and does not not do refills.
- Scott Center Annex, the most commonly used pharmacy outside of NMCP Main, does both renewals and refills—however, their "drive-thru" window is for refills only. If a patient has renewals they go into the building to get them.
- Medications can thus be filled initially at NMCP and then refills can be filled at Scott Center, Sewells Point, Boone clinic, Oceana clinic, TRICARE Prime Chesapeake, TRICARE Prime Virginia Beach, even at Fort Eustis or Langley. New or renewals can also be filled at these outlying clinics.

At each office visit, ask your patient about what medication renewals they need before they leave the office. The patients do not need a hard copy of the script to pick up their medicines or have their labs drawn. All medications, labs, xrays, consults need to be entered via CHCS or AHLTA.

Also at each office visit remember to **DELETE ALL DUPLICATE OR DISCONTINUED MEDICATIONS FROM THEIR MEDICATION LIST**. This is done most easily on the medication tab of the A/P section of your AHLTA note.

Patients are encouraged to call in for medication renewals (rather than walk in) and to use all refills before calling the clinic. The support staff will take a telcon for you with the name of the drug and the pharmacy desired. If you patient is completely out of medicine, they will be referred to the pharmacy for a 3 day emergency refill which gives you time to sign new prescriptions. Tell your patients to call in for renewals several days before they run out of medicine.

The nurses make every effort to instruct the patient to use all their refills before asking for a renewal, but they don't have the same access to pharmacy lists that physicians do. Thus you should try to verify using the Medication lists or Medication tab AHLTA or the MPI menu option in CHCS that a patient indeed has either

- 0 of 5 refills left, OR
- Original prescription is > one year old and thus any refills are expired.

If a patient still has refills left you should call them and encourage them to use the refills before asking for a renewal. Sometimes there are extenuating circumstances, but sometimes the patient is trying to get the medication for pickup at NMCP (remember, refills not done at NMCP main pharmacy, only new prescriptions or renewals). In order to avoid the long lines at the main pharmacy every effort should be made to have the patient use all their refills.

**Narcotics and controlled substances should ideally be filled by the patient's primary physician only.** Please ensure dosages are listed on the 2776, especially for narcotics and benzodiazepines, or the attending will not refill the medicine. The attendings will fill medication for only those patients who are seen in our clinic on a regular basis and for whom there is CLEAR documentation of the indication for the medicine. Each exam room has copies of the "Controlled Substance Agreement" (filed under Narcotic...) which should be completed for all patients on chronic narcotics or other controlled substances. This will be kept in the patient's shadow file in the event you are unavailable and a staff physician must renew a controlled substance for your patient.

The main items to consider when renewing medications are:

1. Send the medicine to the requested pharmacy
2. Make sure that expiration date of the screen is one year from the date you are renewing the medicine (this does not always happen unless it is a new script...if the date is not correct, the script will not be refilled after that date even though the patient still has refills left.) You can type "+365" for the expiration date if it does not automatically do so.
3. If the drug is listed as "Not dispensed at this pharmacy" (particularly for nonformulary items)...do not fill it for that pharmacy. The formulary at all the pharmacies is not the same. If you must fill the drug to NMCP or Scott Center and write in the comments section, "deliver to BOONE (or what ever pharmacy) for patient pickup". Call the patient back to let them know that it will take at least two working days to get the medicine to the outlying pharmacy (for non dispensed meds only).

### **CONSULT CLINIC / SERVICE**

The Consult Service and Clinic provides peri-operative medical services to all surgical specialties in both the outpatient and inpatient setting. The Consult Service also helps other specialties treat non-operative inpatients with complicated medical problems. These patients, whether inpatients or outpatients, are being seen on a consultative basis only and will not be placed in a continuity clinic unless you or the attending give approval. Further guidelines are provided in consult rotation handout.

### **STAFF CLINIC ATTENDING/ PRECEPTOR**

For each half day, there is one staff attending and one staff preceptor. The day attending is responsible for taking outside consult calls, seeing same day appts, and other taskings to "put out fires". Each afternoon there is a separate staff preceptor available for resident and for intern supervision, and review and co-signing of notes. The morning attending and preceptor covers from 0830-1300 and the afternoon staff members cover from 1300-1700. The list is posted in the clinic manager's office (where the mailboxes are located) and behind the clinic check-in desk.

### **NURSING SERVICES**

1. Our Nursing Division Officer, LCDR Eifert, is responsible for supervision of corps staff and nursing staff assigned to the clinic. If you have any compliments, requests, or suggestions regarding any of the clinic staff, please contact the nursing division officer for the clinic or the resident coordinator. Remember that many frustrations in clinic originate from a "systems" problem and that the LPN or HN is only the "messenger". Do not vent your frustrations in these instances to the individual—take it to LCDR Eifert. Even if the issue appears to be with an

individual, redirection, guidance, and feedback can be given to the individual, but not ranting, venting, or harsh criticisms.

## 2. **Diabetic education and monitoring**

The RN's provide diabetes education in the care of our diabetic patients. Specifically they will:

- a. Educate patients on how to use and interpret home glucose monitors.
- b. Instruct patients on how to start and mix insulin.
- c. Make necessary adjustments in therapies in conjunction with the primary physician or staff attending.
- d. Ensure compliance with both medication regimens and SMBG.
- e. Provide basic nutrition counseling.

Consults for the diabetic teaching should include:

(send an email to RN Traci DiGenarro)

- Current level of diabetic control
- Current medications
- Starting dose or changed dose of insulin
- Specific goals of therapy
- Signed prescriptions for glucometer and strips, insulin and syringes (if necessary)
- Definitive follow-up time (when are YOU going to see the patient back).

Patients can be scheduled at the front desk or by the LPN/HN working with you in clinic to see one of the RNs. For strictly diabetic education and diet counseling, encourage your patients to attend the weekly diabetic classes on Tuesday AM, 0730. Handouts with the schedule and other information are available in each exam room.

## 3. **Hypertension education and monitoring**

BP checks are no longer available in the clinic. If a patient needs blood pressure follow-up, they need to schedule an appointment, as with a regular clinic visit.

## 4. **Case Managers**

If you have any patients on your schedules with the following criteria, please bring it to the attention of the RNs so that a Case Manager can be contacted:

- a. TriCare Prime, under the age of 65 and have greater than 4 clinic or ER visits in a quarter.
- b. 3 Admissions or more for the same diagnosis in a 1 year period.
- c. Post-Op wound complications.
- d. Mental or Substance Abuse.
- e. Very Non-Compliant Hx with treatments.
- f. Medication management.

## ADMINISTRATIVE SERVICES

- Check In: Will include chart and IMC folder preparation, vital signs including temperature (when indicated), medication list and notation of allergies.
- Drop Offs: There is a filing box at the front desk where lab chits, prescriptions, medical necessity forms, correspondences, etc. can be left for patients to pick up.
- Local Resource Guide: There is a black binder or packet with names and phone numbers of local resources/support groups for patients (abuse numbers, AA, OA etc). Please take the time to become familiar with what is in this book. If you have any additional items that you think would be a good addition for this book, please let us know.
- Care Guidelines and Patient Education Resources: There are care sheets located in each exam room (MAST, PRIME MD, Functional Assessment, MMSE, headache diet etc). There are patient education sheets/pamphlets located in a file cabinet in one of the vital signs rooms.
- PAPS/Pelvic Exams: Residents are expected to do paps/pelvics for their female patients. If you want to set up a pap for your patient, indicate so in the disposition section of the SF-600. The appointment will be arranged into your clinic schedule for you.
- Standbys: Doctors must have standbys for performing breast, rectal, pelvic exams. The corps staff or LPNs will be happy to help you. **Be sure to document in your note the name of your Standby.**
- EKG's and Blood Draws: If you need an EKG, just ask one of the corpstaff or LPNs to assist you. The corps staff can do blood draws in clinic for our non-ambulatory patients.
- **Treatment Room**: Please see RN Digennaro to arrange... *only* the following procedures:
  - IVF hydration
  - IV steroid or antibiotic infusion
  - Paracentesis
  - Thoracentesis
  - Lumbar Puncture
  - Nebulizer therapy
  - EKG
  - IM / SQ injections
  - Timed blood draws (cosyntropin stim test, e.g.)
  - Oxygen therapy
- **Clinic mailboxes**: Each of you has a mailbox in the clinic. This mailbox is for both clinic and residency program purposes. **Check this box frequently**, do not let "stuff" pile up.

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## COUMADIN CLINIC

The IM clinic sponsors the command's Coumadin Monitoring Service. Internal Medicine physicians are involved with many of the patients with DVT/PE, atrial fibrillation, and CHF with EF <30%, the most common reasons for anticoagulation. Space is restricted due to personnel limitations. All active duty and TRICARE Prime patients should be followed in CMS; Our Medicare-eligible patients The criteria for referring a patient for coumadin are as follows:

### **Information Required to consult patient to the Anticoagulation Clinic**

Provider must enter the following information in the consult via CHCS:

Please enter consult as ROUTINE (not asap or stat)

Patient diagnosis/ reason for anticoagulation

Goal INR

Duration of therapy

Any medical information relevant to the management of patient's anticoagulation (recent surgeries, diagnoses, co-existing medical conditions).

Please allow 24 hours for consult to be appointed. Once consult is appointed, the clinic will contact patient to schedule initial appointment. New patient (SPEC) appointments are usually scheduled for Mondays and Tuesdays. Anticoagulation Clinic phone # 953-2365.

**UNTIL SEEN BY OUR CLINIC, PATIENTS MUST BE MANAGED BY THEIR PCM OR REFERRING PHYSICIAN.**

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## APPENDIX

### **POINTS OF CONTACT**

Scheduling Issues: Dr. Reed/ LCDR Eifert (clinic days, leave papers, adding clinics)  
**\*\*\*All leave papers, TAD papers, C4 etc MUST come thru the clinic and be noted by LCDR Eifert or Dr. Reed before final approval by the main office\*\*\***

Specific Patient Issues: your team attending -see table

Consult Service: Dr. Reed

Ambulatory Rotation: Dr. Reed

Geriatrics: Dr. Reed

USUHS Students: Dr. Tom Hicks

Scheduling patients: Ms. Montague

Correspondence for patients: Ms. Montague

Coding: Ms. Fraser

Corps staff Issues: LCDR Eifert

Nursing Issues: LCDR Eifert

Patient Education: Any RN

Phone numbers:

Clinic 953-2277

MEPRS Clinic Code: BAAA, 1

Clinic manager: 953-2291

Ms Montague 3-2253

RN DeGennero 3-2269

Fax: 953-0859

Clinic front desk: 953-2264

Telephone room: 2251

Printers:

Copy room: PINMEDLEX1

MailRoom: PINTMEDHP6

Email Groups:

G.IMC=all doc's nurses, corpstaff, and civilians

G.ATTENDING=General IM staff and schedulers

G.IMCLPN = clinic LPNs

G.IMCHM = clinic corps staff

G.GEN MED SVC = General IM staff physicians

G.CLINSCHED = for advance notice of clinic schedule change

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## Role of Consulting Services in the Emergency Medicine Department

### Consultant Physician Responsibilities:

1. The Consultant attending physician is ultimately responsible for the content of the consultation, including recommendations for disposition, whether direct or through resident representation.
2. Consulting physicians are required to contact the ED within 15 minutes of being paged.
3. In-patient consulting services should begin evaluation of the patient within 30 minutes of initial contact. Other arrangements may be made at the mutual discretion of both parties.
4. All consultants will make an effort to evaluate and disposition the patients as quickly and safely as possible. The consultant should discuss with the ED attending a disposition plan for the patient within 60 minutes of the evaluation. If disposition is unclear after this workup plan has been completed, the consultant should promptly discuss with the ED attending an alternative plan for disposition. If the original consultant initiates or recommends additional consultation, the ED attending should be notified.
5. Individual departments will determine the guidelines in conjunction with the ED on the most appropriate methods for dealing with the following situations:
  - a. Complicated or prolonged evaluation
  - b. Multiple admissions/evaluations pending for a single service (overflow)
  - c. Time sensitive medications and studies required prior to transfer or while being transferred
  - d. Review of appropriate time limits/guidelines for completing evaluation
6. If an admission is indicated, the consultant shall fill out basic admission orders to be submitted to Bed Management by the ED nursing staff to facilitate timely transfer out of the ED. Basic admission orders should include the following:
  - a. Diagnosis
  - b. Bed type
  - c. Activity
  - d. Time sensitive medications
  - e. Physician contact information
7. In the event of a disposition disagreement between the ED attending physician and a resident consultant, the following steps will be taken to resolve the disagreement:
  - a. The ED attending will have the resident discuss the case with their attending physician, to include the concerns and recommendations of the ED attending.
  - b. In the event there is still a disagreement regarding the treatment and disposition of the patient, the ED attending will discuss the case directly with the consultant attending physician. If necessary, the ED attending will request a formal consultation from the consult attending.
  - c. If consulted directly, the consult attending will arrive in the ED expeditiously to evaluate and formulate a disposition.
8. In the event of a disagreement between two consulting services, the ED attending will facilitate a discussion between the two services and involve the attending physicians as necessary.

### Emergency Department Attending Responsibility:

1. The staff emergency physician remains responsible for the care of all patients until they are transferred or discharged from the ED. By writing admission orders for the patients, consultants accept the transfer of patient care responsibility.
2. Prior to contacting the consulting service, ED staff will have personally evaluated the patient and/or reviewed the current care plan with the trainee who has initiated the evaluation. Consultation will be obtained at the discretion of the ED attending. Initial consultation may be verbal; however, a written request will be provided as soon as possible and depending on the clinical status.

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## WARD 4H ADMISSION CRITERIA

1. Admission criteria for 4H have been delineated by exclusionary parameters to identify those patients that may require a higher level of nursing care management not available on the unit. A 4H patient that displays any of the below mentioned criteria during their inpatient stay will be transferred to the next level of care.
2. The parameters that exclude admission to 4 H or indicate a transfer of care are as follows:
  - A. Hemodynamic Instability
    - Persistent Systolic Blood Pressure  $\geq 220$ mmHg
    - Persistent Diastolic Blood Pressure  $\geq 120$ mmHg
    - Apical pulse rate  $\geq 130$  bpm or  $\leq 44$  bpm and symptomatic
    - Requires titrated IV medications to control vital functions including anti-hypertensives, inotropic agents and/or anti-arrhythmics.
    - Any invasive hemodynamic monitoring
  - B. Cardiac Instability
    - Electrical or chemical cardioversion
    - Unstable angina or uncontrolled dysrhythmia
    - Recent history of myocardial infarction  $\leq 3$  days.
    - Suspicion of acute or evolving myocardial infarction requiring assessment of cardiac enzymes or troponin levels or subsequent evaluation of abnormal cardiac enzymes or troponin levels.
    - Recent cardiac surgery  $\leq 10$  days
  - C. Respiratory Instability
    - Hypoxemia with PaO<sub>2</sub>  $\leq 50$  mmHG
  - D. Neurologic Instability
    - Intracranial monitoring.
    - New onset seizure activity
    - Deterioration of neurological status indicated by pupillary & oculomotor changes, altered level of consciousness or abnormal breathing patterns.
  - E. Laboratory Values
    - Sodium  $\leq 115$  or  $\geq 159$
    - Potassium  $\leq 2.6$  or  $\geq 6.5$
    - Magnesium  $\leq 1.0$  or  $\geq 5.5$
    - Calcium  $\geq 13.4$  with mental status changes
    - Glucose  $\geq 400$  with ketonemia
    - Ph  $< 7.25$  or  $> 7.56$
    - Hgb  $< 5$
    - Hct  $< 15$

- BUN > 110
- Toxic levels of drugs/chemicals with potential for significant dysrhythmia or airway compromise.

F. Miscellaneous Criteria.

- Pregnancy in second or third trimester
- Any monitoring or treatment required more frequently than every one hour or for every two hours longer than 12 hours.
- Any acutely psychotic patients.
- Ongoing active bleeding (i.e. UGI bleed).
- Any patients requiring drip infusions except those that are permitted by hospital policy.

# FORMS

## Internal Medicine NAR/DAR Evaluation

Date: \_\_\_\_\_ Name of Resident: \_\_\_\_\_

Reviewer: \_\_\_\_\_

Instructions: As the attending who receive admissions and reports from the NAR/DAR, you are in a position to assess their performance. Please provide an assessment of the NAR/DAR's performance during the current call period. If you have no contact, please indicate so.

Please return to Ms. Shipley or the Chief of Resident. As always, specific examples are always appreciated. Please use the comments section below.

Number of contacts over the last 12 hours: \_\_\_\_\_ NONE

1=Beginner  
2=Novice  
3=Advanced beginner (AB)  
4=AB/Nearing Competency  
5=Competent (C)  
6=C/Some proficiency  
7=Proficiency  
8=Demonstrates expertise  
9=Demonstrates mastery

	1	2	3	4	5	6	7	8	9
<b>1. Patient Care</b>									
Ability to diagnose problems									
Clinical judgments									
Formulate appropriate management plans									
<b>2. Medical Knowledge</b>									
Integration of clinical information with own knowledge base									
<b>3. Interpersonal Skills and Comm.</b>									
Provides accurate, logically ordered oral Presentations									
Medical records is comprehensive, timely, clear and informative									
<b>4. PBLI</b>									
Follows up on care provided									
Uses evidence from scientific studies									
Recognizes limitations, seeks education									
<b>5. Professionalism</b>									
Ability to manage time, prioritizes tasks									
Able to deal with stress and provide support In difficult situations									
<b>6. Systems Based Practice</b>									
Knowledgeable of and coordinates well the Dispositions of patients									

Comments

## Grand Rounds Assessment

Resident Name \_\_\_\_\_

Date \_\_\_\_\_

Topic \_\_\_\_\_

Approved by \_\_\_\_\_ PD \_\_\_\_\_ COR \_\_\_\_\_

**Instructions:** Residents should provide a copy of this evaluation form to the PD, COR, and selected faculty, such as a specialist in the area of the topic covered (at least 2 of the 3 listed). Evaluators should check the boxes for tasks completed or skills demonstrated in the left column AND for the level of overall skill attained for each item in the right column. Specific comments can be made in Elements and Skill Level boxes, as appropriate.

Elements	Skill level attained				
<p><b><u>Content of lecture:</u></b></p> <input type="checkbox"/> appropriate focus on a reasonable # of teaching points <input type="checkbox"/> depth of pathophysiology appropriate to clinical application, or is an important review <input type="checkbox"/> use of literature—i.e. original literature, review articles, use of text or UpToDate only when appropriate <input type="checkbox"/> presentation reflects understanding of the material	Expertise	Proficiency	Competence	Advanced Beginner	Novice
<p><b><u>Delivery:</u></b></p> <input type="checkbox"/> good eye contact <input type="checkbox"/> clarity, enunciation, volume <input type="checkbox"/> rate of speech appropriate for volume of information <input type="checkbox"/> um's, body language, etc.	Expertise	Proficiency	Competence	Advanced Beginner	Novice
<p><b><u>Effective use of audiovisual aids:</u></b></p> <input type="checkbox"/> slides in bullet format, vice sentence/paragraph <input type="checkbox"/> appropriate # words on slides <input type="checkbox"/> tables and graphics appropriate font size <input type="checkbox"/> slides used to augment presentation, vice reading off slides <input type="checkbox"/> slides used to emphasize important points <input type="checkbox"/> uses references appropriately—i.e. footnotes on slides vice a reference slide	Expertise	Proficiency	Competence	Advanced Beginner	Novice
<p><b><u>Effective use of handout:</u></b></p> <input type="checkbox"/> format focused on the teaching points <input type="checkbox"/> not just a copy of slides <input type="checkbox"/> includes reference	Expertise	Proficiency	Competence	Advanced Beginner	Novice

## RESIDENT LECTURE (rev 10/06)

1. **Goals**
  - a. Demonstrate ability to organize and synthesize original literature
  - b. Develop the knowledge base of a topic through research and reading.
  - c. Improve presentation skills (Powerpoint AND Delivery).
  
2. **Requirement**
  - a. One presentation per year for PGY-2 and PGY-3 residents.
  - b. Scheduled by the COR at the beginning of the academic year.
  
3. **Format requirements**
  - a. Presentation should be available on the server.
  - b. The resident is expected to inform the attendings from the appropriate division that they are giving a lecture in their subspecialty.
  - c. Lectures should also last 30-45 minutes to allow time for questions.
  - d. References should be at the bottom of the slides, not in a reference slide at the end.
  - e. Senior lectures must include a handout.
  - f. The discussion must not be set up like a book chapter – such as “clinical presentation – differential diagnosis – treatment – prognosis, these outline-style presentations cover topics too broadly.
  - g. Original articles (RCTs, cohort studies, etc.) should be the primary source of data, not textbooks, review articles, or UpToDate.
  
4. **Topic**
  - a. Resident lectures must be approved by the COR in advance to avoid duplicating a previously scheduled faculty topic.
  - b. Pick something you are interested in if you want us to be! You will be more passionate, retain the knowledge, like being the “Resident (or Department) Expert”, and have it on hand for the future.

That being said it should still be of use to the general internist.
  
5. **Evaluation**
  - a. Selected faculty in attendance will complete a written evaluation on the level of competence demonstrated in discussing the topic (content) as well as the delivery (format).
  - b. At least two evaluations are needed to complete this requirement.
  - c. Junior residents must achieve advanced beginner or higher in each category to pass. Senior residents must achieve competent or higher.
  - d. If competency is not achieved the resident will complete an additional resident lecture.

## Resident Lecture Assessment

Resident Name \_\_\_\_\_ Date \_\_\_\_\_

Topic \_\_\_\_\_ Approved by \_\_\_\_\_ PD \_\_\_\_\_ COR \_\_\_\_\_

**Instructions:** Residents should provide a copy of this evaluation form to the PD, COR, and selected faculty, such as a specialist in the area of the topic covered (at least 2 of the 3 listed). Evaluators should check the boxes for tasks completed or skills demonstrated in the left column AND for the level of overall skill attained for each item in the right column. Specific comments can be made in Elements and Skill Level boxes, as appropriate.

Elements	Skill level attained				
<p><b><u>Content of lecture:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> appropriate focus on a reasonable # of teaching points</li> <li><input type="checkbox"/> depth of pathophysiology appropriate to clinical application, or is an important review</li> <li><input type="checkbox"/> use of literature—i.e. original literature, review articles, use of text or UpToDate only when appropriate</li> <li><input type="checkbox"/> presentation reflects understanding of the material</li> </ul>	Expertise	Proficiency	Competence	Advanced Beginner	Novice
<p><b><u>Delivery:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> good eye contact</li> <li><input type="checkbox"/> clarity, enunciation, volume</li> <li><input type="checkbox"/> rate of speech appropriate for volume of information</li> <li><input type="checkbox"/> um's, body language, etc.</li> </ul>	Expertise	Proficiency	Competence	Advanced Beginner	Novice
<p><b><u>Effective use of audiovisual aids:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> slides in bullet format, vice sentence/paragraph</li> <li><input type="checkbox"/> appropriate # words on slides</li> <li><input type="checkbox"/> tables and graphics appropriate font size</li> <li><input type="checkbox"/> slides used to augment presentation, vice reading off slides</li> <li><input type="checkbox"/> slides used to emphasize important points</li> <li><input type="checkbox"/> uses references appropriately—i.e. footnotes on slides vice a reference slide</li> </ul>	Expertise	Proficiency	Competence	Advanced Beginner	Novice
<p><b><u>Effective use of handout:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> format focused on the teaching points</li> <li><input type="checkbox"/> not just a copy of slides</li> <li><input type="checkbox"/> includes reference</li> </ul>	Expertise	Proficiency	Competence	Advanced Beginner	Novice

**Landry\* Method: Advanced Critical Reading for Immediate Clinical Application**

Journal Citation: Author, Title, Journal			
Reviewed by:		Date:	
<b>CLINICAL QUESTION (PICO)</b>			
<u>Patient</u>	<u>Intervention</u>	<u>Comparison</u>	<u>Outcome</u>
Read the title: Is it intriguing? Optional: Check authors—well known/known to you/reputable?		No-Stop	Yes-Continue
Read Abstract Conclusion: Would it change your practice?		No-Stop	Yes-Continue
Read the “last sentence” before Methods: Does their hypothesis or research question match the title and sound reasonable so far?		No-Stop	Yes-Continue
Read the Methods (beginner-read the actual Methods section, advanced-read the Abstract Methods section): Valid? [Quick but rigid Validity Checks: Diagnosis-Gold Standard; Therapy-RDBPCT (randomized double-blinded placebo-controlled trial); Prognosis-equivalent cohort; Systematic Reviews-Quality of <u>judging/selecting articles plus the appropriate validity check for the type of study</u> ]		No-Stop	Yes-Continue
Read the Methods and if appropriate look at “Table 1”: Applicable to your patients? [Dx: Broad range of patients including those with different dx than the test is testing; Tx: Patients are similar demographically and clinically to yours]		No-Stop	Yes-Continue
Review the Tables/Graphs quickly: Is it reasonably easy to glean the clinically important data?		No-Stop	Yes-Continue
Review the Tables/Graphs: Is the supporting data for the conclusions available in the tables? Does it make sense?		No-Stop	Yes-Continue
Final recap: Valid? Applicable to your patients? Going to change your practice?		No-Stop	Yes-Apply
Comments:			

\*Frank Landry, MD MPH, FACP

**Citation:**

<b>Are the results of this single preventive or therapeutic trial valid?</b>	
Was the assignment of patients to treatments randomised? -and was the randomisation list concealed?	
Were all patients who entered the trial accounted for at its conclusion? -and were they analysed in the groups to which they were randomised?	
Were patients and clinicians kept "blind" to which treatment was being received?	
Aside from the experimental treatment, were the groups treated equally?	
Were the groups similar at the start of the trial?	

**Are the valid results of this randomised trial important?**

SAMPLE CALCULATIONS:

Occurrence of diabetic neuropathy		Relative Risk Reduction RRR	Absolute Risk Reduction ARR	Number Needed to Treat NNT
Usual Insulin Control Event Rate CER	Intensive Insulin Experimental Event Rate EER	$\frac{CER - EER}{CER}$	CER - EER	1/ARR
9.6%	2.8%	$\frac{9.6\% - 2.8\%}{9.6\%} = 71\%$	9.6% - 2.8% = 6.8% (4.3% to 9.3%)	1/6.8% = 15 pts, (11 to 23)

95% Confidence Interval (CI) on an NNT = 1 / (limits on the CI of its ARR) =

$$\pm 1.96 \sqrt{\frac{CER \times (1-CER)}{\# \text{ of control pts.}} + \frac{EER \times (1-EER)}{\# \text{ of exper. pts.}}} = \pm 1.96 \sqrt{\frac{0.096 \times 0.904}{730} + \frac{0.028 \times 0.972}{711}} = \pm 2.4\%$$

YOUR CALCULATIONS:

		Relative Risk Reduction RRR	Absolute Risk Reduction ARR	Number Needed to Treat NNT
CER	EER	$\frac{CER - EER}{CER}$	CER - EER	1/ARR

**THERAPY WORKSHEET: page 2 of 2**

<b>Can you apply this valid, important evidence about a treatment in caring for your patient?</b>	
Do these results apply to your patient?	
Is your patient so different from those in the trial that its results can't help you?	
<b>How great would the potential benefit of therapy actually be for your individual patient?</b>	
Method I: <b>f</b>	Risk of the outcome in your patient, relative to patients in the trial, expressed as a decimal: _____  NNT/F = ____/____ = _____ (NNT for patients like yours)
Method II: <b>1 / (PEER x RRR)</b>	Your patient's expected event rate if they received the control treatment: PEER: _____  $1 / (\text{PEER} \times \text{RRR}) = 1 / \text{_____} = \text{_____}$ (NNT for patients like yours)
<b>Are your patient's values and preferences satisfied by the regimen and its consequences?</b>	
Do your patient and you have a clear assessment of their values and preferences?	
Are they met by this regimen and its consequences?	

**Additional Notes:**

**SYSTEMATIC REVIEW (of Therapy) WORKSHEET: page 1 of 2**

**Citation:**

<b>Are the results of this systematic review of therapy valid?</b>	
Is it a systematic review of randomised trials of the treatment you're interested in?	
Does it include a methods section that describes: finding and including all the relevant trials?  assessing their individual validity?	
Were the results consistent from study to study?	

**Are the valid results of this systematic review important?**

Translating odds ratios to NNTs. The numbers in the body of the table are the NNTs for the corresponding odds ratios at that particular patient's expected event rate (PEER).

		Odds Ratios (OR)								
		0.9	0.85	0.8	0.75	0.7	0.65	0.6	0.55	0.5
Control Event Rate (CER)	.05	209 <sup>1</sup>	139	104	83	69	59	52	46	41 <sup>2</sup>
	.10	110	73	54	43	36	31	27	24	21
	.20	61	40	30	24	20	17	14	13	11
	.30	46	30	22	18	14	12	10	9	8
	.40	40	26	19	15	12	10	9	8	7
	.50 <sup>3</sup>	38	25	18	14	11	9	8	7	6
	.70	44	28	20	16	13	10	9	7	6
.90	101 <sup>4</sup>	64	46	34	27	22	18	15	12 <sup>5</sup>	

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<sup>1</sup> The relative risk reduction (RRR) here is 10%.

<sup>2</sup> The RRR here is 49%

<sup>3</sup> For any OR, NNT is lowest when PEER = .50

<sup>4</sup> The RRR here is 1%

<sup>5</sup> The RRR here is 9%

**SYSTEMATIC REVIEW(of Therapy) WORKSHEET: page 2 of 2**

<b>Can you apply this valid, important evidence from a systematic review in caring for your patient?</b>	
Do these results apply to your patient?	
Is your patient so different from those in the overview that its results can't help you?	
<b>How great would the potential benefit of therapy actually be for your individual patient?</b>	
Method I: In the table on page 1, find the intersection of the closest odds ratio from the overview and the CER that is closest to your patient's expected event rate if they received the control treatment (PEER):	
Method II: To calculate the NNT for any OR and PEER:  $\text{NNT} = \frac{1 - \{\text{PEER} \times (1 - \text{OR})\}}{(1 - \text{PEER}) \times \text{PEER} \times (1 - \text{OR})}$	
Are your patient's values and preferences satisfied by the regimen and its consequences?	
Do your patient and you have a clear assessment of their values and preferences?	
Are they met by this regimen and its consequences?	

<b>Should you believe apparent qualitative differences in the efficacy of therapy in some subgroups of patients? Only if you can say "yes" to all of the following:</b>
1. Do they really make biologic and clinical sense?
2. Is the qualitative difference both clinically (beneficial for some but useless or harmful for others) and statistically significant?
3. Was this difference hypothesised before the study began (rather than the product of dredging the data), and has it been confirmed in other, independent studies?
4. Was this one of just a few subgroup analyses carried out in this study?

**Additional Notes:**