How to Be an Intern

Columbia University Medical Center
Housestaff Training Program

June 2013
Welcome to your internship! We are so excited that you are joining us at Columbia for this exciting year. You are going to have many questions over the next several months, especially as you encounter a new service. This handout is intended to answer some of the questions that may arise and give you a basic outline of all the services through which you will be rotating. By no means is this handout all-inclusive, but we hope to hit some of the highlights. Most importantly, know that your residents, Chief Residents, and Attendings are always available to answer ANY question at ANY time.

Michaela, Mark, Sam, and Irún

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I. THE MILSTEIN MEDICAL SERVICE: AN INTRODUCTION

The service size cap is a total of 10 patients per intern. The maximum number of new admissions for a 24-hour period is 5. Each team consists of two attendings, two residents, two interns, a night resident, a night intern, and medical students.

The Call Schedule:

Milstein Floor Rotations (excluding ID and Malignant Hematology): Floor rotations at the Milstein generally have the following call pattern:

Pre-Call > Long Call > Post Call > Short Call

The days will cycle Q4 throughout the 4-week rotation while you are on service. You will take “long call” every fourth day, which is the primary admitting day. All interns will share their call schedule with their resident, either a PGY2 or PGY3. Your continuity clinic will fall on your pre-call day, while that of your resident will be in the afternoon of your post-call day.

(1) Long Call:
On the Long Call day, interns should begin rounding at 7 am. Over the day, interns can accept up to 3 admissions. You will have a graduated cap as follows: 2 patients after 4:00 pm, 1 patient after 5:00 pm and no patients after 6:00 pm.

As the long call team, you will receive sign-out from the other teams (short, pre, and post) as they complete their work during the day. If you are on general medicine, a PA may receive the sign-out from these teams starting at 5pm, and then sign over to the night intern at 9:00 pm. You will then sign over your list (all the lists if you are on ID or cardiology), to the night intern at the time of his or her arrival at 9:00 pm.

(2) Post-call:
On your Post-call day, you will again arrive at the usual hour, and receive sign-out from your night intern. On Gen Med 1 and Gen Med 2, you will accept a maximum of 1 night float patient if your census is less than 10. It is important to realize that your resident will be going to clinic during the afternoon of your post-call day.

On weekends, the long call and post-call teams will cover their “co-teams.” Every team has its pre-call and short call days off when they occur on weekends or on official hospital holidays; those teams’ patients are covered by the post call and long call teams, respectively. In other words, when you are long call or post call on the weekend you will be responsible for rounding, writing notes, and
handling cross-coverage for the other team. This also means that when you are short or pre-call on the weekend, you have the day off!

In preparation for your time off over the weekend, you should write orders for all necessary labs for the days you will be gone and the Monday you return. In addition, you should write directed signouts describing any tests or consult notes which may come in over the weekend. Please give verbal signout as well to the intern who will be covering you.

(3) Short Call:
On Short Call, the team will accept a combination of one night float admission and one new admission prior to 12:00PM. The resident is required to interview and examine the night float admissions but only the intern needs to write a brief “Accept Note.” The Accept Note can be quite succinct, and should primarily serve to underscore the primary points of the assessment and plan. The night float admission note should not be copy and pasted.

(4) Pre-call
On Pre-Call, the interns have continuity clinic in the afternoon. The teams on the GM1 and GM2 services only can accept 1 night float admission if their census is less than 10 patients. For more specific on clinic days and hours on each rotation, please refer to [www.medicineclinic.org/contrules.html](http://www.medicineclinic.org/contrules.html)

**PMD Follow-up for discharges from your service**

Your patient census will include ward and private patients. Ward patients who do not have medical follow up already by an AIM (our clinic) physician or an outside physician will be followed by the intern who discharges the patient. You can call the clinic to schedule an appointment for the patient in your clinic at the special MD appointment line 305-5549, or the general line 305-6354. Alternatively, for patients on 6GN, 6GS and 7GS, you can place an order for an appointment to be made in Eclipsys, under “Appointments” in the order entry system. An appointment will be made at the appointment center and you will be notified prior to the patient’s discharge. It is an extremely important component of care and teaching that you follow your own hospital discharges when possible. Please have your discharge summary for the patient finalized prior to discharge and if possible fax this summary to their PMD office if not within the NYP system.

If you do not have available clinic sessions for follow up within a timely fashion (usually two weeks or less), you should consider the following alternatives:
1. You can schedule the patient for our “discharge clinic” where the patient will have a one-time visit with a PGY2 with clinic time devoted to facilitating transitions of care to the outpatient setting.
2. Have the patient follow-up in your resident’s clinic.
3. Arrange a follow up with another intern or resident on OPD block, geriatrics, CRC, neurology, etc.
Important Points for the Wards:

- ACGME regulations require that interns do not work more than 16 hours in a row. Additionally, you should have 10 hours off between shifts, although at minimum you are permitted to have as little as 8 hours. This means that you should leave the hospital at 9 – 9:30 pm on your call day.

- It is the responsibility of your resident to ensure that each patient on service has the mandated number of notes written at the end of the call day. It is important to schedule your day such that you are able to complete your admission notes by the required time. If necessary, your resident is allowed to write the primary admission note on either one private patient, or one ward patient that will be presented by a medical student. In general your resident will also write a separate, shorter admission note on each new patient.

- Your daily progress notes should reflect a clearly defined plan generated in conjunction with your resident during sign-out rounds the prior evening. Intern progress notes are the primary source of information for consultants and cross-covering interns and residents. Be clear and concise but show your thought process.

- Evaluate your admissions as soon as possible.

- All paper records from the ER or affiliated clinics should be available in Eclipsys under the Documents tab. You can also request the old paper chart from Medical Records (305-7690).

- Always ask your patient if he or she is followed by another physician outside the hospital and then pursue relevant information from outside hospitals or doctors. You will need a patient’s signed consent for the release of medical information. The forms are found in all nursing stations. You can use the fax machine at any nurses’ station.

- Review EMS sheets, rhythm strips from outside, and the ER chart.

- Never hesitate to call interpreter services for any language.

- Do a complete history and physical.

- When you are cross-covering other interns’ services, you should ask for their cell number so that you can contact them if needed. You can usually reach the resident as well.

- Whenever possible, try to read about your patients’ medical problems. Use AccessMedicine, UpToDate, Medline, and Harrison’s, or search for a review article on PubMed, to learn about your patient’s problems at a slightly more in-depth level prior to morning rounds. Citing primary research in an admission note is always appreciated.
II. SPECIFIC ROTATIONS: THE DETAILS

*General Medicine 1:*

- **Teams:** 4 teams, named A, B, C, and D. Teams A and C round together and teams B and D round together.
- **Staff:** 2 “super teams” (A/C and B/D), each consisting of 2 attendings, 2 residents, 2 interns.
- **Patients:** any general medicine patients, although GI cases are preferentially admitted to Gen Med 2
- **Daily Schedule:**
  - 6:30 – 8am: Pre-rounding with resident
  - 8:00-8:45: Morning Report for resident. Work time for intern.
  - 8:45-9:00: Multidisciplinary rounds
  - 9:00-10:30: Attending Rounds
  - 10:30-12:00pm: Work time for housestaff
  - 12:00-1:00: Noon Conference. Sign pager to resident during intern report.
  - 1:15: Touch base with care coordinator and social worker
  - 5:00 or later: Pre-call, short call, and post-call teams sign out to cross coverage PA
  - 9:00-9:30: Long call intern signs out to night intern

- **Call schedule:** You take call every 4th day.
- **Clinic:** Pre-call Monday through Thursday in the afternoon
- **Days off:** Any pre-call or short call day that falls on a weekend or holiday. You sister team will cross cover your list. You should sign out to the intern who will be covering your list. If you are working on a holiday or weekend day and are cross covering, you will pre-round and write notes on cross coverage patients. Your resident will help you with this task in the beginning of the year.
- **Admitting schedule:** Long call can admit up to 3 patients. Post call can accept 1 night admission. Short call can accept 1 night admission and 1 new admission before noon. Pre-call can accept 1 night admission. Your list should not have more than 10 patients.
General Medicine 2:

- **Teams:** 4 teams, named A, B, C, and D. Teams A and C round together and teams B and D round together.
- **Staff:** 2 “super teams (A/C and B/D), each consisting of 2 attendings, 2 residents, 2 interns.
- **Patients:** Liver pre-transplant patients and any general medicine patients. GI cases are preferentially admitted to Gen Med 2
- **Daily Schedule:**
  6:30 – 8am: Pre-rounding with resident
  8:00-8:45: Morning Report for resident. Work time for intern.
  8:30-8:45: Multidisciplinary rounds.
  8:45-9:30: Liver transplant rounds in morning report room (all 4 teams)
  9:30-10:15: Ward attending rounds (A/C and B/D teams split up)
  10:30-12:00pm: Work time for housestaff
  12:00-1:00: Noon Conference. Sign pager to Resident during intern report.
  1:15: Touch base with care coordinator and social worker
  5:00 or later: Pre-call, short call, and post-call teams sign out to cross coverage PA
  9:00-9:30: Long call intern signs out to night intern

- **Call schedule:** See Gen Med 1.
- **Clinic:** See Gen Med 1.
- **Days off:** See Gen Med 1
- **Admitting schedule:** See Gen Med 1.
**ID Service:**

- **Teams:** 2 teams which round together in 9GS conference room
- **Staff:** 2 attendings (at least one HIV specialist), 2 junior residents, 2 medicine interns, 1 ED rotator
- **Patients:** Traditionally, this service was reserved for both HIV and TB patients; however this service has expanded to include patients with more complicated infectious problems.
- **Schedule:**
  - 6:30 – 8:00: Pre-rounding with resident
  - 8:00-8:45: Morning Report for resident. Work time for intern.
  - 8:15-8:45: HIV Multidisciplinary rounds with intern
  - 8:45-10:45: ID Attending Rounds
  - 10:45-12:00: ID multi-disciplinary rounds, then work time for housestaff
  - 12:00-1:00: Noon Conference
  - 9:00-9:30: PM Handoff
- **Call schedule:** The call schedule for this team is unique. It is important that you look very carefully at your day-to-day schedule to confirm when you are on call. There is no short call, only long, post and pre-call. Admitting responsibilities are rotated between the three daytime interns as depicted in the table below:

<table>
<thead>
<tr>
<th>Day</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intern A</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intern B</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED Rotator</td>
<td></td>
<td>x</td>
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<td></td>
<td>x</td>
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</tbody>
</table>

Long call team stays until 9:00pm, when they sign out to the night team.

- **Admitting Guidelines:**
  The admitting guidelines are the same for ID as for the other services with the following exceptions: (1) ID will have one admission spot reserved for an HIV patient until 2pm. (2) General medicine overflow can be admitted to ID only with chief approval. (3) Fridays, all overnight admissions go to the on call team.

- **Clinic:**
  Clinic is variable, please view the day-to-day schedule on amion to see when you are expected at clinic.

- **Days off:**
  Day off is variable. Please see the day-to-day schedule posted to see when you have days off.

- **Miscellaneous:**
  Interns on ID will also attend a multidisciplinary meeting led by Dr. Brudney on Friday mornings 8:30am at the Atchley Pavilion 13th Floor. You are expected to discuss both the medical and psychosocial barriers facing each patient.
Cardiology:

- **Location:** 5GS (occasionally 5GN)
- **Staff:** 2 Cardiology attendings, 2 residents, 2 interns, medical students
- **Patients:** All floor patients with primary underlying cardiac condition (heart failure, ischemic disease, valvular disease, arrhythmia, etc.). During this rotation you will follow both “ward” patients where your ward attending will be the attending of record, and “heart failure” patients where the attending of record will be the attending on the heart failure service. It is important to touch base with the heart failure fellow throughout the day to discuss plan for these patients. Rarely, you will get a private patient on the cardiology service.

- **Admitting Guidelines:**
  Admitting guidelines are similar to other ward rotations with the following exception: occasionally there will be an admission spot held until 2pm for CCU transfers.

- **Typical Schedule:**
  - 6:30-8:00 Housestaff Rounds.
  - 8:00-8:45 Morning Report for resident. Work time for intern. The intern will speak with the care coordinator and social worker from 8:30 to 8:45.
  - 8:45-9:30 CHF Rounds (combined, all four teams in the 5GS conference room)
  - 9:30-10:30 Cardiology Ward Rounds
  - 10:30-12:00 Work time for housestaff, multi-disciplinary rounds
  - 12:00-1:00 Noon Conference
  - 2:30 Intern briefly “regroups” with care coordinator, social worker
  - 9:00-9:30 PM Handoff

- **Clinic:**
  Pre-call Monday through Thursday in the afternoon

- **Days off:**
  Any pre-call or short call day that falls on a weekend or holiday

- **Misc:**
  - Telemetry: many of your patients will be on telemetry while admitted to the hospital. Each morning you can check a report at the telemetry desk which will give you an update of overnight events. Please review the need for continuing telemetry each day with your resident. For patients not on 5GS or 5GN you can call the Telemetry Office (305-6018) for a 24 hour Telemetry Report.
  - Transfers to intensive care: if you and your resident believe a patient belongs in the CCU, page the cardiology fellow assigned to the CCU for that day.
**Night Intern Rotations:**

**Description:**
- Interns generally have three “night intern” rotations over the course of the year. Night intern rotations provide an excellent learning opportunity. The intern will only be responsible for a single admission, which affords a unique opportunity to read and learn in depth about the interesting facets of a particular case. Additionally, while on night intern, you will be responsible for “cross-covering” the floor, which will give you experience in dealing with a variety of acute medical issues. Finally, while on night intern rotations, you will generally be able to attend morning report.

**Schedule:**
- 9PM arrival (exception 9:30 in MICU and CCU): receive signout from the long call intern (or, in the case of oncology, from the long call resident).
- 6AM – 7AM: Sign lists back over to primary team.
- 8 – 8:45AM: attend morning report
- 8:45AM: present your new admission on rounds (your resident will notify you which team you will be presenting to).
- 10AM (exception 10:30 in MICU and CCU): required that you leave by this time

**Night rotations:**
- Six different night intern rotations: general medicine 1 and 2, cardiology, ID, oncology, and a “variety rotator”. The “variety” rotation is unique in that each night you will be paired with a different resident on a different service. Additionally, one night a week you will have the opportunity to work in the MICU and CCU. Details on your responsibilities in the units can be found in the appropriate section below.

**Day Off:**

<table>
<thead>
<tr>
<th>Night Intern</th>
<th>Night Off</th>
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</thead>
<tbody>
<tr>
<td>GM 1</td>
<td>Sunday</td>
</tr>
<tr>
<td>GM 2</td>
<td>Tuesday</td>
</tr>
<tr>
<td>Cards</td>
<td>Monday</td>
</tr>
<tr>
<td>MICU</td>
<td>Wednesday</td>
</tr>
<tr>
<td>CCU</td>
<td>Thursday</td>
</tr>
<tr>
<td>AICU</td>
<td>Friday</td>
</tr>
<tr>
<td>ID</td>
<td>Saturday</td>
</tr>
<tr>
<td>Onc-Variety</td>
<td>Friday</td>
</tr>
</tbody>
</table>
**CCU:**
- **Location:** 5 Hudson South
- **Staff:** 4 residents, 4 interns, 2 cardiology attendings, one cardiology fellow
- **Call:** Residents q4 27 hour shifts; Interns q3 days with call schedule as follows:
  - **Pre-Call**  Long Call  Post Call
- **Patients:** critically ill patients with primary cardiac underlying condition (e.g. heart failure, MI, severe valvular disease, arrhythmias).
- **Schedule of the day:**
  6AM: post call intern arrives to start pre-rounding
  6:30AM: pre-call intern arrives (Thurs-Sun) to assist with prerounding
  7AM: long call intern arrives and if no new admissions assists with pre-rounding
  8 – 9:30 AM: work rounds in call room with residents
  9:30 – 12: attending rounds, present new patients
  10:30AM: night intern needs to leave by this time.
  12-1PM: Lunch and typically teaching session by cardiology fellow
  1-9PM: continued patient care
  9-9:30PM: rounding with night team
  9:30PM: long call intern leaves

**Summary of hours for CCU/MICU by intern shift:**

<table>
<thead>
<tr>
<th>Shift</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Long Call:</strong></td>
<td>7 AM – 9:30 PM</td>
</tr>
<tr>
<td><strong>Night Intern:</strong></td>
<td>9:30 PM - 10:30 AM</td>
</tr>
<tr>
<td><strong>Postcall:</strong></td>
<td>6 AM – work completed</td>
</tr>
<tr>
<td><strong>Precall, weekday:</strong></td>
<td>7 AM - 1 PM, then clinic to 5:00 pm</td>
</tr>
<tr>
<td><strong>Precall, weekend:</strong></td>
<td>7 AM - 3:00 PM</td>
</tr>
</tbody>
</table>

The structure of the day is as follows:
- **Job responsibility;**
  - **Long call:**
    - Primary responsibility is to admit patients with your resident throughout the day (including any lines, labs, history, exam, speaking to outside physicians, family, and writing the admission note). You will admit until 7PM, any admissions after 7PM you will assist with patient care until you leave at 9:30PM but you are not responsible for writing the admission note or presenting the patient the next day.
  - **Post call:**
    - Pre-rounding: Each morning, the post call intern assigns patients among the interns for pre-rounding. Generally, the post call intern can pre-round on the most patients because he or she arrives earliest, at 6 am. The long call intern arrives at 7
am and assists in pre-rounding, unless there is a new admission to be evaluated at that time. The night intern is also expected to help with prerounding, unless he or she is fully occupied with admissions. A precall intern will additionally arrive at 7 am, but only on Fridays – Sundays. On Mondays - Thursdays, the residents are expected to assist with pre-rounding when needed. Pre-rounding consists of reviewing overnight events with the postcall team, a focused H and P, and writing down labs, meds, and the physical exam on the progress note, as well as starting to formulate a plan for the day. As many of these elements are now automatically incorporated into the interns note through Eclipsys (e.g. medications, VS, some labs), the intern is expected to spend time contemplating the care plan for the patient.

- **Pre-call intern:**
  - Primary responsibility on Thurs – Sunday is assisting the post call intern on pre-rounding on each patient, then staying around throughout the day on Sat/Sun to assist with any procedures, trips, etc. On Thurs and Friday you will have clinic in the afternoon.

- **Day / Night off:**
  - Day: precall day, when it falls on a Monday, Tuesday, or Wednesday.
  - Night: Thursday night

- **Clinic:**
  - The pre-call intern will have clinic on Thursdays and Friday afternoons. (On Saturdays, the pre-call intern will work in the CCU, but generally should leave by 3 pm.) After clinic it is the intern’s responsibility to call or stop by the unit to see if they are needed any more before heading home.
**MICU:**

- **Location:** 4 Hudson
- **Staff:** 4 residents, 4 interns, 1 pulm/critical care attending, one pulmonary fellow
- **Call:** Residents q4 27 hour shifts; Interns q3 days with call schedule as follows:
  - Pre-Call | Long Call | Post Call
- **Patients:** critically ill patients with a variety of underlying disease ranging from pulmonary to hematologic.
- **Schedule of the day:**
  - 6AM: post call intern arrives to start pre-rounding
  - 6:30AM: pre-call intern arrives (Thurs-Sun) to assist with prerounding
  - 7AM: long call intern arrives and if no new admissions assists with prerounding
  - 7:30-8AM: work rounds in call room with residents
  - 8-11AM: attending rounds, present new patients
  - 10:30AM: night intern needs to leave by this time.
  - 12-11PM: Lunch and typically teaching session by pulmonary fellow
  - 1-9PM: continued patient care
  - 5-6PM: pre and post call interns typically begin to leave
  - 9-9:30PM: rounding with night team
  - 9:30PM: long call intern leaves

**Summary of hours for CCU/MICU by intern shift:**

<table>
<thead>
<tr>
<th>Shift</th>
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The structure of the day is as follows:

- **Job responsibility:**
  - **Long call:**
    - Primary responsibility is to admit patients with your resident throughout the day (including any lines, labs, history, exam, speaking to outside physicians, family, and writing the admission note). You will admit until 7PM, any admissions after 7PM you will assist with patient care until you leave at 9:30PM but you are not responsible for writing the admission note or presenting the patient the next day.
  - **Post call:**
    - Pre-rounding: Each morning, the post call intern assigns patients among the interns for pre-rounding. Generally, the
post call intern can pre-round on the most patients because he or she arrives earliest, at 6 am. The long call intern arrives at 7 am and assists in pre-rounding, unless there is a new admission to be evaluated at that time. The night intern is also expected to help with prerounding, unless he or she is fully occupied with admissions. A precall intern will additionally arrive at 7 am, but only on Fridays – Sundays. On Mondays - Thursdays, the residents are expected to assist with pre-rounding when needed. Pre-rounding consists of reviewing overnight events with the postcall team, a focused H and P, and writing down labs, meds, and the physical exam on the progress note, as well as starting to formulate a plan for the day. As many of these elements are now automatically incorporated into the interns note through Eclipsys (e.g. medications, VS, some labs), the intern is expected to spend time contemplating the care plan for the patient.

- **Pre-call intern:**
  - Primary responsibility on Thurs – Sunday is assisting the post call intern on pre-rounding on each patient, then staying around throughout the day on Sat/Sun to assist with any procedures, trips, etc. On Thurs and Friday you will have clinic in the afternoon.

- **Day / Night off:**
  - Day: pre-call day, when it falls on a Monday, Tuesday, or Wednesday.
  - Night: Wednesday night

- **Clinic:**
  - The pre-call intern will have clinic on Thursdays and Friday afternoons. (On Saturdays, the pre-call intern will work in the ICU, but generally should leave by 3 pm.) After clinic it is the intern’s responsibility to call or stop by the unit to see if they are needed any more before heading home.

**MICU Night Intern Transitions:**
Each MICU night intern begins a sequence of night shifts on a Thursday and ends the sequence on a Tuesday night shift into Wednesday morning. Wednesday night is off for that intern. The intern is expected back in the MICU on Friday for a long call day and the beginning of the q3 daytime call cycle. See below for an example:

<table>
<thead>
<tr>
<th>Day</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intern A</td>
<td>Long</td>
<td>Post</td>
<td>NI</td>
<td>NI</td>
<td>NI</td>
<td>NI</td>
<td>NI</td>
<td>NI</td>
<td>Off</td>
<td>Clinic only</td>
<td>Long</td>
</tr>
</tbody>
</table>

NI = Night Intern shift
Long = Long call daytime shift
Post = Post call daytime shift
Allen Hospital
It's at 220th and Broadway accessible by:
1 train: get off at 215th street and walk north until you hit 220 and Broadway.
A train: get off at 207th street (the last stop!)
Shuttle from Milstein: a navy blue van leaves from the front door of Milstein and Allen Hospitals, Monday through Friday at the following times:
Allen: Starting at 5:45am, every 30 minutes (on the :15 and :45) until 6pm.
Milstein: 6:00am, 6:30am, 7:00am, 7:30am, 7:45am then every 30 minutes (on the :15 and :45) until 6pm. At all other times you can request a ride from Allen Security at 4-4400 (932-4400)
Depending on traffic the trip is usually 10-20 minutes.

Rotations:

Allen Wards:
- **Location**: 2nd floor of Allen Pavilion, meet in the morning report room
- **Staff**: 1 resident, 2 interns, 2 attendings
- **Patients**: only ward patients, no privates. Typically patients present to the Allen with more “bread and butter” medical problems; this is a great rotation to improve on the basics of medicine.
- **Schedule**
  6:30-7AM: arrival and taking sign out from the overnight PA
  7:45am-8:30am: Work Rounds with senior resident
  8:30am-10:00am (10:30am if necessary): Attending Rounds
  10:00am-11:15am: Multidisciplinary rounds, daily work, and patient care.
  12-1: noon conference
  1PM on: patient care
- **Conferences**:
  - On Tuesdays, there is intern report from 11:15 am – 12:00 am. The pre-call intern will present a patient from their service to an attending for discussion. You must sign over your pagers to the senior resident during this period and they will cover the floors while you are in report. Medical students should attend.
  - Thursdays, Chief of Service is 11:15am-12:00pm. The pre-call intern presents a case to an attending at bedside. Residents and medical students should attend.
  - Daily Noon conferences
- **Admitting guidelines**
  - Long call will get 3 long admission, rarely one overnight admission
  - Short call: will get 2 overnights
  - Post call: 1 overnight
  - Pre-call: no admissions
- **Clinic**
  Like Milstein, clinic is on the pre-call day and but starts at 2pm to allow for travel time from the Allen. The pre-call intern signs out to the post-call intern
when leaving for clinic. The long-call intern ultimately hears signout from the short-call, and postcall interns. The overall cap for patients is 10 per intern.

- **Days off:** Pre call or short call days that fall on weekends or holidays.
- **Readmission Policy:** During your month at the Allen you will be tied to any patient you discharge. If the patient is admitted to the Allen for a medical problem at any time prior to the end of your rotation the patient will be placed on your list. If the patient returns during off hours or days you are not admitting, the admitting intern/nightfloat will be responsible for covering the patient and transferring back to you on the morning of your next shift. The readmissions will not count toward your team’s daily admission caps but your list cannot have more than 10 patients. The intern or nightfloat resident covering a new readmission will never be asked to absorb more than one “extra” patient during their admit cycle (i.e. the limit is 3 admissions + 1 readmission).
Allen ICU

- **Location:** 2nd floor of Allen
- **Staff:** 4 interns, 1 Senior Resident, 2 Attendings (typically 1 pulmonologist, 1 cardiologist)
- **Call cycle:**
  While in the AICU, as in the MICU and CCU, you will spend one week out of three on a nights. While not on nights, you will take Q3 call.
- **Patients:** patients requiring ICU level that do not require Milstein-specific services
- **Schedule:**
  6AM: post call intern arrives to start pre-rounding  
  6:30AM: pre-call intern arrives (Thurs-Sun) to assist with prerounding  
  7AM: long call intern arrives and if no new admissions assists with pre-rounding  
  7:30-8AM: work rounds in call room with residents  
  8-11AM: attending rounds, present new patients  
  10:30AM: night intern needs to leave by this time.  
  12-1PM: Medicine Noon conference  
  1-9PM: continued patient care  
  5-6PM: pre and post call interns typically begin to leave  
  8:30 pm. At that time the night intern, the day long-call intern, the senior resident, and the hospitalist will conduct one hour walk-rounds on all patients.  
  9-9:30PM: long call intern leaves
- **Specific responsibilities:**
  - Long call: The long-call intern ‘holds the board,’ overseeing the operations of the unit and is the point-person responding to all changes in patients’ conditions  
  - Night intern: Takes over responsibilities from long call intern. There is no senior resident coverage overnight, but a hospitalist attending will be available for questions, admissions, and supervision of procedures.  
  - Post call: the post call intern will arrive in the unit at 6am to pre-round, but there are additional responsibilities including reviewing and responding to the AM labs and reviewing the daily EKG on all patients.  
  - Pre-call: The precall intern, on days when there is one, will arrive at 7 am and begin seeing follow-ups.
- **Clinic:**
  If the pre-call day falls on a Monday through Thursday, you will have clinic starting at 2pm after completing your daily duties in the AICU.
- **Days off:**
  pre-call day is your day off if it falls on a Friday through Sunday (unlike Milstein)
- **Of note:** This is one of the more challenging months of internship both emotionally and physically, but also is very rewarding as you have a greater degree of autonomy within a well-supervised setting.
Geriatrics/CRC:
This is a one-month rotation consisting of a comprehensive interdisciplinary experience. You will also attend Continuity Clinic and conferences while on this rotation. There will be didactic sessions in the beginning of the month to introduce you to the language of gerontology and geriatrics. You will perform consults on inpatient geriatric patients at the Allen Pavilion. There is a palliative care and evidence-based medicine curriculum as well. You will give a noon conference lecture (20-30 minutes) on a topic relevant to geriatric medicine and present a geriatric journal club article. Dr. Evelyn Granieri coordinates this rotation and will orient you more on the first day of your rotation. Geriatrics interns may be rarely called on for sick pull coverage if the elective sick pull pool is exhausted or under other special circumstances.

Integrated into the geriatrics rotation is a Clinical Research Curriculum (CRC) in which interns will be immersed in basic methods of clinical research. You will learn more about asking research questions, employing statistics in research, and designing research studies. You will be expected to devise an IRB proposal for a research project of your interest. You will work with world-renowned Columbia faculty to develop your research project and will then present a research proposal to a faculty panel. This is a unique experience that will allow you to get an early start on a research project that you will hopefully be able to carry through to fruition by the end of your residency. Specific information regarding schedules, etc. will be provided at the beginning of the rotation.
III. DAILY SCHEDULE ON WARD MONTHS: IN DEPTH

6:30 AM – 8:00 AM: *Housestaff Rounds*
It is in your interest to have ample time to adequately evaluate all of your patients. Therefore, you should arrive in the hospital and receive signout from the night intern no later than 7 am. It is crucial you speak with the night intern even if all your patients appear stable, as you cannot anticipate what may have transpired overnight. Ensure the virtual pager is signed over to your pager at this point, and then begin seeing patients. Sometimes, you will see all of the patients together with your resident, and other times you will only see a select few. You will, however, discuss all of the patients with your resident. Ultimately, it is your responsibility to have seen all of your patients prior to attending rounds.

During these “housestaff rounds,” although you will usually see patients together, it is the responsibility of the intern to briefly present each patient. Presentations should be concise and problem-oriented, focusing on events overnight and relevant studies, consults, etc. that have occurred over the past 24 hours. Each day the disposition for the patient is revisited. This is also a time for your resident to teach both you and your medical students informally. Medical students should have their presentations ready and practiced and their notes reviewed and co-signed before attending rounds. This is generally the responsibility of the resident. During the interview season, you should expect to have interviewees join you every Tuesday and Thursday for rounds.

8:00 – 8:45 AM
Residents go to Morning Report from 8:00am to 8:45am Monday-Thursday, allowing time for interns to review the daily plan with patients’ nurses, schedule diagnostic studies, call consultants, and check that morning labs were drawn, before you start attending rounds. This is also the time to see any patients that were not seen with your resident. Having your notes written before 8:45am work rounds also makes the entire day run more smoothly and helps guarantee that you will leave at a reasonable time, however, patient care responsibilities ALWAYS supersede note-writing. Before your resident, attendings, or consultants generate a lot of work for you, try to formulate a daily plan before work rounds and have your progress notes written.

This is also a good time to begin to arrange discharges for your patients, and to place pending discharge orders. If the patients are awaiting approval for discharge from attendings or need certain services from social work, these orders can then be simply released after multidisciplinary rounds, which run from 8:45 – 9:00 AM (although these times may vary by service).

You are encouraged to check that morning labs were actually drawn before you enter attending rounds. Labs not drawn in the morning are either ordered to be
redrawn, or you and your medical student should draw them. Morning labs are usually back before noon conference, so it is best to check the results right after rounds, or earlier if you are waiting for a critical lab. As your intern year progresses and you become more efficient, and all of the “scut” is completed before attending rounds, do not hesitate to join your resident at Morning Report.

**Multidisciplinary Rounds**

On multidisciplinary rounds, interns, residents, and attendings will discuss patient care with care coordinators and social workers. Who attends multidisciplinary and when is dependent on the service, and can be determined by consulting the schedule above. During these rounds, the intern will briefly present each patient, and state the social work needs of the patient and the disposition plan. This is also the time to relate important studies, tests etc. to the care coordinator, who can help ensure the tests are done that day. This is a good time to place active discharge orders for patients who are ready for discharge, to have attendings fill out forms required by social work, and to discuss barriers to discharge.

On ID, as indicated above, the intern has a specific role for multidisciplinary rounds: they will attend a meeting led by Dr. Brudney on Friday mornings 8:30am at the Atchley Pavilion 13th Floor. You are expected to discuss both the medical and psychosocial barriers facing each patient.

**Attending Rounds:**

Attending Rounds at Milstein are at the times listed above. All new ward admissions, including night resident/intern admissions, are presented at attending rounds. The ward patients, both new admissions and follow-ups, are presented by the intern or medical student. If time allows, the team may also briefly review interesting private patients. The entire team must be familiar with all of the patients. This will be relevant when providing cross-coverage for your co-interns when they are in clinic or on the weekends.

Presentations for attending rounds should be concise and contain a clear chief complaint, history and physical, pertinent lab results, CXR, EKG, and a well-developed assessment and plan. Be prepared to present at the bedside. In the beginning of the year, your resident should assist you with the structuring of your presentation and the assessment and plan.

On the GM1 and GM2 service, a dedicated care coordinator will be assigned to each team on these services to act as a liaison between the teams and social work. These care coordinators will touch base with the teams at various points throughout the day but specifically during work rounds, after attending rounds, and at the end of the work day, and will cover every patient on your list regardless of their location. They will also serve to identify barriers to discharge and facilitate discharge planning.
**Signout Rounds (and Transfer of Care):**
Interns and Residents should meet formally each day in the afternoon to review the day’s events and data. Each patient is reviewed including significant lab data, diagnostic studies, and consultant’s notes. These rounds are brief and problem-oriented. Plans are generated for the following day, and potential issues for the team intern and overnight cross-coverage intern are identified.

Before leaving for the day you will update your sign out list from Eclipsys, including the following data:

- Patient’s name, unit number, and location
- Chief complaint and short sentence or two on the patient
- Working Diagnosis (this should evolve as the admission progresses).
- Plan
- List of all medications, which should be reviewed and edited daily, especially the current antibiotics and day started
- Attending’s name if private, or “Ward” with the ward attending’s name
- List if an IV is in place and necessary if it falls out
  - IV +/+ has one/needs one
  - IV +/- has one/don’t worry if it falls out
  - IV -/- doesn’t have or need one
- What temperature you should pan-culture at: Cx temp >101
- Code status: DNR or Full Code
- Long call intern/Night intern tasks, and how to respond

For example:
*Doe, John 5GS MR#1234567*
*Impression: CHF exacerbation*
*62 M w/HTN, DM, CHF, admitted w/ increased SOB and PVC on CXR, found to be in CHF exacerbation.*
*Plan: admitted for IV diuresis*
*Meds: lasix 40 mg IV bid, lisinopril 10 mg po daily, toprol xl 25 mg po daily, ECASA 81 mg po daily, Tylenol 650 mg po q6h prn*
*Ward (Dr. A. Smith), +/-, Cx>101, full code*
*Team intern (TI): f/u 8 pm Chem 7-replete potassium for K<4.0*

This is the basic data that must be entered into your signout and updated daily. It is important that signouts do not become a log of a patient’s hospitalization. While signouts will be somewhat longer on patients who have been in the hospital for an extended period of time, it is important that only essential information be included so that cross-coverage physicians can easily navigate the signout if they are notified about the patient.

Each day, add to your paper copy of the signout any labs or studies that need to be checked while you are out of the hospital, or “vital sign checks”, “neuro checks,” or “lung checks” on unstable patients. This work will need to be signed over to the long call intern, who will then sign it over to the night intern at 9:00 pm.

Only lab data and studies that may actually change the management of your patient overnight should be signed over (i.e. no need to check c-anca results at
midnight). Labs should be signed over with specific instructions on how to handle them. (e.g. if K+ is >6.0, give Kayexelate 15gm and check EKG etc. or if K+ <3.5, give Kcl 10meq x 3 runs IV).

On your signout, include what time the labs are ordered (e.g. 9 pm BMP) or entered in the computer so the night intern knows when to check results. Tests signed out, such as a CXR or head CT, should specify what is being assessed and what should be done in the event of a positive study (e.g. if CXR is + for pneumonia, start ceftriaxone 1 gram IV daily). Certain tasks for signout also require some preparation. For example, if signing out a possible blood transfusion after a nighttime lab check, you should have consented your patient for blood and obtained a type and screen (T&S) on that patient before you sign out.

You should not be signing out acute, active or emergent issues on your patients. For instance, if you have a high suspicion that your patient has worsening mental status because of an intracranial hemorrhage, you should follow-up the CT before signing out. This is not to imply that you should never sign over ill patients, but they should be quasi-stable with a clearly communicated verbal and written signout - not on the cusp of an arrest or an ICU transfer. Indeed, you should never leave the hospital in an emergent situation. Your resident will be crucial in the assessment of these patients and mobilizing the appropriate resources. Once the emergent issue is resolved or is being adequately addressed by your resident and other housestaff, it is then appropriate to leave the hospital. Your resident is also responsible for the transfer of care to covering physicians. If an issue is not clear or if a patient is not completely stable, the resident will also endorse this to the covering resident.

**Do Not:**
1) Sign out too little in order to minimize work for your co-interns. Patient care comes first.
2) Sign out too much – only things that will change management or the patient’s safety while you are gone.
3) Give sign out without explicit instructions
   - DO NOT sign out []PM CBC
   - DO sign out []PM CBC – transfuse 2 units PRBCs if Hgb<8, has T&S, has consent
4) Keep the same signout for weeks. Signout should be updated daily.
5) **LEAVE AN UNSTABLE PATIENT UNLESS YOU HAVE ENSURED SAFE TRANSFER OF CARE**
IV. ARRESTS

At Milstein, Long-Call Interns on Gen Med 1, 2, Oncology, Cardiology and ID are responsible for responding to all arrests and assisting with resuscitative efforts. At night, all night interns are responsible as well. You should not leave an arrest until asked to do so by the resident running the arrest or the ICU triage resident. At the Allen Pavilion, all interns on the ward service should respond to arrests regardless of your day in the call cycle.

V. NOTES

Daily Progress Notes:
A daily progress note must be written on every patient on your service every day. The daily note should follow the basic SOAP format. It should clearly state the patient’s status and orientation when you examined them. This is essential for those who may see the patient later and may have to compare and contrast from baseline. Each daily note should have the vitals, physical exam, new data, a succinct assessment and a clear plan for the day. All notes should be written in Eclipsys. While you may paste the results of vital signs, labs, and radiology studies into your note, it is unacceptable to cut and paste the subjective portions, physical exam, and assessment and plan from previous notes. Additionally, it is better to summarize lab or study results in your note in your own words, as opposed to simply transferring in toto long-winded reports. Your assessment and plan should be updated daily to indicate changes in the patient’s status and disposition.

Weekend Coverage Notes:
On the weekend, the long and post-call interns are responsible for writing cross-coverage notes. You should be familiar with your co-intern’s patients from attending rounds. The intern who is on long call on Saturday will pick up the signout list and write progress notes on Saturday and Sunday for the intern who has the weekend off. It is the responsibility of the intern who has the day or weekend off to identify and sign out to the intern who will be covering his or her service. The intern who has the day off is also responsible for ordering tests, particularly blood tests, before he or she leaves.

*Gen Med 1 and 2, Oncology, Cardiology, and Allen Wards:*

*Saturday Post-Call Intern:* These interns must write the notes and manage the patients of the interns who are on call on Sunday and absent on Saturday.

*Saturday Long Call Intern:* Starting at 7:00am Saturday morning until 9:00 pm that night, and then again on Sunday from 7:00 am until the time of departure, this intern will carry the lists, write the notes, and manage the
patients of the interns who were post-call on Friday (and have their golden weekend).

**Sunday Long Call Intern:** Write the notes and manage the patients of the intern who would have been short call (but instead has the day off).

**ID:**

**Long Call Intern:** covers Pre-Call Intern on Friday, Saturday, or Sunday. This includes writing notes, following up on labs, and answering cross-coverage phone calls.

When you receive a signout from an intern, call the page operator immediately (305-2323) and sign their team pager over to yours.

**Admission Note:**
Your admission note should be thorough and completed on Eclipsys. In general, you should follow the standard admission note template but try to streamline your note to focus on the most important information. Write your note in a format that is easy to read. For instance, it may be easier to read a list detailing the chronology of related events than to sift through prose describing the same medical history. Pay particular attention to the history and to the med list, as many others will be using your note for reference. Patients' medication lists should be reviewed meticulously at each transition of care and the process must be documented.

**Event Note:**
These are some of the most important notes in the chart that document events on your patients and patients you may be covering at any given time. Events may include, but are not limited to, acute changes in the patient’s status (i.e. fever, fall, change in mental status, any pain, cardiac arrest, DNR discussion), discussions with the patient or patient’s family, elopement or leaving AMA (against medical advice). Remember your best tool for communicating with the entire team (MDs, RNs, nutritionists, social workers) is the medical record.

**Procedure Note:**
Any procedure, such as lumbar puncture, thoracentesis, central line, and arthrocentesis requires documentation of informed consent and a brief procedure note in Eclipsys. A “Time Out” to confirm the patient, procedure, and correct site should be completed prior to every procedure, and its occurrence documented in at Time Out form and the procedure note. Procedure notes should include the site of the procedure, including side, what specimens were collected and sent to the lab, and any complications. Aborted, unsuccessful procedures must also be documented. You must document all procedures performed in E*Value PxDx. Please read the Procedures Manual for a full outline of the procedure requirements for the Internal Medicine Housestaff at Columbia University Medical Center/New York Presbyterian Hospital.
**Transfer Note:**
Any patient leaving or entering an ICU, nursing home, or another hospital should have a concise transfer note of the pertinent history and physical, the events that led to their transfer, and an updated medication list. If they are leaving the hospital, print out important information such as labs and tests as well.

**Discharge Summary:**
Discharge summaries should occur at time of discharge. Timely discharge summaries are not only a requirement, but they improve patient care as many patients return to the ER or clinic soon after discharge. This information allows for appropriate care and reduces redundancy of treatment or treatment failure. Discharge summaries should be completed within 48 hours of discharge and, if the patient’s PMD is not affiliated with NYPH, the note should be faxed to the appropriate physician to ensure continuity of care. You should not leave your ward rotation without having your dictation summaries completed for all your patients. Please submit an NYP Discharge Note on Eclipsys. A discharge summary does not need to regurgitate all the information from the admission note, but should be a summary of the events of the hospitalization. It should include changes to the patient’s outpatient medications as well as a description of future treatment plans and the follow-up scheduled for the patient. The intern is responsible for all ward and liver service inpatient discharge summaries. Private attending, including private cardiology or CHF attending, should dictate their patient’s discharge summary themselves.
VI. CONFERENCES AT MILSTEIN

Grand Rounds:
Every Wednesday (except during July and August) at noon, the Department of Medicine holds Grand Rounds in the Heart Center Auditorium. Attendance while on the wards is required for all house officers. Please be sure to sign in. The conference presents speakers, largely nationally recognized leaders in academic medicine, on various topics including biomedical technology, research, ethics, health care economics, and so forth.

Noon Conference:
Noon Conference will be held either in the Morning Report Room or in the Heart Center classrooms. Noon conference is the hallmark of the educational curriculum of the residency program. Noon conference is mandatory for all house staff not in the ICU, on vacation, or in the ER, and daily attendance is recorded. This conference presents core didactic sessions throughout the three years of training. Lectures are presented by faculty of the Department of Medicine and other departments. Lunch is provided daily. Interns rotating through the ER and ICU have separate noon conferences. In the summer months the Noon Conferences both at The Allen and Milstein will consist of a “Fundamentals in Medicine” lecture series. Attendance at this series is particularly important for new interns and your resident should make every effort to ensure your attendance. Starting in September, noon conferences will consist of didactics, senior talks, Morbidity and Mortality conferences, Clinical Pathologic Conferences and Autopsy Conferences presented by a Chief Resident.

Intern Report:
Every Monday at noon Intern Report is held in the 6GS Lindenbaum Conference Room (Room #303, a.k.a. the “Morning Report Room”). This conference is the premier weekly conference for interns and attendance is mandatory. An intern presents an interesting case to one of our senior attendings, similar to the format at morning report. A Chief Resident selects the case, and the intern presenting is usually asked one to two weeks before the report, so that he or she can prepare to present the case. During this conference, all interns must sign over their beepers to their residents for the hour.

Resident Report:
Resident report is geared to the schedule, and the knowledge level, of junior and senior residents. That being said, interns are strongly encouraged to attend resident report, when able. This will primarily be possible, and is in fact mandatory, during night intern blocks, when the interns will have only a single admission to prepare, and will sign over the lists to the day interns at 7 am.

Chief Rounds:
Daily from 2:00-3:00 pm Tuesday to Thursday in the Morning Report room, a chief resident or PGY3 resident will lead a conference on the topic of their choice. It is an informal time to learn from your colleagues. All interns not involved in urgent patient care are encouraged to attend and all others are welcome, especially medical students.

VII. MISCELLANEOUS MILSTEIN ROTATION INFORMATION

Discharges:
Discharge planning should start the day of admission. Do not wait until the day of discharge to discover that your patient is homeless and cannot pay for medications; this will increase their length of stay considerably. A social worker should be involved with all of your patients within 24 hours of admission. Fill out pertinent forms, such as the M11Q and the so-called “Pink” as soon as possible. These forms will be discussed in morning multidisciplinary rounds. To discharge a patient properly, you should write a set of orders similar to admission orders (this is done in Eclipsys). You will also need to perform medication reconciliation in the Eclipsys prescription writer.

For example:
- Discharge patient to home with family
- Discharge diagnosis: Pneumonia
- Discharge Activity: as tolerated
- Diet: low cholest, low salt
- Discharge Meds: levaquin 500 mg po daily x 7 days, Tylenol 650 mg po q6h prn
- Discharge Follow Up: Appt with Dr. Doe in one week in AIM clinic.

You should write the final order for discharge and have prescriptions written (your resident will help you with this in the beginning). When the patient leaves, you can write the discharge summary, and proceed with your day (see above section on discharge summaries). If a patient returns to the hospital requiring re-admission within 24 hours of discharge they are considered a “bounce back” and will be admitted to the team from which they were discharged, even if the discharging team is not on call. If the discharging team is on call and they receive a bounce back that patient does not count toward their daily admitting cap. However, an intern can still not carry more than 10 patients at any given time.

You are encouraged but not required to write a PENDING discharge order the night before a patient is expected to be discharged. Doing so permits the overnight nurse to prioritize that patient for discharge and to prepare nursing paperwork that goes into an admission. This order can be released (i.e. made ACTIVE) the morning of admission before attending rounds if there were no major events overnight.

Telemetry:
There are 2 telemetry orders at Milstein. One labeled as “Milstein Telemetry-Cardiac Floors” and the other as “Milstein Telemetry-Non Cardiac Floors.” It is MANDATORY that providers use the “non-cardiac floors” order for all patients on non-cardiac floors (all hospital floors except for 5GN, 5GS, 5HN, 7HN). This order will automatically expire after 48hrs at which time Eclipsys will prompt you to discontinue or re-order telemetry. You may re-order tele for your patient if you think he or she requires it after the initial 48 hours, but you should discuss this with your resident and attending.

Alternate Level of Care (ALC):
This is a term that the hospital uses for patients who are ready to be discharged from a medical perspective, but are delayed for social service reasons. This can apply to ward or private patients. You should confirm that a patient is appropriate for ALC with your resident, attending, and social worker. To make a patient “ALC,” write an order in Eclipsys. You are required to write a note on ALC patients every other day (i.e., 3-4 times per week). You must also keep ALC patients on your signout. ALC patients do count toward your cap of 10 patients. There is a hospitalist-run ALC service that you sometimes can transfer such patients to; speak to your resident about this if it arises.

Private Patients:
Patients with private attendings may be admitted from the ER, directly from private offices, or transferred from outside institutions or the ICUs. The team is responsible for contacting the private attendings of patients they admit. This exchange must occur even if the ER or ICU physicians have spoken with the attending. The case and plan for the patient is discussed and documented at the end of your note as “discussed with attending.” A member of the team should discuss the patient’s progress with the attending on a daily basis. If an attending wants to make any order changes he or she must contact a house officer to write an order. Current regulations, discussed in the separate “Policy and Procedures Manual,” from the American Council for Graduate Medical Education (ACGME) require that all physician orders for on-service patients be written by the house staff caring for the patient. This policy of the “closed order book” exists to ensure that residents are involved in all aspects of the decision making process in the care of their patients. This is also important in order to avoid duplicate or conflicting orders for patient safety. If any attending is writing orders in Eclipsys please contact the Chief Resident on call or e-mail the information (attending, pt MR# and date of occurrence) to intmedchiefs@columbia.edu. Additionally, if you think the private is stable and/or is not providing significant educational opportunities for the team please contact the private attending and ask if he or she would allow the patient to be transferred to the PA service. If the attending agrees, page the admitting PA (88774) and make sure they have admitting capacity for the patient and give them sign out on the patient. You will also need to write a transfer summary note.

Off-Service Patients:
Not all patients are on the teaching service or hospitalist service. Off-service patients are covered solely by their private attendings. Interns do not cover these patients. Off-service patients can be made on service if an attending feels the patient needs closer care. If a patient is made on-service to your team, it counts as a long call admission. If a previously on-service patient is made off-service and then is placed back on service within 24 hours of being made off-service, the patient will return to your panel whether or not you are on call, and does not count towards your cap, but this is a rare occurrence.
VIII. ADDITIONAL INTERN ROTATIONS

*Emergency Room:*
Psychiatry interns rotate for two-week blocks through the ER. Resident shifts are 12 hours long and are rotated on a staggered basis to include 8am-8pm, 12noon-12midnight, and 9pm-9am shifts. Conferences will include a daily noon conference and Wednesday didactics from 8am to 1pm, which will take place either at Columbia or Cornell on an alternating-week schedule. Medicine housestaff who are on during these conferences will be released from their clinical duties. Attendance to didactic sessions is mandatory, including the Cornell sessions (transportation is available via the Cornell Shuttle outside the Milstein main entrance).

*Outpatient:*
The Ambulatory block curriculum and schedule are generated and provided by AIM (Associates in Internal Medicine). Dr. Steve Mackey (beeper 81396) coordinates the PGY1 rotation. You will receive a separate syllabus, schedule, and orientation at the start of your outpatient month. There will be some morning conferences for you to attend, and otherwise you should attend resident report. Interns are required to attend Noon Conference and Intern Report while on this rotation. The day is comprised of a morning clinic session (9am-12pm) and an afternoon session (1-5 pm). Clinic sessions may be in AIM or some other subspecialty clinic. At 5 pm Monday through Thursday, there are additional hour didactics on core ambulatory topics.

Note that while on outpatient (OPD), you will be asked to cover two Friday night night intern shifts in either the Allen ICU or in the CCU. This is to permit your colleagues to have a night off during their time as unit night interns. These nights have been determined in advance and are viewable on amion under “Shift” for your OPD block or in your personal schedule.

*Elective:*
Generally, interns rotate through subspecialty consult services or get involved in research. You will still have continuity clinic (two sessions per week) during elective. All elective proposals should be submitted one month in advance to the Chiefs’ Office for approval. Away elective proposals should be submitted two months in advance for GME approval. Elective proposal forms are available in the Chiefs’ office. Please utilize the Chief Medical Residents if you have any questions regarding the scheduling of your elective. You will be evaluated by your attending at the end of the month, and you will evaluate the rotation. These evaluations and your elective proposal will be added to your permanent open file, which you can review at any time. During your elective month, you have sick pull responsibilities. Prior to the start of the elective, a sick pull order list should be generated. If your group of four interns is unable to generate a reasonable list
before the first day of the rotation, the Chief on Call will generate the list. While on sick call, particularly if you are first and second pull, you must wear your beeper at all times and be within one hour of the hospital. You can be called at any time. If you are not available for your sick pull the next person on the list will be pulled, and you will owe that individual two times the number of hours worked. Please be sure to review the sick pull policy.

IX. CONTINUITY CLINIC:
Continuity Clinic is scheduled to fall on your pre-call day while on-service. When in the AICU, clinic will start at 2pm on your pre-call day when your pre-call day falls on a Monday through Thursday. While in the CCU or MICU, the clinic begins at 1pm. OPD, Geriatrics/CRC, and elective also have clinic responsibility. No clinic is scheduled during night rotations or vacation. You can find the clinic rules on www.medicineclinic.org, under housestaff schedules.

Typically, you will see one or two new patients and three to four follow up patients in one session. All patients are presented to the PIC (Physician in Charge). This attending is responsible for reviewing the H&P, and assisting you in the management of all your clinic patients. Make no mistake though, you are the primary care doctor for these patients, and they will see you as such. Many of them will never meet or even know that there is an attending ultimately responsible for their care. However, feel free to have the PIC come in to your room if you have questions about the patient’s history or physical.

If for some reason you are unable to attend your clinic session (i.e., you have been pulled from elective for sick pull or you are sick yourself), call the Chief-on-call and email the chiefs at intmedchiefs@columbia.edu. Only a Chief Resident can cancel clinics for the house staff.

X. ILLNESS, ABSENCE, AND SICK PULL
A. General rules when sick
   1) Be reasonable: Don’t work while requiring IV hydration, but don’t call in sick for allergic rhinitis.
   2) If you do plan to call in sick, call as soon as possible before your shift starts to allow adequate time to arrange coverage.
   3) Notify the Chief on Call if you are sick on a clinic day so that he or she can cancel your clinic.
   4) You must speak to the chief by direct phone conversation or in person. E-mail and/or messages on the chiefs answering machine are NOT acceptable alternatives. PLEASE CONTACT THE CHIEFS AS EARLY AS POSSIBLE if you know (or even suspect) that you will be unable to make it to work. All absences, even those not requiring coverage, must be reported to the chief resident on call. If you call in sick for three consecutive days, you are required to see a doctor and
obtain a note. If you do not have an MD, you can be seen in Occupational Health.

5) Interns absent from work due to illness should be reachable to provide information that may be needed about their patients.

6) Interns with non-emergent absences must arrange for coverage of their clinical responsibilities. Interns absent for reasons other than illness or emergency for whom another intern is pulled will be scheduled to pay back twice the number of hours worked by the pulled intern. Submit coverage schedule requests in advance to the Chief’s Office.

7) You are allowed 3 days off without payback requirement in an academic year, but if you call in sick more than 3 days, you will be required to pay back each subsequently pulled intern after the 3rd, for each shift that was covered. This will be decided on a case-by-case basis by the chief residents.

B. Sick-pull

Interns on elective may be pulled to cover sick or absent interns. The list of pull order should be submitted to the chief’s office prior to the start of each new block, with contact info for each intern. Any changes to this list must be given to the chiefs. Interns who are on sick pull must be available by beeper or phone at all times, and must be able to reach the hospital within one hour in the event that they are pulled. If you are called by the chiefs, you must work unless you yourself are sick.

If someone on the pull list is unreachable for their pull, the next person down the list will be pulled and the designated pull intern will owe that person two shifts.

In the unlikely event that the sick pull list has been exhausted (i.e. everyone has been pulled), the interns on geriatrics/CRC will be called at the chief’s discretion. Hopefully this will not be necessary, but if called by the chief, you must work unless you yourself are sick.

If you are on the sick pull list and are working someone else’s shift by previous arrangement (i.e. a trade or pay-back which has been approved by the chiefs), we strongly recommend that you are as far down on the pull schedule as possible. We also recommend that you identify another intern who will be able to perform your sick pull duties should you be called into work.

Sick pull coverage may also be arranged in the event of family emergencies such as a death or serious illness. As these matters are of a highly personal nature, we do not feel it is necessary or possible to create a comprehensive policy that specifically outlines which emergencies will and will not be covered. In general, our policy will be to discuss each case on an individual basis with the intern involved. Interns with non-emergent absences are required to find coverage themselves. This includes jury duty during ward months. If an intern misses a
shift for any reason other than illness or family emergency, and a sick pull intern covers, the absent intern will owe the pulled intern twice the number of covered hours.

C. Trading Shifts
Interns may trade equivalent shifts or calls with other Interns. **All changes to your previously assigned clinical responsibilities must be approved by the chief residents.** The most appropriate means of switching is to e-mail intmedchiefs@columbia.edu and all involved residents. It is unacceptable to trade shifts without involving the chief residents’ office.

D. Moonlighting
Interns are not allowed to moonlight, even if you have a license.

E. Jury Duty
From time to time, interns will be called upon by New York State to cover jury duty. You should postpone your duty if it falls at a time when you have inpatient clinical responsibilities and re-schedule it for your elective or outpatient blocks. The state allows a one-time postponement of jury duty. If you are unable to postpone jury duty to a non-ward month, you will be asked to present your papers showing that you have not been allowed to further defer jury duty and that you had attempted to schedule it for a non-inpatient month. Otherwise, you will be asked to find coverage for yourself, or you will be required to pay the sick-pull resident back two-fold. When re-scheduling jury duty, keep in mind that even if you are not selected for a jury, you will spend 2 days at jury duty for the selection process.

F. Pager policy
For periods when you are not carrying your pager, it is policy that the pager be signed ‘out of hospital’ through the page operator. This helps the outpatient staff and your patients recognize when you are unavailable and facilitates the process of getting problems resolved through the covering outpatient physician.

**XI. IMPORTANT WEBSITES**

**www.columbi_residents.org**
This web site is the web site for the house staff. It contains important information and documents, which can be downloaded, as well as a weekly conference schedule.
The username to access restricted resources is: residents
The password is: milstein

**www.medicineclinic.org**
This website points you to vital information: how to refer your patient to a psychiatrist, how to decipher the clinic codes in
WebCIS, and lots of other useful information. Familiarize yourself with this website on your first day of clinic so that you can use it often.

**www.columbia.edu:**
The university’s web site. You can access everybody’s email address using the search function.

**www.amion.com**
This is the key to your schedule for the year. The password is milstein. Please check your schedule over carefully for any problems with block to block transitions, clinic scheduling etc. After you request any schedule change, check and make sure that the correct change is reflected in Amion.

XII. **COMPUTERS**
The House Staff Library on 6 Hudson has several computers, as well as a printer. The computers have many software programs, including Excel, Powerpoint, and Word. Other computers with Microsoft Word capabilities can be found in the resident lounge on 6GS and the Second Floor of the P&S Library across the street from Milstein.