

How to Be a Senior

**Columbia University Medical Center
Housestaff Training Program**

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INTRODUCTION

The *How to Be a Senior* manual has been written to serve two purposes. While it provides many helpful hints for working effectively as a third year resident, it is also a guide to the policies of the Chief Resident's Office regarding the operations of the Medical Housestaff. We hope that this guide helps you navigate some of the challenging and unfamiliar territory that comes with the transition to becoming a senior resident. Please come to the office to ask any specific questions you have about anything regarding your senior year.

As a senior you will be responsible for managing patients in the following clinical settings: General Medicine, Cardiology, Allen Wards, Allen ICU, Senior Medicine, Consult Medicine and Neurology. You will also spend time seeing patients in the ER and in the outpatient clinic. All third year residents will also have two blocks of elective.

As a senior resident, your primary role will be as a supervisor and teacher. The role of the senior residents is distinct from that of the junior resident. You will now be looked to as the "Senior Internist" to your colleagues, various surgical services, the emergency room and sometimes even your attendings! Early in the year your interns, as well as the new junior residents, will be particularly dependent on you for guidance in taking care of patients on the ward and in the ICUs. It is critical that you pass on the organizational skills that you have learned to interns and new co-residents. These skills include how to keep a useful patient list, tracking patient data, formulating a sign out list, and presenting patients in various settings.

Of course, it is also your responsibility to provide adequate supervision of all procedures until your interns and new junior residents are certified. If you feel unsure of these procedures yourself, feel free to ask another resident or any of the chiefs for assistance.

Remember the above especially for interns from outside medical schools – they know nothing about how the hospital works. They will need you to show them not only how to keep a service organized, but even more basic things like where the blood drawing supplies are, how to enter orders in Eclipsys, how to use the GE Centricity web imager, how to write prescriptions, etc...

The Milstein Wards: Structure of the Day

Daily Schedule: GM1

7:00-8:00: Housestaff work rounds (residents, intern, medical student). From 7:30am the resident also takes sign-out on new admissions.
8:00-8:45: Morning Report for resident. Work time for intern.
8:45-9:00: Multidisciplinary rounds with attending, resident, intern, SW, care coordinator.
9:00-10:30: Attending Rounds
10:30-12:00: Work time for housestaff
12:00-1:00 Noon Conference
1:15 Intern briefly “regroups” with care coordinator

Daily Schedule: GM2

7:00-8:00 Housestaff Rounds. From 7:30am the resident also takes sign-out on new admissions.
8:00-8:45 Morning Report for resident. Work time for intern.
8:30-8:45 Multidisciplinary rounds with intern, attending, SW, care coordinator. Resident does not attend.
8:45-9:30 GM2 Attending Rounds (teams congregate separately in assigned conference rooms). May be extended to 9:45 if the team is not accepting a liver short admission.
9:30-10:15 Liver Rounds (all four teams assemble in the Morning Report Rooms)
12:00-1:00 Noon Conference
1:15 Intern briefly “regroups” with care coordinator

Daily Schedule: Cardiology

7:00-8:00 Housestaff Rounds. From 7:30am the resident also takes sign-out on new admissions.
8:00-8:45 Morning Report for resident. Work time for intern.
8:45-9:30 CHF Rounds (combined, all four teams in the Morning Report Rooms)
9:30-10:30 Cardiology Ward Rounds
10:30-12:00 Work time for housestaff, multi-disciplinary rounds
12:00-1:00 Noon Conference

Daily Schedule: ID

7:00-8:00 Housestaff Rounds. From 7:30am the resident also takes sign-out on new admissions.
8:00-8:45 Morning Report for resident. Work time for intern.
8:45-9:00 HIV Multidisciplinary rounds with intern, attending, SW, care coordinator.
9:00-10:30 ID Attending Rounds
10:30-12:00 Work time for housestaff, ID multi-disciplinary rounds
12:00-1:00 Noon Conference

Admitting Guidelines 2011-2012

General Principles:

- Private patients will preferentially be admitted to the PA service or made off-service. When private patients are too ill for these services or would provide a unique learning opportunity for the housestaff, they may be admitted to a housestaff service.
- Ideally, CCU and ICU transfers should not be assigned to night residents admitting without an intern. These patients should be cared for by the medicine consult until the day team arrives unless he or she is overburdened; this can be decided upon at the discretion of the medicine consult.
- There should be direct communication between a physician taking care of the patient and the accepting resident.
- Resident on call will begin hearing about new admissions at 7:30 AM from the ED, and may get signout on additional patients from the night resident upon arrival.
- Short call and pre-call ward teams are off on weekends and hospital holidays.

General Medical Service - 1: Max 10 patients on an intern service.

Patients: All general medicine patients.

Short Call Intern: Monday – Friday, up to 3 night resident “short” admissions. If there are fewer than 3 night resident admissions, one additional *new* admission may be assigned before 12:00 noon.

Long Call Intern:

- (1) Monday – Friday, the long call intern can accept one night resident short admission, followed by up to 3 new admissions. If there is more than one night resident short, only 2 new admissions can be accepted.
- (2) Saturday – Sunday, the intern can accept up to two night resident admissions, followed by 3 new admissions. If there are 3 or more night resident admissions, only 2 new admissions may be accepted.

There is a graduated cap for new admissions on both weekdays and weekends, with no more than 2 new admissions after 4pm, 1 new admission after 5 pm, and none after 6 pm.

Post Call Intern: On weekend days only (Saturday, Sunday, and Holidays), the post call intern may accept a single night resident short admission.

Night Resident: The night resident admits up to 3 patients until 5:00 am, one of which should be done with the night intern. The first admission should generally be done with the intern. After 3:00 am, the night resident may accept no more than 2 new patients, and after 4:00 am no more than 1 new patient. Night resident patients should be distributed to the short call teams in the morning; we should try to avoid overflow being distributed to the long call teams Mon-Fri. If teams are full, patients may at times be directed to short or long call senior medicine service or appropriate subspecialty services, as circumstances dictate.

Night Intern: Admits 1 general medicine patient overnight with the resident, and is responsible for cross-coverage of the day teams’ patients.

General Medical Service - 2/Hepatology: Max 10 patients on an intern service

Patients: Patients with liver and GI disease should preferentially be directed to this service, although GM2 can accept all general medicine patients.

Short Call Intern: Monday – Friday, up to 3 night resident “short” admissions. If there are fewer than 3 night resident admissions, one additional *new* admission may be assigned before 12:00 noon.

Long Call Intern:

- (1) Monday – Friday, the long call intern can accept one night resident short admission, followed by up to 3 new admissions. If there is more than one night resident short, only 2 new admissions can be accepted.
- (2) Saturday – Sunday, the intern can accept up to two night resident admissions, followed by 3 new admissions. If there are 3 or more night resident admissions, only 2 new admissions may be accepted.

Graduated caps as per GM1 above.

Post Call Intern: On weekend days only (Saturday, Sunday, and Holidays), the post call intern may accept a single overnight short call admission.

Night Resident: The night resident admits up to 3 patients until 5:00 am, one of which should be done with the night intern. The first admission should generally be the one done with the intern. After 3:00 am, the night resident may accept no more than 2 new patients, and after 4:00 am no more than 1 new patient.

Night intern: Admits 1 general medicine patient overnight with the resident, and is responsible for cross-coverage of the day teams’ patients.

Cardiology: Max 10 patients on an intern service

Patients: Patients whose primary reason for admission is cardiac should preferably be directed to this service.

Short Call Intern: Monday – Friday, up to 3 night resident “short” admissions. If there are fewer than 3 night resident admissions, one additional *new* admission may be assigned before 12:00 noon.

Long Call Intern:

- (1) Monday – Friday, the long call intern can accept one night resident short admission, followed by up to 3 new admissions. If there is more than one night resident short, only 2 new admissions can be accepted.
- (2) Saturday – Sunday, the intern can accept up to two night resident admissions, followed by 3 new admissions. If there are 3 or more night resident admissions, only 2 new admissions may be accepted.

Graduated caps as per GM1 above.

Post Call Intern: On weekend days only (Saturday, Sunday, and Holidays), the post call intern may accept a single overnight short call admission.

Night Resident: The night resident admits up to 3 patients until 5:00 am, one of which should be done with the night intern. The first admission should generally be the one done with the intern. After 3:00 am, the night resident may accept no more than 2 new patients, and after 4:00 am no more than 1 new patient.

Night intern: Admits 1 cardiology patient overnight with the resident, and is responsible for cross-coverage of the day teams’ patients.

ID: Max 10 patients on an intern service

Patients: ID will preferentially admit HIV/AIDS and TB patients, but can now also admit any patients whose *primary* reason for admission is an infectious disease, whether HIV-related or non-HIV related. One spot a day will be reserved for a patient with a diagnosis of HIV or TB until 2pm. However, priority will be given to HIV/TB patients. General medicine patients without a primary infectious issue *cannot be accepted without approval of a chief*. If HIV/TB patients need to be admitted to the ID service the team coordinator may bump another case to the general medicine service or night float to facilitate the admission of appropriate patients to ID. No more than 2 private patients may be admitted to the ID service; however, ID patients should receive preference for admission over private patients.

Long Call Intern:

- (1) Monday – Friday, the long call intern can accept one night resident short admission followed by up to 3 new admissions. If more than one night resident admission is received, only 2 new admissions may be accepted. One spot a day will be reserved for a patient with a diagnosis of HIV or TB until 2pm.
- (2) Saturday – Sunday, the intern can accept up to two night resident transfers, followed by 3 new admissions. If there are three or more night resident admissions, only two new admissions may be accepted

Graduated caps as per GM1 above.

Post call intern: Will accept one short-call admission from the overnight team, up to a census of 10.

Night Resident (NR): The ID/onc night resident admits up to 3 patients until 5:00 am, one of which should be done with the ID night intern (an infectious case) and one of which should be done with the Onc night intern (an oncologic case). After accepting two oncology patients the third patient accepted should be an ID patient, and after accepting two ID patients the third patient accepted should be an oncology patient. However, starting at 3 am, a third patient of either type may be accepted.

Graduated caps as follows: After 3:00 am, the night resident may accept no more than 2 new patients, and after 4:00 am no more than 1 new patient. Up to 1 non-ID/onc overflow patient may be admitted by the night team, though this patient should be worked up and presented by the resident and should not be one of the admissions for the interns. However, if for example, the team admits two oncology patients and one non-ID overflow, it would be acceptable to assign the non-ID overflow patient to the ID night intern.

Night Intern: Admits 1 ID patient overnight with the resident and is responsible for cross-coverage of the day teams' patients.

Oncology: Max 10 patients on a resident/PA service (to be increased to 12 at unspecified later date)

Patients: Only patients with a hematologic or oncologic diagnosis related to their admitting diagnosis may be admitted to this service.

Short Call Resident: Monday – Friday, up to 3 night resident “short” admissions. If there are fewer than 3 night resident admissions, one additional *new* admission may be assigned before 12:00 noon.

Long Call Resident:

- (1) Monday – Friday, the long call resident can accept one night resident short admission followed by up to 3 new admissions. If more than one night resident admission is received, only 2 new admissions may be accepted.
- (2) Saturday – Sunday: The resident can accept up to two night resident transfers, followed by 3 new admissions. If there are three or more night resident admissions, only two new admissions may be accepted.

Post Call Resident: On weekend days only (Saturday, Sunday, and Holidays), the post call resident may accept a single overnight short call admission.

Night Resident: See ID/onc night resident above

Night intern: Admits 1 oncology patient overnight with the resident and is responsible for cross-coverage of the day teams' patients.

Senior Medicine: Max 12 patients on a resident service

Patients: Senior medicine admission should include all general medicine patients who are not acutely or severely ill. Some examples of inappropriate diagnoses would include ACS 2 with positive troponins, DKA, active upper GI bleed, severe sepsis, patients on vasoactive infusions, or a patient requiring an ICU triage consult. Clearly, there is a role for the discretion of the resident, and in difficult cases the chief-on-call should be contacted. The number of private patients admitted to this service is minimized in an attempt that no resident should receive more than 1 private patient per short or long call.

Short Call Resident: Residents may receive up to 3 short call admissions Monday-Friday. If they receive fewer than 3 short call admissions, they may also admit one long admission before 1 pm Monday-Friday. Overnight patients should be taken from the house doctor and the Gen Med 1 & 2 night residents.

Long Call Resident: Resident may receive up to 4 patients until 6:30 pm with no more than 2 patients after 4:00 pm and no more than 1 patient after 5:00 pm. Long call resident may receive overnight overflow if the short call senior medicine is capped (but each overnight admission counts as one long call admission towards the cap of 4). On weekends, the long call resident can accept 2 night admissions and up to 3 new admissions with the graduated cap at 4 pm and 5 pm as above.

Allen Pavilion: Max 10 patients on an intern service

Patients: Private patients should not be on the ward teams unless the patient's private admitting doctor is also the ward attending at the time.

Short Call Intern: Monday – Friday, up to 2 night resident “short” admissions can be accepted.

Long Call Intern: Can accept up to 3 new admissions from 7:30AM-6PM Monday-Friday. In rare cases when the post call and short call teams are full in the morning, 1 overnight admission can be given to long call in addition to the 3 new admissions for that day. On weekends and holidays the long call intern can also accept up to 2 short admissions, followed by three new admissions.

Post-call Team: The postcall team can accept one night resident short call admission.

Night Resident: The night resident admits up to 3 patients until 5:00 am. After 3:00 am, the night resident may accept no more than 2 new patients, and after 4:00 am no more

than 1 new patient. One admission, generally the first, should be done with the PA. If the PA is not present, the night resident will perform cross-coverage only, and do no admissions.

Medical Intensive Care Unit – Milstein (MICU): Max 12 patients in the MICU
Private and ward patients are cared for in a closed order-book fashion by the managing MICU service.

Short call resident: Up to 2 admissions (may be either primary work-ups or transfers from the inpatient medical services) from 6:00 am – 1:00 pm. The short call resident admits with the long call intern.

Long call resident/intern: The long call resident admits with either the Long call intern (7 am – 7:00 pm) or the night intern (9:30 pm – 6 am). These interns will assist in evaluation and management of patients which arrive during their shifts but are outside of these hours, e.g. between 7 pm – 9:30pm on long call. There is some flexibility with these hours for exceptionally busy or exceptionally light days. The long call resident starts admitting at 1:00 pm, unless the short call resident “caps” with 2 admissions before 1 pm, in which case further admissions go to the long call resident regardless of time. Caps are as follows. The long call resident may admit a total of 10 new patients during call. However, a maximum of 5 new patients may be admitted with each intern. The long call resident may admit an additional 2 patients with both the long call intern and the night intern to the Milstein MICU during this period if they are transfers of care for patients currently on a medical service. In circumstances where additional patients need to be admitted to the MICU, the long call overnight resident will triage/stabilize the patient, including initial admission orders, prior to the arrival of the short call resident who will complete the evaluation and management of that admission.

Night Intern: As above, the night intern admits with the long call resident from 9:30 pm – 6 am).

Allen Pavilion Intensive Care Unit (AICU): Max 12 patients in the AICU
Private and ward patients are cared for in a closed order-book fashion by the managing AICU service.

Long call intern: The long call intern admits a maximum of 5 new admissions under the supervision of the senior resident between the hours of 7 am – 7 pm. The long call AICU intern may accept an additional two patients, but only if it is a transfer of care from a medical service. The night intern similarly may also admit a maximum of 5 new admissions under the supervision of the hospitalist from 8:30pm to 6am the following day.

Night intern: The night intern may admit a maximum of 5 new admissions under the supervision of the hospitalist from 8:30pm to 6am the following day. The night intern may accept an additional two patients, but only if it is a transfer of care from a medical service.

AICU Resident: There are two residents in the AICU rotating on shift schedule. One resident supervises the AICU from 7:45 am – 3:00 pm. The second resident arrives at 11:00 am for teaching and management rounds and remains in the unit until 9:30 pm. Alternatively, residents may elect to alternate individually covering the unit for the entire day.

Cardiology Care Unit (CCU): Max 14 patients in the CCU

Short call resident: Up to 2 admissions (may be either primary work-ups or transfers from the inpatient medical services) from 6:00 am – 1:00 pm. The short call resident admits with the long call intern.

Long call resident/intern: The long call resident admits with either the Long call intern (7 am – 7:00 pm) or the night intern (9:30 pm – 6 am). These interns will assist in evaluation and management of patients which arrive during their shifts but are outside of these hours, e.g. between 7 pm – 9:30pm for the long call intern, or between 6 am – 7 am for the night intern. There is some flexibility with these hours for exceptionally busy or exceptionally light days. The long call resident starts admitting at 1:00 pm, unless the short call resident “caps” with 2 admissions before 1 pm, in which case further admissions go to the long call resident regardless of time. Caps are as follows. The long call resident may admit a total of 10 new patients during call. However, a maximum of 5 new patients may be admitted with each intern. The long call resident may admit an additional 2 patients with both the long call intern and the night intern to the Milstein CCU during this period if they are transfers of care for patients currently on a medical service. In circumstances where additional patients need to be admitted to the CCU, the long call overnight resident will triage/stabilize the patient, including initial admission orders, prior to the arrival of the short call resident who will complete the evaluation and management of that admission.

Night Intern: As above, the night intern admits with the long call resident from 9:30 pm – 6 am).

Morning Report

Morning Report will begin promptly at 8:00 am, please make every effort to arrive on time. Morning Report is a mandatory daily conference during which a resident presents a case to an attending. This is the core conference of the residency program. All residents on non-ICU rotations are expected to attend daily. The day’s attending, with direction from the Chief Resident, will lead a discussion based on the case that should be interactive, fun and include all the residents in the room. This a great opportunity to learn from various experts and to get your questions answered about relevant clinical management questions.

If you have a case that you would like to present at morning report, please contact one of the chiefs. If you want to use path slides, echo videos, or need other technical support, please let the chief’s office know at least one day in advance so we can make the appropriate arrangements. Also, if you want to share an article relevant to the case, please drop it off in the chief’s office and we will provide copies for the conference. Presentations should be focused on the main points of the case, and many times should not be comprehensive attending rounds-level presentations.

If you are having difficulty attending morning report for any reason, please let one of the chief residents know. The chiefs are committed to making it possible for every resident to attend morning report on a daily basis.

Firm Rounds (to begin in September)

Firm Rounds will take place on Friday afternoons. Some of the details have yet to be determined. All ward teams will participate in firm rounds, with the exception of teams on-call. Obviously interns and residents in clinic will be unable to attend as well.

Firm rounds will be an important component of resident and intern education, but they are also an important opportunity to become better acquainted with the housestaff and attendings of your firm.

One firm attending or guest attending will be assigned in advance for every Friday firm rounds. A resident will also be assigned to each firm round in advance. It is the resident's responsibility to choose a case to present to the attending. The attending will then interpret the case, discuss the differential, and demonstrate physical examination maneuvers at the bedside. The bedside component of these rounds will be emphasized, and is what differentiates firm rounds from, for instance, morning report.

Chief-of-Service (COS) Rounds:

Firm Rounds will generally be replacing COS rounds in Milstein, with the exception of ID. ID COS rounds will be scheduled by the ID attending on the ID service, and COS at the Allen will be on Thursdays at 11:30 AM.

The agenda for COS will be determined by the pre-call resident in advance. Goals may include assisting with a challenging case, generating differential diagnoses, and teaching physical exam skills.

Housestaff Rounds

Morning work rounds are one aspect of the daily schedule which is undergoing significant change in the present year. The essence of the change is that residents are now expected to walk round with their intern to see the service's patients. The resident should generally see the majority, and preferably all, of the patients on the service with the intern and medical students. The fact that the intern now has from 8:00 – 8:45 to order studies, call consults, place orders, etc. facilitates true work rounding, as it frees the team from being fettered to the phone and computer during work rounds.

Housestaff rounds are fundamental to both patient care and education. From the patient care perspective, work rounds allow evaluation of the patient's progress, monitoring of changes in exam findings, assessment of the patient's readiness for discharge, discussion of management, and formulation of a plan of care for the day.

We recommend the following structure for seeing patients during housestaff rounds, although we understand that resident-intern pairs will develop their own variations as well.

- (1) Outside the patient's room, the intern briefly states the patients name and reason for admission, followed by the overnight events and vital signs.

- (2) The team then sees the patient. The intern is to be the primary physician in this setting, relating information, presenting findings, and discussing the day's plans with the patient. The intern will perform the primary exam, while the resident can focus on the more dynamic, or educational, aspects of the exam.
- (3) The intern then presents the plan of the day for the patient, including tasks that need to be done, studies that need to be reviewed, and the patient's disposition. The resident uses this as a teaching opportunity for both intern and medical students, whether with respect to physical exam, differential diagnosis, a discussion of the primary literature, or management.

By the end of the month, the intern should be able to succinctly present a patient by citing their admitting diagnosis, response to treatment, active issues and discharge plan. Time will still be limited during housestaff rounds, as the team may also have to hear presentations of private admissions during this time, and because the you may also be taking sign-out on new admissions. However, every attempt should be made to maximize the usefulness of housestaff rounds, both from a clinical care and an educational standpoint. Housestaff rounds are an opportunity for the resident to serve as teacher, and team leader.

Also, during these work rounds, please consider the need for telemetry on your patients every morning, and whether private patients could be transferred to the PA service (with private attending approval).

Teaching (Attending) Rounds:

As the resident, you are responsible for leading rounds. The attendings *expect* you to direct them. This is especially important when you are post call and have a lot of admissions to get through. Do not be afraid to ask the attendings to move along to the next case in the interest of time; *they expect you to do this!*

The main focus of these rounds should be on hearing new presentations, generally at the bedside. Bedside rounds actually are more efficient than rounding in the conference room and allow hands on teaching of the housestaff. You are also encouraged to include the patient's nurse during bedside rounds. You are encouraged to dedicate specific time during attending rounds to discuss literature and participate in case base teaching. You may also discuss interesting follow-ups during this time. On Gen Med services, each Resident-Intern team will be paired with one attending in order to help streamline patient management. The resident and intern will meet with his or her attending after teaching rounds for management rounds, to go over all other follow-up information for all of the other patients on their service. This is not meant in any way to take away from the discussion by both attendings of patients at teaching rounds. *You are also expected to touch base with your attending toward the end of each on-call night to briefly discuss the patients you are admitting as well as any management issues that have come up throughout your call day.*

GM2 teaching rounds have been organized to facilitate the integration of the liver transplant service into general ward attending rounds, to better both patient care and

resident education. The “superteam” (or all 4 teams) will meet in the Morning Report room from 9:30-10:15am for combined liver transplant attending rounds.

Interdisciplinary Rounds

Multidisciplinary rounds occur at different times on different services (please see the daily schedule above). During these rounds, housestaff briefly review patients’ status and discharge planning. Be sure to enlist the social workers and care coordinators to help navigate the pre-discharge bureaucracy. Important questions to ask: does this patient have insurance? Do they have a stable home environment? Do they have services that need to be reinstated? Addressing these questions early is crucial to a smooth discharge. Be sure to help use these members of the medical teams to mobilize services for your patients, including physical therapy and nutrition.

On GM1 and GM2, a dedicated care coordinator will be assigned to each team to act as a liaison between the teams and social work. They will be present during multidisciplinary rounds, which takes place immediately before attending rounds on both services. Care coordinators will touch base with the teams at various points throughout the day. Indeed, there should be a designated afternoon “re-group” between intern and care coordinator, generally at 1:15 pm. Coordinators will serve to identify barriers to discharge and facilitate discharge planning.

ID: On ID, when the intern has their day off, the resident will be expected to attend the multidisciplinary meeting with Dr. Brudney on Wednesday mornings at 8:30 AM in PH-8.

Regardless of which service your patient is on, it is vital to work closely with the patient’s nurses, social workers, and other non-physician members of the patient care team. By having regular discussions with the patient care team about your patient’s progress and changes in disposition, your patient will experience improved care, more efficient discharge planning, and you will likely be paged less often as the patient’s nurses will be aware of why particular orders were written or why a patient’s plan of care has changed. You or your intern are expected to touch base with each member of your patient’s care team at least once a day.

Noon Conference

This is a one-hour lecture Tuesday, Thursday and Friday given by various attendings in the institution. The lectures in the summer consist of the “Fundamentals of Medicine” series and cover material directly relevant to patient care (e.g. management of SVT, ACS, GI bleed, etc), and will occur most days Mon-Fri. These lectures are specifically geared to orient the new interns to taking care of serious medical conditions on the medicine floors and every effort should be made by the residents to both encourage and help their intern attend. It is our goal to make these valuable lectures available online so that all interns and residents may have the opportunity to learn from them.

Starting in September, roughly every other Thursday will be dedicated to senior talks, and intermittent Tuesdays will be a Clinicopathological Conference, Morbidity and Mortality Conference, or Quality Assurance session run by one of the Chief Residents.

Grand Rounds

Every Wednesday at 12pm (with the exception of a short summer break) the Department of Medicine invites a speaker to talk about a clinical or research topic. These are often world-renowned experts in their fields, often from peer institutions. Grand Rounds represents a unique opportunity for residents to learn the latest advances in a variety of subspecialties from the people making those advances. Residents are responsible for facilitating attendance by the whole team including the interns. Attendance is required and a sign in sheet will be collected.

We hope to continue to increase the housestaff exposure to the grand round speakers by inviting the speakers to attend rounds and conferences during the day, as well as dinners the night before with selected residents and representatives of the host division. If you have a suggestion for a grand rounds speaker please let one of the chief residents know.

Journal Club

This is a one-hour conference held on Monday afternoon (12-1pm). The conference is held in the Oncology Conference Room on 5GS (Room 411). Junior residents present a case and an article from the literature. The primary objective of this conference is to learn how to critically review an article from a medical publication. Subject material is also important, but significant time will be dedicated to study design and statistical analysis. We will be including a statistical or epidemiologic topic to review each week. Please note that a variety of study types are appropriate: clinical trials, observational studies, epidemiology, and science topics are all You will choose the stats/epi topic and incorporate it into your discussion and analysis of that week's article. Article selection should stem from a clinical, patient management, or scientific question that prompted a literature search. The choice of paper should be made in conjunction with a chief resident to help avoid repetition of papers and ensure a variety of topics. As you prepare your slide presentation, the chiefs will provide you with a journal club template to help structure your talk. The chief residents are available to assist with the development of the presentations. To facilitate distribution and reading, you should select an article 1-2 weeks before your talk. In addition, 4-5 days prior to the presentation the presenting resident should contact either Dr. Walter Palmas or Dr. Graham Barr to review the study's design, strengths, weaknesses and application of that weeks' statistical topic. Journal club is successful and worthwhile when people read the article and participate: please make every attempt to do so. Finally, please remember to take your interns' beeper for the hour so they can enjoy Intern Report.

Chief Rounds

On Tuesday, Wednesday and Thursday afternoons, Chief Rounds will occur from 2:00 to 3:00pm in the morning report room. This time will be used for board review, case discussions, or to review physical exam findings. Chief Rounds will be open to all those residents who are able to attend and will be mandatory for all team interns. Barring

emergency patient care situations, you should encourage your team interns to attend this conference instead of working on the wards during that hour. You should additionally strongly encourage your medical students to attend if they do not have other scheduled teaching sessions.

Sign Out Rounds

At the end of the day, the resident and intern should reconvene to go over the service. The events of the day should be reviewed with a focus on how any new test results or other information changes the management plan. The patient's record should be reviewed at the end of the day for recommendations from consult services and from private attendings. You should generate the next day's plan for each patient. Also, this is a good opportunity to identify potential discharges and write tentative discharge orders that night to increase the chance of a fully orchestrated discharge as early as possible the next day. This information should be communicated to the Admitting Coordinators (5-9150) at the start of every day by the intern or the resident. The earlier the Care Coordinators get information on potential discharges and problem areas delaying patient care, the sooner they can assist. Finally, please review the actual sign out sheet that your interns are giving their cross-covering intern -- particularly in the beginning of the year. 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 to facilitate necessary cross-coverage.

Intern's signouts in Eclipsys should include the following information:

Patient's name, unit number, and location
Chief complaint and short sentence or two on the patient
Working Diagnosis
Medication Allergies
List of all medications, which should be reviewed and edited daily, especially the current antibiotics and day started
Attending's name if private, "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 panculture at: Cx temp >101
Code status: DNR or Full Code
NF/Cross-cover tasks and how to respond

For example:

*Doe, John 5GS MR#1234567
62 M w/ HTN, DM, CHF, admitted w/ increased SOB and PVC on CXR,
Impression: CHF exacerbation
NKDA
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, pager 85555), +/-, Cx>101, full code
NF: f/u 8 pm Chem 7-replete potassium for K<4.0*

Notes

The intern writes the definitive admission note. A resident's note should be very different from the intern's H&P. It should not be an exhaustive rehashing of the data. It should focus on only the most pertinent portions of the H&P. In addition, the assessment and plan should be a higher level discussion of what is going on with the patient, and the major aspects of your plan for their hospitalization. Residents should attempt to include citations of the literature in their notes. Essentially, the resident note is as much an academic exercise as it is a practical contribution to the patient's medical chart.

Residents write notes on all admissions except night float admissions. For night float admissions, both the resident and the intern must interview, examine, and formulate an assessment and plan for the patient but only the intern needs to write the admit note. On the weekends your team is responsible for writing progress notes on all cross-covered patients. If possible the intern should round on these patients and write their cross coverage notes, but when the cross-cover list is long or if your intern does not have enough time you are expected to help and see cross-cover patients and write their progress notes.

A note must be written on every patient seven days a week. The admission note counts as the patient's note on the day of admission and the attending's admit note counts on the new admission's post call day. It is your responsibility to ensure that every patient has notes written in Eclipsys each day of the week.

Work Hours

ACGME and IPRO work hour regulations have impacted the architecture of our admitting days as well as service capacities. These rules include a work hour limitation of 80 hours per week, preferably 10 hours off between shifts (8 hours minimum), a maximum of 24 hour shifts with 3 hours allowable for transfer of care, and an average of one day off in seven. It is the job of the resident to help ensure that interns leave the hospital at the appropriate time. Current ACGME guidelines do not allow interns to work in excess of 16 hours in a single shift. It is critically important in the current regulatory climate that we adhere to these guidelines, and we ask that residents do everything they can to make this happen.

Clinic/OPD:

Schedule information is also available on the website www.medicineclinic.org, and on www.amion.com as well. *Please note that residents on OPD1 are responsible for NR coverage on **Sunday nights (except for when a block switch day occurs on Monday, then the coverage will be on Saturday night)**.* Additionally OPD2 and E2 residents will cover the occasional Friday night ID NR. Please check the day-to-day schedule at the beginning of your OPD rotation to identify your weekend cross coverage duties!

Clinic Rules and Scheduling

Clinics start at 1pm. Exceptions are in the Allen Wards, MICU, and AICU during which clinic starts at 2pm. If clinic falls on the first day of a rotation for interns (except in the ICU), it is cancelled. Residents will have clinic on the first day of a new rotation except during the first block of the new academic year.

1. **GM1, GM2, Cardiology:**
 - a. Clinic 1pm Mon-Thurs post call for residents
 - b. Clinic 1pm Mon-Thurs pre-call for interns
2. **Inpatient Oncology (PGY2):** Clinic 1pm on pre-call
3. **ID:**
 - a. Mon-Wed post-call for residents
 - b. Tues-Thurs pre-call for interns. Thursday intern clinics start at 2 pm.
4. **CCU:**
 - a. 1pm Mon-Wed pre-call for residents
 - b. *1pm Thurs-Fri pre-call for interns.*
5. **MICU:**
 - a. 2pm Mon-Wed pre-call for residents
 - b. 2pm Thurs-Fri pre-call for interns
6. **OPD:** OPD Block Schedule will be determined by the outpatient scheduling team and e-mailed to you 1 week before block.
7. **Senior elective:** **E1-** Two morning continuity clinics/week. **E2** – One clinic a week. On E1/E2, rarely residents may be asked to swap one of their clinics for coverage of walk-in clinic.
8. **ER:** One clinic session per week for a total of two sessions, Tuesday mornings for PGY2s and Friday mornings for PGY3s.

Please note that residents on Cards, ID, GM1, GM2, Onc should not be scheduled for clinic on June 14th (the first day of the new academic year. Interns should not be scheduled for clinic on the first day of each new intern ward block (Cards, ID, GM1, GM2, Allen)

Clinic Cancellations Policy:

To ensure our patients' continuity of care, your best efforts should be made to avoid unnecessary clinic cancellations. Cancellations of any outpatient clinics or conferences must be approved in advance by the chief residents and Dr. Nancy Chang (Dr. Fleck or Finkelstein at the ACNC)

If you do need to cancel a session, please alert us as soon as possible; you will likely be asked to provide an alternate date to make up any cancelled session.

For:

1. ***Predictable cancellations*** - (example: away electives, ACLS/BCLS training, USMLE Step III, routine physician appointments, jury duty, conferences, “special” family events) Please communicate this request to us at least 2 months in advance. Email instructions below.
2. ***Unpredictable cancellations*** - (example: last minute fellowship interviews, last minute jury duty notices, personal/family illnesses) these must be communicated as soon as you are aware of the dates.
3. Cancellations during the OPD blocks need to be approved in advance by Dr. Nancy Chang. Coverage will be required for cancelled walk-in clinics (coverage may be required for last minute (<1-2week) cancellations of preop/diabetes f/u).
4. Clinic will not be cancelled to accommodate personally arranged shift swaps and pay back.
5. Fellowship/Job Interviews (Jan-Apr) - Please email us as soon as you know the dates. Depending on the number of sessions/pts cancelled, we may ask you to provide alternate clinic dates to ensure patient care does not get compromised. During OPD blocks, coverage will be required for any cancelled walk-in clinics. To help you plan your interview dates, feel free to email Dr. Chang for an advance copy of the OPD block schedules.

All AIM Clinic cancellation emails should be addressed to all 3 of the following: Christina Collado (chc9091@nyp.org), Chief Residents (intmedchiefs@columbia.edu), and Nancy Chang (nmc5@columbia.edu).

Ward Rotations

I. General Scheme: GM1, GM2, and Cardiology

Seniors will be rotating through the following milsteinward rotations: GM1 or GM2, and Cardiology.

The following description of the call cycle applies to all senior Milstein ward rotations.

The call schedule is: Long Call → Post Call → Short Call → Pre Call

Long Call

The resident arrives at the usual hour, around 7:00 am, on call days. The pager is taken from the admitting night resident, who also endorses patients to the long call resident that had been signed out her earlier. The long call resident than begins housestaff walk

rounds with the intern, and at 7:30 am will begin hearing about new admissions from the ER.

On weekends and holidays, short call and pre-call teams have the day off. Since there is no short call team, night resident “short” admissions are also accepted by the long call team.

Beginning at 7:30 AM, the team can accept up to three new admissions. Some of the new admissions may have already been signed out to the Night Resident and already be on the floor at this time. The on-call team also accepts one overnight “short” admission.

If the long call team is given more than one short admission, these count as 0.5 of a long call admission. Practically, this means that if the long call team receives one short admission, they can then admit three new patients. If, however, they receive two or three short admissions, they can only admit two new patients. But regardless, interns can never carry more than 10 patients at any time.

Long Call Weekend Admissions

NR	Long	Total
0	3	3
1	3	4
2	3	5
3	2	5
4	1	5
5	0	5

they can then admit three new patients. If, however, they receive two or three short admissions, they can only admit two new patients. But

Long Call Weekday Admissions

NR	Long	Total
0	3	3
1	3	4
2	2	4
3	2	4
4	1	5

On the weekends, the teams are allowed to accept two night resident short admission and still accept three new admissions. See the table above for various other permutations of short-long admissions. There is a graduated cap for new admissions on both weekdays and weekends, with no more than 2 new admissions after 4pm, 1 new admission after 5 pm, and none after 6 pm.

The short call, post-call, and pre-call teams will sign-out to the on-call team in the afternoon or evening. For GM1, GM2, and oncology they will sign out to the PA. The PA will generally sign out to the long call intern around 7:30 pm. For cardiology and ID, interns sign-out to the on-call intern. At 9:00pm, the night resident and night intern arrive, and take over the long-call resident and intern pagers. *It is expected that prior to signing out to the night junior resident that the on-call resident will touch base with the ward team attending to briefly go over the new admissions and discuss any management issues and/or questions that came up throughout the call day.*

Post Call

On the post call day, the resident and intern should arrive at the usual hour, around 7 am. Housestaff work rounds proceed as usual. On this day, it will be particularly important to use this time efficiently to be caught up on the previous night’s events as well as to formulate the plan for the day.

On ID and on the Allen Wards, the postcall team may accept one night resident short admission, if they are not yet full. Additionally, on the weekends, general medicine, cardiology and oncology may also accept on night resident short admission.

In the afternoon of the postcall day, the resident has his or her clinic. Usually, it may be necessary to return to the hospital to resolve any remaining clinical issues.

The postcall team, when all work is completed, signs out to the on-call team.

Short Call

The short call team accepts those admissions worked up by the night resident to a maximum of three. If less than three night resident admissions are accepted, the short call team may accept one new admission before 12:00 noon. The resident is required to interview and examine the night float admissions but only the intern needs to write an accept note. All orders from night float admissions should be reviewed by the accepting team. There is no short call on weekends or holidays.

Pre Call

The interns have continuity clinic in the afternoon, during which time the resident should cover the service. The intern is expected to sign over their pager to their resident.

Senior Medicine:

The Senior Medicine rotation places the senior resident back on the front lines. You will carry a service of up to 12 patients without an intern. You and your co-resident will be supervised by one of the Hospitalists. The Hospitalist attending allows you a lot of autonomy and expects you to act as the “attending” when the junior night residents present to you. We are trying to limit the # of private patients admitted to this service.

Call structure: Long -> Post -> Short -> Pre

Long/Short Call

On long call days, you can accept up to four or five admissions (depending on the number of night floats you receive) before 6:30pm, through any combination below. On short call days, you may accept up to three night floats or short call admissions prior to 1:00pm. While long call residents should in general not be receiving night admissions from either the House MD or the night residents, guidelines for these admissions are included should this become necessary in unusual circumstances. A graduated cap is in effect, so that you may accept only 2 patients after 4pm and 1 patient after 5pm. No patients may be admitted to the SM service after 6:30pm.

Admission Caps for SM Service

Short Call: Max 3 Patients		Long Call: Max 6 Patients	
NF/HD	SC	NF/HD	LC
0	3	0	4
1	2	1	3
2	1	2	3
		3	2
		4	2
		5	0

Consultative Medicine:

Medicine Consultation

The weekday Medicine Consult will be responsible for daytime general medicine consultations. The day will begin with Morning Report, followed by a didactic session with the consult attending at a time determined by the Hospitalist attending. The consult resident is responsible for following the patients on the consult service. If the patient no longer requires your follow up, the consult resident should explicitly sign off the case after discussion with the attending and primary team. Work rounds with the consult attending and the pre-op resident will occur daily and will include presentation of any new consults or important follow up. Rounds must be conducted in person daily and every effort will be made to conduct walk rounds and include further didactic during work rounds. The time of work rounds is subject to variability and will be decided upon daily by the resident and attending. You also have the authority to accept transfers of patients from other services onto the medicine service, when appropriate. If you find that a patient should be transferred to medicine, contact the admission coordinator at 5-9150 to find the patient a team, and make sure the team from whom the patient is being transferred has written a transfer summary and verbally signs out to the accepting team.

The consult resident should not leave earlier than 5pm and should not sign over any new consults to the ICU triage night resident. It is acceptable to have this person follow up on an issue pertaining to a patient that you are following. You will have one morning clinic per week during which time the pre-operative consult resident will hold the medicine consult pager. You will hold the pre-op consult pager one morning a week while the pre-op consult resident attends clinic. You may also hold the pre-op consult pager on occasions when the pre-op consult resident is coming off of ICU triage nights and would therefore be post-call.

Pre-operative Consultation

The weekday pre-operative consult will be responsible for daytime preoperative consultations. When the medicine consult is in clinic or transferring from nights to days, they will cover both pre-op and medicine consults. The day will begin with Morning Report, followed by a didactic session with the consult attending at a time determined by the hospitalist attending. As the preoperative consult resident you are responsible for following the patients on the pre-op consult service. Patients should be seen post-

operatively. Once the patient no longer requires medicine follow up, the consult resident should explicitly sign off the case after discussion with the attending and the primary team. Work rounds with the consult attending and the medical consult resident will occur daily and will include presentation of any new consults or important follow up. Rounds must be conducted in person daily and every effort will be made to conduct walk rounds and include further didactic teaching during work rounds. The time of work rounds is subject to variability and will be decided upon daily by the resident and attending.

The consult resident should not leave earlier than 5pm and should not sign over any new consults to the ICU triage night resident. It is acceptable to have this person to follow up on an issue pertaining to a patient that you are following. You will have one morning continuity clinic per week during which time the medicine consult will hold the pre-op consult pager. You will hold the medicine consult pager one morning a week while the medicine consult resident attends clinic. You may also hold the medicine consult pager on occasions when the medicine consult resident is coming off of ICU triage nights and would therefore be post-call.

ICU triage

There will be a daytime triage resident and a nighttime triage resident (who will also be responsible for overnight medicine and pre-op consults). The ICU triage resident will identify patients in the ED, on the floor and at outside institutions who are appropriate for transfer to the ICU. You will round and confer with a dedicated ICU triage attending who will help you in making triage decisions as well as facilitating ICU bed availability. More details regarding your responsibilities during this rotation will be reviewed with you during your orientation at the start of the rotation.

Allen Wards:

The Allen Pavilion allows senior residents to care for patients in a community hospital setting. Teams follow only ward patients with acute and chronic medical issues spanning general internal medicine, GI, cardiology and neurology.

The Allen Medicine Service consists of two teams. Each team consists of two attendings, one senior resident, two interns and, at times, medical students. This is the only service in which the resident to intern ratio is 2:1.

The resident call schedule is therefore changed to on call -> post call -> on call, whereas your two interns will keep the usual schedule of pre-call -> long call -> post call -> short call. There are no team interns up at the Allen so when the post call intern goes home at 10am their pager gets signed out to the other intern on your team who is pre-call and together you care for your two lists of patients.

Your long call weekend day is your day off each week, during which time a resident on OPD or elective will cover you. You must work on your post call weekend day; the pre-call intern has this day off and the post call intern will go home at 10am, leaving you covering both intern's lists and pagers.

You will have no outpatient clinic responsibilities during this half-block rotation but your interns will have clinic on their short call day Mon-Thurs.

The general structure of day is as follows:

7:45am-8:30am: Work Rounds, Long call intern arrives 7am at the earliest

8:30am-10:00am: Attending Rounds

-Night float (a PGY-2 resident) presents new admissions (max of 2) to the short call team

-Long call intern must leave the hospital by 10am at the latest

10:15am -11:00am: Multidisciplinary rounds at all nursing stations, must be attended by either intern or resident

11:15am-12:00pm: Resident report (M,W) with Dr. Ridge and the Chief Resident

- Tuesdays: Intern Report (starts 11:15am, hold your interns' pagers)

-Thursdays: Chief of Service Rounds (start 11:15am, starting in Sept.)

- Fridays, 9am – 10 am Geriatric Journal Club

Noon-1:00pm: Noon conference

After 1pm: Daily admissions (for long call team) and patient care, clinic for short call intern at 2pm

8:30pm: Long call resident signs out to night resident

General Admitting Principles

The long call resident (carrying the 9000 pager) and the service coordinator (carrying the 4558 beeper) communicate closely throughout the admitting day. The service coordinator serves as a quasi-MAR and triages admissions. If you hear about an admission through an alternate route (i.e. from the ED, Milstein, or a private attending), please refer them to the service coordinator.

Please see “admission guidelines” above for specific admission rules. After hearing about an admission, please see your admission as soon as possible and if necessary get further direct sign-out from the ER provider. Please understand that the service coordinator is in charge of making a decision about triage and often will not have the amount of information you are used to obtaining during sign-out from the ER on the Milstein wards. However, you should be given the pertinent information and vital signs. If this is not happening, please let the chief resident know as issues of triage have arisen. Only ward patients may be admitted to the Medicine Service; all private patients are now admitted either to the PA service or off-service, unless the private attending is currently the ward attending. Be sure to obtain the off-service attending list and other critical numbers that are updated by the Allen Hospitalists. This document also indicates which nursing homes are covered by private attendings and should not be directed to your housestaff service.

Additional Allen Information

1. There is a resource locker (#28 in hospitalist attending call room, combo 31-13-27), contains an ophthalmoscope, otoscope, and electronic recording stethoscope.

2. You will be assigned a locker at the Allen by Felisha, whose desk is located down the hall from the morning report room.
3. Pick up your Allen contacts/faculty and important numbers from the Hospitalist Office (2FW).
4. Night residents and on call residents arriving at and leaving the Allen Pavilion after 8pm will be allowed to take any car to and from the Allen Pavilion and will be reimbursed 100% of the cost up to \$20.
5. **Bounce-back policy:** Bounce-backs are permitted within 24 hours of discharge. If the resident/intern team that discharged the patient is not in the hospital at the time of the bounceback, but it is within 24hrs of pt discharge, the medicine resident/intern team that is in the hospital will watch the patient (not a new admission) and transfer the patient back to the original team when they return. This policy will also be true of patients transferred to the ICU that are then transferred out of the ICU within 24 hours.

Duties on Long Call

In addition to carrying the 9000 pager and serving as the admitting medicine resident, you are the **Arrest Resident** and carry the arrest pager. Each unit and radiology has its own defibrillator and arrest cart. You may use these defibrillators when arrests are called in non-patient care areas. On occasion, the AICU will activate an arrest page, you should respond to these calls to assist the AICU team.

Allen ICU

This AICU rotation is now a 2 ½ week rotation split evenly between the two residents, decided by the residents. Once you arrange your upcoming schedule, please notify the chiefs so the schedule is accurately reflected in amion. Arrive to accept sign-out from the overnight hospitalist attending at 7:45am in the Hospitalist Office. After sign-out, you should meet with the charge nurse to go over restraints in the unit and email Dr. Neuberg the people who are on restraints, and then make sure they are renewed (need to be renewed q12hrs, at the beginning and end of your shift).

You will then work round with the interns until attending rounds, which begin at 8:30 am. You will admit with the long call intern during the day until 7 pm. The overnight hospitalist and the night intern come in at 8:30pm. 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. Subsequent admissions will be done by the night-intern under the supervision of the hospitalist. At this point you will and also go over the restraints with the charge nurse and email Dr. Neuberg once renewed (see above). Each resident will have clinic once a week, both are AM clinics. After your AM clinics, you will come back to the AICU and give a 30 min teaching session to the AICU interns while your colleague is covering the unit. The teaching session should be on an ICU topic of your choosing, and we ask you use a powerpoint as a guide (5-10 slides) to quickly review that topic.

The long call intern holds the ICU board in the AICU. Therefore, the senior acts more like a critical care fellow – teaching, supervising, and discussing new admissions and acute events. Hospitalist attendings are available 24/7 and should be contacted for assistance with all procedures. The exception is the Swan-Ganz PA catheter, which requires a Cardiology attending for supervision. Didactics and other teaching sessions should be the major contribution made by the senior resident.

Interns in the AICU include three Medicine interns and a Family Medicine PGYI or II, rotating q3, with the same rotation as in the MICU and CCU at Milstein: Pre/Call/Post with one week of nights each month. Interns go to clinic on their pre-call day Monday through Thursday.

Before rounding with the Hospitalist and night intern at 8:30 pm, *the senior and the intern should call the AICU attendings to discuss the day's new admissions and to review significant events and plans for the already admitted patients.*

The ICU team, led by the senior, directs the flow of patients in and out of the AICU. Transfers out of the AICU are given to available admitting teams (Medicine, Family Medicine, Hospitalist, PA service) through the service coordinator. The AICU resident is responsible for seeing all ICU consults within one hour, though the expectation is for a rapid response and delivery of critical care. For patients who you are asked to see as an ICU consult but are not accepting to the ICU, you must write a note describing your assessment of the patient. Patients being admitted from the ER to AICU who are waiting for a bed will be managed by AICU team. You should remind both ER nursing and attending staff that changes in clinical status and major developments should be relayed to the AICU resident. Please be sure to review an orientation packet from the chief resident and Dr. Neuberg prior to the start of this rotation.

Neurology:

Educational Purpose

Medical residents must acquire the knowledge of neurology needed to practice general internal medicine and to pass the ABIM certification examination. The resident needs to:

1. Recognize the clinical presentation of common neurological diseases
2. Perform appropriate neurological histories and examinations
3. Develop accurate assessments and plans
4. Order and interpret appropriate neurodiagnostic tests
5. Demonstrate professionalism and the humanistic practice of medicine, including awareness of cultural, socioeconomic, ethical, environmental, and behavioral issues.

Clinical Encounters

Medical residents will perform initial evaluations on inpatients referred for neurological consultation, and follow these patients throughout the rotation. Medical residents may also accompany the neurology resident to evaluate acute neurological emergencies. The medical resident is expected to act as a contributing member of the neurology consult team.

Logistics

One to two senior medical residents will be scheduled to rotate with the Neurology consultation service at any given time. The only non-neurological clinical responsibilities the medical resident will have during this time include attending his or her continuity clinic for one half day session on Friday mornings. The weekend and hospital holidays are off while on neurology.

The medical resident should meet the neurology consult team in the Neurological Institute neurology call room at 7:45 am on their first day (first floor, NI 1-17). Please page the neurology consult pager (b.86876) if there are difficulties locating the team. Neurology consult attending rounds will occur during the morning and during the afternoon. The neurology consult resident will keep you informed on times and locations. The medical resident should be prepared to present their patients on attending rounds daily from Monday-Friday, and will typically present new cases during the afternoon rounds.

Medical residents will be excused from the neurology consult team for up to two days during the rotation if they have fellowship interviews scheduled. Otherwise, attendance is mandatory and medical residents will be expected to get coverage.

The Medical Resident is also expected to attend the following conferences as their clinical duties permit:

Tuesday:

8am: Neuroradiology conference (NI 1st floor Auditorium)

12 noon: Neurology didactics

Wednesday:

10am: Neurology Grand Rounds

12 noon: Neurology Evidenced Based Medicine discussion

Thursday:

8am: Morning Report (NI 14 library)

12 noon: Neurology didactics

Friday:

11am: Neurology Chief of Service Rounds

12 noon: Stroke Conference/Epilepsy Conference

When not scheduled to attend a neurology conference during the rotation, the medicine resident is strongly encouraged to attend the department of medicine morning reports and noon conferences.

Emergency Room:

Resident shifts will continue to be 12 hours long; rotating on a staggered basis to include 8am-8pm, 12noon-12midnight, and 9pm-9am shifts. Please notify the chiefs immediately if you are being told to stay later than 12 hours. You must leave the ER once your shift is completed and you have signed out your patients to the resident taking your place. You are not expected to stay for ER walk rounds once your shift has ended. Conferences will include a daily (M-F) noon conference (located in the ER resident's rooms in the Garden Café of the P&S building) and Wednesday didactics from 8am to 12pm (which will take place either at Columbia or Cornell on an alternating-week schedule). Medicine housestaff who are in the ER during these conferences will be released from their clinical duties. Attendance to didactic sessions is mandatory – otherwise, you should be in the ER.

Medicine residents on ER rotations will work an average of 5-6 shifts in 7 days (60 hours a week), as will the residents rotating in the ER from other services. In addition, you will have clinic on two mornings, generally Fridays, during the rotation. For schedule requests, please email the EM Chiefs at columbiaedschedule@gmail.com at least 2 or 3 months in advance. The EM Chiefs will attempt to honor requests, especially earlier requests, but they cannot guarantee it.

Outpatient Clinic

A detailed schedule is provided for each resident at the beginning of the OPD rotation. Schedule information is also available on the website www.medicineclinic.org.

OPD 2/Teaching Senior

Seniors have a second OPD block scheduled, during which, in addition to the regular OPD 2 curriculum, there will sessions planned to let you focus on developing and focusing your teaching skills.

The activities currently scheduled for residents on the TS rotation include morning teaching didactics, as well as several afternoons a week set aside to prepare for conducting Chief Rounds and preparing the Senior Talk. You will also be a PIC during this time. You should expect to receive feedback on all these sessions. A schedule of these didactics and additional information will be provided at the beginning of the rotation.

OPD2 residents also attend Harkness Report daily from 1pm-2pm in the AIM conference room in VC 205. The schedule of case presentations will be assigned in advance (posted in VC 205). Please be sure you are aware of the presentation schedule, and check it against your outpatient schedule, as last minute switches in clinic timings can occasionally produce conflicts that could be addressed by switching presentation days with your co-residents.

During OPD1 or 2 or E2, you may be scheduled for coverage of an Allen long call shift, which is the Allen Resident's weekend day off. Please look at amion to find out which days you are expected to be there.

Arrests:

The CCU residents act as the primary arrest resident. In general these duties are covered by the short call resident until 5pm, then by the long call resident. During the day, the cardiology long call resident is expected, at an appropriate point during the arrest, to "take over" as arrest resident so the CCU resident may return to the unit. Overnight, the cards NF resident fulfills this role. If this hand-off occurs, the long-call/NF cardiology resident is expected to write an arrest note, communicate with nurses and supervise any post-arrest arrangements. In the event that a second arrest is called, in general, the MICU resident should respond. Given the limitations of the overhead paging system, it may be necessary to call the MICU to alert them.

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). Approval for telemetry monitoring beyond 72 hours will soon be required.

Elective:

Each resident has two blocks of elective time. This time must be spent on either research or clinical experience or on a consult service. An elective proposal form (available in the Chiefs' Office) must be filled out **at least one week prior** to starting the rotation. These forms should outline your elective plans and must include the signature of the attending physician who will serve as your advisor.

Inquiries about away electives are considered on an individual basis. Those who wish to do away electives must contact the chiefs and submit a formal proposal **AT LEAST TWO MONTHS IN ADVANCE** of their elective date (3 months if proposing an international elective) if they wish to be considered. We actively and vigorously encourage residents to arrange away electives. However, the GME office must ultimately approve away electives, and they have strict time-sensitive criteria for doing so.

Therefore, in order to allow us to advocate for you most effectively, please try to get the elective packets back to us in a timely fashion. Additionally, residents should be advised that we have had particular difficulty in arranging away electives at Mount Sinai because of irreconcilable differences in the legal interpretation of agreement forms between the respective GME offices, and electives at Mount Sinai may not be possible. NY Hospital (Cornell) is considered an internal site. On E2, PGY3 residents are allowed to apply for international elective opportunities. Priority will be given to residents who desire to have an international elective experience at the Edendale Hospital site in South Africa or in our primary care elective in the Dominican Republic. Funding from the Department of Medicine is available for residents going to Edendale. All away electives must be

approved by the GME office. Please ask the Chief Residents for a full description of international elective policies.

Residents on Elective 1 are responsible for providing sick pull coverage (see below). One week prior to starting the rotation, the residents obtain a “sick pull block form” from the Chiefs’ Office and then create and submit a mutually agreed upon schedule detailing the sick pull order for the block. This schedule should also include as many forms of contact information as possible (home #, cellular phone #, etc.) If no list is submitted, then the Chiefs will randomly generate a sick pull schedule.

There are no coverage responsibilities on the E2 elective.

As stated above, there will be two AM clinic sessions per week during E1, and one clinic session per week on E2. Because of the flexibility the clinic directors need to accommodate fluctuations in staffing and to correct for potential pulls, this might consist of either continuity sessions or walk-in clinic. Most walk-in sessions will be in the OPD blocks to minimize walk-in clinics during elective. The specific schedule will be determined shortly before the rotation begins, so that amion may not accurately reflect your full clinic schedule during elective. Please check with Christina Collado (chc9091@nyp.org) a week or so prior to the start of your rotation to find out what you are scheduled for.

Sick Pull

General Rules for Sick Call:

- 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 onCall if you are sick on a clinic day so he or she can cancel your clinic. All AIM Clinic cancellation emails should be addressed to all 3 of the following: Christina Collado (chc9091@nyp.org), Chief Residents (intmedchiefs@columbia.edu) and Nancy Chang (nmc5@columbia.edu).
- 4) You must speak to the chief by direct phone conversation or in person- i.e. e-mail, text pages, 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.
- 5) 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 a MD, you can be seen in Occupational Health. Residents with more than 5 absences from work due to illness over a 12-month period are also required to have a letter from a treating physician on the first day of any subsequent illness that requires an absence from work.
- 6) If you are absent from work due to illness you should be reachable to provide information that may be needed about patients.
- 7) For non-emergent absences you must arrange for coverage of your clinical responsibilities. This includes jury duty. If you are absent for reasons other than

illness and require someone to be pulled, you will be scheduled to pay back twice the number of hours worked by the person pulled. Please submit coverage schedules in advance to the Chiefs by emailing intmedchiefs@columbia.edu.

- 8) You are allowed 2 days off without payback, but if you call in sick more than 2 times, you will owe payback equivalent to the number of hours that were covered.

Additional Rules for Sick Pull

- 1) If you are on elective E1 you may be pulled to cover sick or absent colleagues. The list of pull order should be submitted to the Chief's Office prior to the start of each new block. The list may be handed in person to one of the chiefs or e-mailed to intmedchiefs@columbia.edu. Any changes to this list must be given to the chiefs.
- 2) If you are on sick pull, you are expected to be available by beeper or phone at all times, and must be able to reach the hospital within one hour in the event that you are pulled. If you are called by the Chiefs, you must work unless you yourself are sick.
- 3) If someone on the pull list is unreachable for their pull, the next person down the list will be pulled and the unavailable person will owe the person who works double payback.
- 4) In the unlikely event that the sick pull list has been exhausted (i.e. everyone has been pulled), residents on OPD or E2 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.
- 5) 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. If you are working for someone else while you are on the pull schedule, we recommend that you identify someone else who will be able to perform your sick pull duties should you be called into work.
- 6) 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 person involved. For reasons of confidentiality you may not be told exactly why you are being pulled.

Emergency Jeopardy

In the unlikely event that the sick pull list has been exhausted (i.e. everyone has been pulled), the residents on E2 and OPD2 and OPD1 will be called at the Chiefs' discretion. Hopefully this will never be necessary, but if called by the Chiefs, you must work unless you yourself are sick. Payback policies apply in such instances as well.

Trading Shifts

Residents may trade equivalent shifts or calls with other residents. 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 Resident's Office.

Moonlighting

Seniors may qualify for moonlighting privileges after having received their medical license (and thus having passed Step 3). In order to be eligible for moonlighting, you must have no pending discharge summaries and be up to date on evaluations and duty hour log in. Juniors are currently permitted to moonlight if they have no other clinical responsibilities and only if they are on vacation, outpatient, or elective. Moonlighting is prohibited during the weekday daytime hours except while on vacation and is prohibited during all inpatient rotations. Moonlighting while simultaneously assuming other clinical responsibilities (“double dipping”) is strictly prohibited. In addition, moonlighting which results in working for greater than 24 hours (overnight shifts between on service days) is also prohibited, as is moonlighting that leads to more than 80 hours of work during a week or less than 10 hours between shifts of duty or duties. Splitting of shifts to avoid this is acceptable. Moonlighting during the evening and nighttime hours while on elective is permissible but arrangements for sick pull must be made in advance. Moonlighting privileges will be revoked if a resident violates any of these restrictions.

Jury Duty

Residents will be called upon by New York State to perform 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 will often allow multiple postponements 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.

Pager Policy:

Pagers are to be kept on at all times while on service or when on call (i.e. OPD AIM telephone coverage). Residents and interns on vacation or night rotations should sign their pager “out of hospital, unavailable” when unavailable. Do not sign your pager over to the AIM clinic, or to the chief residents’ office. Interns and Senior Medicine Residents should always have their pager signed over to the in-hospital doctor covering their hospitalized patients.