UNDSMHS Internal Medicine Residency Program

Internal Medicine Teaching Service

Policies and Procedures

MeritCare Hospital

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Organization and Supervision

The Internal Medicine Teaching Service (IMTS) at MeritCare consists of four teams (A, B, C, and D). Each team consists of two first-year residents from the UNDSMHS Internal Medicine (IM), Transitional Year (TY), or Psychiatry Residency Programs; one second- or third-year (senior) resident from the UNDSMHS Internal Medicine Residency Program; and one attending physician from the MeritCare or UNDSMHS Department of Internal Medicine.

One or two medical students may be assigned to each team. Residents or students from other health professions programs may also be assigned to the teams.

The assigned attending physician for each IMTS team functions as the managing attending physician of record for all patients admitted to the team. The IMTS has direct in-house supervision by qualified staff physicians, 24 hours per day, 7 days per week. The assigned attending physician takes call with the team until 9:00 PM Monday through Friday or until 7:30 PM Saturday and Sunday. When the team's attending physician goes off duty, a night hospitalist comes on duty. The night hospitalist supervises the on call IMTS team and staffs all new patients with the team until 7:30 AM when the team's attending physician returns to duty.

Required Teaching and Learning Activities

Residents are required to attend Morning Report, held Monday through Friday from 7:30 AM until 8:00 AM in the Roger Maris Cancer Center conference room.

Residents are required to attend Noon Conference, held Monday through Friday from 12:00 PM until 1:00 PM. Schedules and locations are posted.

Professor's Rounds are held Monday through Thursday from 1:30 PM until 3:00 PM. Each IMTS team is assigned to participate once weekly on a day when the team is on call. Teams meet the assigned faculty member in the Medical Education Conference Room. Schedules are posted.

Resident Clinic Assignments and Coverage

IM and TY residents are scheduled to attend their continuity clinic one-half day per week. Schedules change from week to week because of many logistical factors. Residents must check their schedules and arrange coverage with their teammates when they are in clinic.

First-year residents should sign-out their hospital patients and give their pagers to the senior resident during clinic. Senior residents may sign-out their hospital patients and give their pagers to the attending physician by mutual agreement.

First-year residents assigned to a morning clinic should not be expected to complete all the usual work on their hospital patients before attending clinic. When a first-year resident has a morning clinic assignment, the senior resident should assist the first-year with completion of hospital responsibilities.

Duty Hours

Duty hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours *do* not include reading and preparation time spent away from the duty site.

Residents must not work more than 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.

A period of at least 10 hours must be provided between all daily duty periods and after in-house call for rest and personal activities.

All residents on IMTS teams must be on duty and available for patient care from (not later than) 7:30am until 4:00pm Monday through Friday, with the exception of the post-call day after a 24-hour shift. Duty hours are necessarily extended until patients are stabilized, daily assigned tasks are satisfactorily completed, and patients are signed-out to a covering resident.

At least one resident member of each IMTS team must be on duty and available for patient care from (not later than) 7:30 AM until noon on weekend and holiday days.

On-Call Activities

Each team is scheduled to be on-call every fourth day. In unusual circumstances, this may be more frequent, but In-house call must occur no more frequently than every third night.

Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. When residents are scheduled for a 24-hour on-call shift (7:30 AM until 7:30 AM the following day), they should not report to the hospital before their on-call shift begins at 7:30 AM.

Monday through Friday, the on-call team begins admitting new patients to the IMTS at 4:00 PM and continues until 7:30 AM. The on-call team also provides cross-coverage for other IMTS teams and other teaching services (e.g. the Internal Medicine Consult Service) from 4:00 PM until 7:30 AM. On weekends and holidays, the on-call team admits new patients and provides cross-coverage from 7:30 AM until 7:30 AM the next day.

Internal medicine consultations requested during on-call hours must be seen by the on-call senior resident and staffed by the attending or seen by the attending independently. Consult patients are signed over to the Internal Medicine Consult service the next morning, Monday through Friday. On weekends, follow-up of new consultations is the responsibility of the IMTS team. These patients should be signed over to the Internal Medicine Consult Service the next weekday morning.

First-year residents take in-house call overnight with their teams.

Senior residents take in-house call with their teams until 9:00 PM Monday through Thursday, or 7:30 PM Saturday and Sunday. A Night Float Resident assumes the role of the senior resident when the senior resident goes off duty. The senior resident takes in-house overnight call with the team on Friday nights. This provides the Night Float Resident with one day off each week.

Post-call, residents may remain on duty for up to 6 additional hours to participate in teaching activities, transfer care of patients, attend the resident continuity clinic, and maintain continuity of care. They must *not* assume care for any new patients. A first-year resident on duty beginning at 7:30 AM on a call day should be relieved of all clinical and administrative duties by noon on the post-call day. The resident then may attend a noon conference, but must leave the hospital by 1:30pm.

After completing their post-call duties, residents must sign-out their patients to a covering resident. After signing-out, post-call first-year residents are encouraged to give their pagers to the senior resident for the rest of the workday to facilitate coordination of patient care.

Providing Emergency Care to Non-teaching Patients:

Non-teaching patients are those who are not cared for by residents on one of our medicine teaching services during regular working hours. ACGME accreditation requirements stipulate that residents must not be responsible for the care of such patients. Residents will provide care for non-teaching patients only in an emergency.

Night Float Resident

A second- or third-year resident is assigned to night float duty in blocks of one-half month. The night float resident is on duty from 9:00 PM until 7:30 AM Monday through Thursday nights, and from 7:30 PM until 7:30 AM on Saturday and Sunday nights. When on duty, the night float resident assumes all of the responsibilities of the IMTS senior resident outlined in this document.

The on-call team's senior resident must sign-out to the night float resident before going off duty each evening. Subsequently, the night float resident must sign-out to the senior resident before going off duty each morning.

Limits on Admissions and Patient Load

First-year residents are limited to 5 new patients plus 2 medical service transferred patients per 24-hour period, or no more than 8 new patients plus 2 transfers in any 48-hour period. Transfers are defined as patients previously admitted to another internal medicine service (e.g. the Critical Care Medicine Service) then transferred to the IMTS.

Senior residents are limited to 10 new patients (admissions and consults) per 24-hour period or 16 new patients in any 48-hour period.

First-year residents should not be responsible for the ongoing care of more than 10 patients.

Senior residents should not be responsible for the ongoing care of more than 16 patients, and must not be responsible for the ongoing care of more than 20 patients for more than one day.

Assignment of Patients to the IMTS

The Medical House Officer (MHO) or attending physician will accept new patients for admission to the IMTS. The MHO or attending physician will assign the patient to a team and notify the senior resident.

The post-call IMTS team admits no new patients after 7:30 AM. Monday through Friday, new admissions to the IMTS between 7:30 AM and 4:00 PM are distributed to the teams who are neither on call nor post-call. New admissions to the IMTS between 4:00 PM and 7:30 AM go to the on-call team. The on-call team admits all new patients to the IMTS on weekend and holiday days.

The senior resident will assign the patient to a first-year resident, or if first-year residents are unavailable, care for the patient directly. If the IMTS has an excessive patient load, the MHO or attending physician will arrange for new patients to be admitted to the hospitalist (non-teaching) service.

The resident team must follow all patients admitted to the IMTS and must bear the major diagnostic and therapeutic responsibility for these patients.

Readmission of recently discharged patients ("Bounce Back")

Any patient being readmitted to the MeritCare IMTS after being discharged within the same calendar month should return to the original team. If the original team is unavailable (post-call or off duty) another team must admit the patient and transfer care to the original team the next day.

H&Ps and Admission Notes

First-year residents must independently:

- obtain a comprehensive medical history (chief complaint, history of present illness, past medical history, family history, social history, and complete review of systems);
- perform a comprehensive physical examination;
- review initial investigations;
- develop a prioritized problem list;
- formulate a differential diagnosis for major undifferentiated or partially differentiated problems;
- outline a management plan; and
- document all of this in the medical record.

First-year residents should dictate the admission note. Dictated notes facilitate coordination of patient care because they are legible and accessible in the Electronic Patient Record. A copy of the dictated admission note should be sent to the patient's Primary Care Provider. In addition to the dictation, a short hand-written admission note should be placed on the chart since the dictated H&P may be delayed in transcription or in filing.

First-year residents must not dictate an admission note until after they have fully evaluated the patient and discussed the case with a senior resident and/or attending physician. Dictating from a senior resident's note before independently completing a full evaluation is *unacceptable* and will place both the senior and first-year resident at risk of disciplinary action.

A medical student's admission note must not substitute for a resident's admission note.

Senior residents should perform a history and physical examination and write a Resident Admission Note (RAN) on all new patients admitted by a first-year resident. This requirement may be waived if the attending physician chooses to directly supervise the first-year resident's admission work-up when the senior resident is unavailable because of other urgent patient care demands.

The RAN should not be another comprehensive H&P. The RAN should include a concise, focused distillation of the most relevant findings from the history, physical exam, and investigations along with a sophisticated and comprehensive assessment and plan which justifies the patient's care and educates the junior members of the team.

If a first-year resident is unavailable because of other admissions, urgent patient care responsibilities, or excessive workload, the senior resident or night float resident must admit new

patients without the involvement of a first-year resident. In this circumstance, the senior resident must perform and document a comprehensive H&P as described above for first-year residents.

Admission Orders

After discussion of the patient with the senior resident and/or attending physician, the first-year resident should write appropriate admission orders. If the senior resident admits the patient without the involvement of a first-year resident, the senior resident must write appropriate admission orders.

Admission orders should be written as soon as possible after the IMTS accepts care of the patient. As a matter of safety, patients must never be left waiting on hospital wards for long periods without essential orders. In some circumstances, a partial set of "survival" orders should be written before the evaluation of the patient is complete. If the resident team is unable to evaluate and care for a new patient expeditiously for any reason, the senior resident must notify the attending physician immediately.

All admission orders must be written using Standing Physician Orders. Standing Physician Orders improve the quality of patient care by facilitating standardization of practices grounded in evidence-based clinical practice guidelines. Standing Physician Orders are available via CareNet for numerous common problems (e.g community-acquired pneumonia, congestive heart failure, suspected myocardial infarction, stroke, and diabetic ketoacidosis). Generic Standing Physician Orders should be used when none of the available sets of Standing Physician Orders apply.

Admission orders must include:

- the admitting diagnosis;
- the IMTS team name (A, B, C, or D);
- the name of the responsible first-year resident;
- the name of the responsible senior resident;
- the name of the attending physician (the team's designated attending who will have management responsibility the next day); and
- the name of the admitting physician (the staff physician on duty if different from the attending).

All orders must be signed. The resident's name and pager number must be legibly printed beneath the signature or stamped.

Dangerous or ambiguous abbreviations prohibited by MeritCare (q.d., q.i.d., q.o.d., cc, U, MS, MSO4, SQ, IU, µg) must not be used in the orders or elsewhere in the medical record.

First-year residents should not write orders they do not understand. As supervisors and teachers, senior residents and attending physicians must explain the rationale behind all orders and assist the first-year resident in writing them correctly. Repeated violations of this expectation should be reported to the Program Director.

Order Writing:

Residents cannot appropriately grow in understanding patient care responsibilities if others write orders for patients under their care. Thus, **residents should write all orders for patients under their care**. Attending physicians must refrain from writing orders except in emergencies or in the unlikely situation that no resident is on-duty. If your attending physician writes an order, remind him/her that accreditation requirements forbid this and work with them to ensure the type of availability and relationship that allows them to defer all order-writing to you. Report any repeated violations of this rule to the residency office.

Consulting physicians and their residents may write orders on the charts of patients on internal medicine teaching services at the discretion of the referring resident(s), who should clarify this issue during the consultation request.

Infractions of this policy must be brought to the attention of the program director or key faculty member. This policy applies to residents in all clinical settings and all training sites, including but not limited to inpatient medicine, critical care medicine, subspecialty medicine, and ambulatory medicine.

It is important to be able to track and identify the person who is writing orders in each patient's chart. Delays and errors are possible if orders are misinterpreted or unclear and the signature of the physician is illegible. **The resident's clearly printed or stamped name and pager number should follow ALL orders**.

Resident Work Rounds

The purpose of Resident Work Rounds is:

- to allow appropriate resident input into clinical decision making and formulation of a plan of management prior to Attending Rounds;
- to expedite implementation of the plan of care;
- to foster resident skills in leading an internal medicine team;
- and to allow for more efficient Attending Rounds (focus on new, complex, or seriously ill patients and relevant learning objectives.

Resident work rounds led by the senior resident, usually without the attending physician, should occur daily between 8:00am – 10:00am. This may vary according to the preferences of the group as long as it does not interfere with teaching rounds, clinics or mandatory conferences.

Attending Rounds

Management Attending Rounds occur daily with the attending physician and at least one resident member of the rounding group. The timing of management rounds may vary according to the preferences of the group and should not interfere with teaching rounds, clinics or mandatory conferences. Management rounds are distinct from teaching rounds.

Teaching Attending Rounds occur at least three days per week for a total of at least 4½ hours. Teaching Rounds educate residents regarding issues more general than the immediate management of patients assigned to the residents' care. Teaching Attending Rounds must:

- Be regularly scheduled
- Be conducted on a formal basis on at least three days of the week for a minimum of four and one-half
- Be separate and distinct from work/management rounds.
- Include direct bedside interaction with the patient by the residents and the teaching physician

In addition, Teaching Attending rounds should:

- Involve only a few cases, for discussion of such points as: interpretation of clinical data; pathophysiology; differential diagnosis; management of this *category* of patients, not a *specific* patient; appropriate use of technology
- Include personal evaluation of the history and physical examination by the teaching physician
- Preserve and emphasize the dignity of the patient/physician relationship
- Be conducted by faculty members selected for their knowledge of medicine, clinical skills and interest and ability in teaching.

Consultations:

If you request a consultation for one of your patients:

- Appropriately contact the consulting physician. A phone call is preferred.
- Communicate the urgency of the consult (emergent, urgent, routine)
- Communicate the reason for the consult (answer a particular question, perform/assist with a procedure, make management suggestions, co-manage, take over management); asking specific questions ensures more meaningful feedback.
- Inform your consultant whether you want them to write orders or not. If not, establish a communication strategy that allows you to understand and write orders reflecting the consultant's recommendations.
- If you would like to do a procedure with the consultant's supervision, make your request clear when you discuss the case with the consultant.
- Advise your patient of the consultation and what to expect.

If you serve as a consultant to another physician: talk directly with the referring physician to clarify expectations and our role, especially if reason for consultation is not clear. Document your consultation using the duplicate copy Consultation sheets placed in the chart when a consultation is formally requested. Although a consultation usually includes a complete H & P, be sure to answer the referring physician's questions succinctly at the close of your note. If significant detail is needed, you may dictate the full consultation and use the consultation sheet only to summarize your recommendations. Consultations should be performed within 24 hours of the request. You must present the case to your attending physician or supervising senior resident. This can be done initially in some cases with a phone call, but the attending physician must document/sign all consultations. When answering consultations from the Emergency Department, make sure a senior physician is contacted; the attending physician must be notified before a patient in the ED for whom an internal medicine consultation is provided can be discharged. **Failure to appropriately involve attending supervision is a serious offense and may result in your dismissal from the program**. Remember that if you serve as a consultant to a patient on a resident teaching service, you must refrain from writing orders on your fellow resident's patient unless specifically instructed otherwise.

Transfers to the Other Services:

Patients are transferred to the Critical Care Medicine (CCM) service for the duration of their critical care unit stay. When a patient requires transfer to CCM (or to any other service such as surgery, psychiatry, etc.) the transferring resident should verbally report to the accepting physician and write a note summarizing the patient's significant problems and events. If the patient is transferred back to the IMTS during the same calendar month, the patient must go back to the original team.

Patient Deaths:

If a patient dies or has a significant change in clinical status, the resident should immediately notify the attending physician and the appropriate nurse supervisor, so that family can be notified. Residents may be asked to pronounce a patient dead, although nurses often do this. Only physicians with a permanent medical license can sign a death certificate, so in most instances the resident should defer to the attending physician for the completion of this form.

You must report all deaths of teaching service patients to the residency office at the time of death, or as soon as possible if the death does not occur during business hours. This is required to coordinate resident participation in autopsies, selection of cases for M&M/Peer Reviews conferences, and appropriate review of all deaths.

Off Service Notes:

Sign over of patients from one resident team to the next is expected, and is important to continuity and quality of care. Residents should make sure that an off service note is written **and** that they speak with their incoming replacements for the next rotation to make sure they know about the patients. This is not solely the job of the post-call residents at morning report on the first day of the rotation change. Attending physicians should also sign over patients at the change of attending assignments.