

TriHealth
Good Samaritan Hospital
Internal Medicine Residency Program
and
The Center for the Advancement of Humanism in Medicine

This document describes the curriculum for the Good Samaritan Hospital Internal Medicine Residency Training Program. The didactic curriculum is discussed first. The curriculum for every rotation offered by GSH follows, with both content and process goals. These goals are the observable activities by which resident performance will be measured by the attending faculty. Following the rotation curricula are month-by-month calendars with all scheduled curricular activities listed for the 18 months beginning July 1, 2013.

The curriculum is a continuously evolving collaborative effort. Please do not hesitate to make suggestions at any time, which can be communicated by email to our Program Coordinator, Beth Mack, at Beth_Mack@trihealth.com.

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GSH INTERNAL MEDICINE RESIDENCY

Conrad Fischer, MD, said it best in the introduction to his Internal Medicine Review for the ABIM Exam book. “You are a doctor because you have a calling. A calling means you try to grasp where your great passion and the world’s great need meet.” Your calling will require of you traits and behaviors not required of any other person, and these are what make you a professional. “We do not seek suffering for ourselves. We do not create pain or make the training process needlessly difficult. When pain comes in the process of our mission, our goal, our duty, however, we do not avoid it... We get the job done whether it is easy or not. We are not done when the shift is over, we are done when we are done. We are done when our patients have been cared for. This is what makes us, as physicians, worthy of the designation professional”.

EDUCATIONAL PURPOSE

During your residency you will develop the tools necessary to become comprehensive internists capable of independently managing diverse patients with a broad range of diseases. You will graduate prepared to enter primary care internal medicine, or to pursue fellowship training.

CURRICULUM

1. The didactic curriculum is discussed in a different document.
2. The core conference types as defined by the ACGME are present in the curriculum, and include morning report, journal club, M&M, and Grand Rounds. Quarterly GME Grand Rounds feature talks about cutting edge topics from experts in the field.
3. All disciplines defined as necessary content in the ACGME IM program requirements are represented in the curriculum.
4. All rotations are described in the curriculum manual. Content and process objectives are defined for each rotation. **These objectives are not the only things you will learn, but they are what you will be measure by.** Before and after quizzes on rotation content are conducted.
5. A simulation curriculum has been developed.

OUR EXPECTATIONS OF YOU

You will:

1. Recognize that you are ultimately accountable for your own patient care and education, and this requires continuous high intensity effort. You understand there is a direct connection between effort and results.

2. Seek feedback, and be willing to make changes to improve performance if needed. You will understand that feedback is sometimes difficult to accept, and is offered only in the spirit of helping you achieve the goal of independent practice. Studies show that resistance to feedback often predicts continued poor performance.
3. Self-reflect to foster personal growth. You will develop strategies for self-assessment.
4. Help your teammates if they are struggling; if unable, you will seek help on their behalf. You will support your team.
5. Attend at least 80% of all educational conferences for which you are eligible. You will organize your day to prioritize educational sessions, and help your colleagues do the same.
6. **Be on time and be prepared.** You will demonstrate respect for your teachers and colleagues, and ultimately for yourself, by being on time, and doing any assigned reading and work.
7. Develop and commit to a reading plan. You will read something substantial almost every day. This will sometimes be difficult, and require sacrifice.
8. Provide feedback to the program to optimize your experience and those of your colleagues. Your feedback is one of the most important ways we can improve.
9. Embody the core humanistic values of honesty, integrity, caring, compassion, empathy, respect and trustworthiness. You will remember that you are always an ambassador for the department and profession.

LEVEL OF SUPERVISION

You will be supervised by an attending physician for all patients that you encounter. These levels of supervision include:

1. Direct Supervision – the supervising physician will be physically present with you and your patient.
2. Indirect Supervision:
 - a. With direct supervision immediately available – the supervising physician will be physically within the hospital or other site of patient care, and will be immediately available to provide
 - b. With direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

EDUCATIONAL RESOURCES

You will have the following educational resources at all times, as well as resources specific to each rotation:

1. Article collection bank for each learning objective for each rotation
2. Article collection bank for each conference series
3. Online journals through GSH Library (both on and off campus access):
<http://libraries.uc.edu/research/journals/index.html>
4. UpToDate (on and off campus access)
5. MKSAP
6. MedStudy

EVALUATION

You will be evaluated during residency via multiple sources. Each rotation will use a combination of the elements below. We will share the expectations for each rotation with you at the beginning of the rotation.

1. Direct observation by attending physicians
2. Multisource (360 degree) feedback by inter-professional team members (e.g. nurses, case managers, pharmacists), as well as peers and students
3. Self-Evaluation
4. Patient Evaluation
5. Clinical Quality Data Evaluation
6. Simulation Exercises
7. Chart Review
8. Research Quality and Output
9. Knowledge Testing
10. Participation Levels

For the specific goals and objectives listed in this document, the basic evaluation unit will be one of **Entrustment**.

WHAT LEVEL DO YOUR EVALUATORS TRUST YOU TO DO EACH SKILL?

Evaluation Scale Based on Level of Entrustment

1. You cannot achieve the goal even with assistance
2. You may act under proactive, ongoing, full supervision
3. You may act under reactive supervision, (i.e. supervision is readily available upon request)
4. You may act independently
5. You may act as a supervisor and instructor

This means that most interns will start with a 2 and progress to 3 on most measures by the end of the year, and most PGY-2/3 residents will start with 3 and progress to 4 on most measures by the end of residency.

How to Use this Document

- Each rotation in the residency program will have content-based goals and objectives, and process-based goals and objectives.
- **Content-based** goals and objectives are specific for each rotation – these are the skills you will learn on the given rotation. Therefore, each set of content based goals and objectives is different from rotation to rotation.
 - o Examples: titrate insulin, manage arrhythmia, and assess pain using an established pain scale.
- **Process-based** goals and objectives are the same for each type of rotation, and are generally skills needed for a particular type of work (e.g. inpatient, ambulatory, consults).
 - o Examples: minimize unnecessary care including tests, Integrate clinical evidence into decision making, teach physical findings for junior members of the health care team, use feedback to improve performance.
- Each of the goals and objectives will be used in your end-of-month evaluation. You should review them with your team and attending at the start of each rotation to know what you will be expected to do.
- In addition, this document lists the **competencies and milestones** that will be evaluated during the rotation
- After each description of the rotation you will find a grid that contains the competencies and milestones for the content-based portion of the rotation – **shaded areas** indicated the competencies and milestones that will be covered
 - o **Process-based com** competencies and milestones can be found after the rotation listings
 - o A **key for each milestone** (coded by letters in the grids) can be found at the end of document
- Most rotations will also include narrative/written comments, as well as 360 degree/multisource component, and a self-evaluation (see page 108)

INTERNAL MEDICINE RESIDENCY/GSH DIDACTIC CURRICULUM

1. The curriculum is designed to ensure that each resident passes the ABIM certification examination.
2. The curriculum differs for each PGY year.
3. All sessions occur at 0700 on each M-Tu-Th-F, unless otherwise noted. This ensures the maximum possible attendance at the conferences.
4. The didactic curriculum content for the month of July for the PGY-1 residents is designed to review core content topics of outpatient and inpatient medicine. See attached schedule. Thereafter, each Monday session for PGY-1 residents will be devoted to learning the content of “Hitchhiker’s Guide to Internal Medicine” by Atif Qasim. Tuesday and Friday sessions are devoted to outpatient medicine and are directed by Dr. Neha Gandhi. Thursdays are the same for all PGY years.
5. The didactic curriculum for PGY-2s and PGY-3s repeats itself every 18 months. Content emphasis is apportioned according to the weight each discipline receives on the ABIM examination. For example, 14% of the Board Exam questions are related to cardiology, so 14% of the curriculum is related to cardiology, and so on for each discipline. The individual topics for each discipline are chosen according to the emphasis the ABIM places on these topics. An entire week is devoted to each topic. All topics of any given discipline will occur in succession until the allotted number of sessions for that discipline have been used. The MedStudy series “Internal Medicine Review” will be core to this portion of the didactic curriculum. Monday each resident will have prepared by studying source material relevant to that week’s topic. A resident will be chosen at random to lead a discussion of the topic. On Tuesday a specialist in that discipline will give a “nuts and bolts” talk on the topic of the week, emphasizing the 4-5 most important considerations in the evaluation and management of the topic. Friday will be a clinical reasoning conference, with specific case discussions relevant to the topic. The format will follow that of “Case Files Internal Medicine” by Toy and Patlan. One Thursday each month will be devoted to Chest Conference, and one will be devoted to the Med-Surg conference. One Thursday will be a traditional M&M discussion. The remaining Thursdays each month will be “Talk It Out Thursday”. Any and all stakeholders in the IM residency, including, but not limited to, faculty, nurses, therapists, techs, and coordinators, are invited to talk about any residency-related issue.
6. The last six months of the PGY-3 year are devoted to an intensive board review. Until that time, use of board practice questions will be limited, the notion being that such practice questions should only be studied after a reasonable mastery of the subject matter. Exactly as

the curriculum was apportioned according to ABIM weighting of topics, so will Board review sessions. Again, each discipline will be reviewed linearly as with the curricular content. Board review materials will include Conrad Fischer's Internal Medicine book; MKSAP; The Johns Hopkins Internal Medicine Board Review Certification and Recertification; First Aid Internal Medicine Boards; and any other material the resident may find useful.

7. All residents will take the annual In-Training examination. Areas of deficiency will be identified, and a resident-specific study plan based on this analysis will be implemented, monitored and enforced.

Good Samaritan Hospital
Internal Medicine
Didactic Curriculum 2013-2014

Post-Graduate Year 1:

1. Immersion

Objective: To provide each PGY-1 resident a review of many of the common problems that are encountered almost every day in the clinic or on the wards.

- a. The Basics of Infections and Treatments
- b. Fluid and Electrolyte Basics
- c. ABG's: The Basics
- d. Hypotension/Sepsis: Basic Approach and Treatment
- e. Code Blue/RRT
- f. Chest Pain/Acute MI
- g. Syncope/Stroke/Seizure: The Work-up
- h. HTN In the Clinic: Basic Principles and Treatments
- i. Altered Mental Status in the Hospital
- i. Atrial Fibrillation
- k. Anticoagulation
- l. CHF
- m. Diabetes in the Clinic: Basic Principles and Treatments
- n. Screening for the Clinic
- o. Bronchitis and Sinusitis in the Clinic
- p. Immunizations and Antibiotic Prophylaxis
- q. COPD and Asthma
- r. Pain Management
- s. Leukocytosis and Fever: Approach in Hospitalized Patient
- t. Scenario Absurdio
- u. PFT's: The Basics
- v. Pre-Op Evaluation in the Clinic

2. Hitchhikers Guide to Internal Medicine

Objective: To give each intern the knowledge base that will become the framework for all future learning. The goal is to teach PGY-1 residents how to think like an internist.

- j. The entire text will be covered in 46 weeks
- k. Time assigned to each subject will be based on ABIM board examination emphasis of the subject
- l. To be conducted on Monday morning at 0700-0800, and will be led by Chief resident or faculty
- m. Breakdown: (approximations, not exact)
 - i. Cardiology – 7

- ii. Pulmonology – 5
- iii. Gastroenterology – 5
- iv. Rheumatology – 5
- v. Endocrinology – 5
- vi. Infectious Disease – 5
- vii. Oncology – 4
- viii. Nephrology – 3
- ix. Hematology – 3
- x. Neurology – 3
- xi. Dermatology – 1

2. Ambulatory

Objective: To become familiar with subjects that will be commonly encountered in the out-patient setting. To teach how to diagnose and treat diseases that will be seen often in the clinic.

- a. With each topic will have a pre and a post-test.
- b. Will be led by Chief Resident, Faculty, and Pharmacy
- c. Will include major topics encountered in the clinic setting (*Topics through December 2013, will add topics to the rest of the year in near future*)
 - i. Hypertension
 - ii. Hyperlipidemia
 - iii. Diabetes Mellitus
 - iv. Headaches
 - v. Thyroid Disease
 - vi. Back Pain, Chronic Pain, Fibromyalgia
 - vii. Asthma
 - viii. COPD
 - ix. Osteoporosis/Falls

3. Dr. Sheldon Lecture Series

Objective: To expose interns to the very important topics of humanism, professionalism, ethics, empathy, systems analysis, and quality and safety. The goal is to instill in each resident a knowledge of what the calling to be a physician really entails and to hopefully help them strive to become the new generation of altruistic doctors.

- a. Currently in Production

4. MedSurg Conference

Objective: To expose residents to cases that involve the Gastrointestinal tract. Two cases will be presented; one from the surgical point of view and one from the medical point of view. All residents will be exposed to cases and will see how they were approached and learn from the attending physicians on how the cases should be approached.

- a. Will happen on the third Wednesday of each month.
- b. Joint effort between the surgery and internal medicine residency.

- c. Resident on GI rotation will present a case with the help of the GI attending.
 - d. If no resident on GI service then presentation will be assigned.
5. CHEST Conference
Objective: To be exposed to cases presented by the Pulmonologist and cardiothoracic surgeons that are unique and interesting as well as those that need a multidisciplinary approach.
- a. Will occur on the second Thursday of each month.
 - b. Radiologist, Pulmonologist, and Cardiothoracic surgeons will be present to discuss cases.
6. Talk-It-Out with Dr. Friedstrom
Objective: An open, free, unlimited space to talk about residency issues. Will be able to talk about positive cases, learning issues, resident successes, and any other areas that may need to be discussed. An open time for any faculty or staff to attend and talk about any issue that may affect the residency and hospital.
- a. Will occur on Thursday morning at least one time per month.
 - b. A reprisal-free time to talk about issues that plague the residents.
 - c. Keep open, good communication between residents and the program director.
 - d. Find areas of weakness and quality and safety improvement projects.
7. Morning Report
Objective: Present interesting cases as a group and work through the differential diagnosis of admissions to the hospital.
- a. Will occur every Wednesday morning.
 - b. All residents present to work through the differential diagnosis of a chief complaint.
 - c. Find areas of weakness of the admission and work on improvement.
8. Morbidity and Mortality
Objective: To review cases that were difficult to manage and those that may have had unintended consequences that can be a learning point for all the residents.
- a. Will be led by chief resident or faculty.
 - b. Each case will be dissected without any individuals being blamed in the process.
9. Clinical Pathology Scholarly Conference
Objective: Will expose residents to unusual cases and allow the opportunity to work through the differential diagnosis.
- a. Will occur on Wednesday mornings during the year.
 - b. Each resident will present one case in each year.
10. Grand Rounds
Objective: Expose residents to specialist in different fields on practice and learn from the topics that they present.
- a. Will occur on Wednesday mornings during the year.

- b. Topics that are needed may be submitted for possible lectures.

11. Tumor Board

Objective: Expose residents to a multidisciplinary approach to malignancy.

- a. Occurs on Friday at noon.
- b. Oncologist, Radiologist, Radiation Oncologist, Surgeons and others involved in cases meet to discuss difficult and unique cases for the betterment of patient care.
- c. Optional lecture for all residents.

12. Summer Lecture Series

Objective: Expose residents to Graduate Medical Education topics that will be important to them in their education.

- a. Topics:
 - i. Research
 - ii. Effective Patient Communication
 - iii. Introduction to Pharmacy
 - iv. Medications and Patient Safety
 - v. Pain Management
 - vi. Palliative Care
 - vii. QSS
 - viii. Fatigue Mitigation
 - ix. Health Care Reform/Affordable Care Act
- b. Will occur on Friday mornings at 0645 – 0730.
- c. Topics chosen by GME staff

Updated June 2013

Good Samaritan Hospital
Internal Medicine
Didactic Curriculum 2013-2014

Post-Graduate Years 2-3:

1. ABIM Board Preparation

Objective: To pass the ABIM boards. Residents will learn the most tested upon subjects on a weekly basis that will span 76 weeks giving room for holidays to be missed. The breakdown of how the topics are chosen are directly from the percentage of each discipline off the latest ABIM internal medicine boards breakdown.

a. Monday:

- i. The topic of the week will be known by each resident
- ii. The resident will choose a text of his/her liking and will be ready to present to the entire group what he/she has learned.
- iii. Since every resident will have read and multiple texts will be represented then the breadth of information will help all to learn.
- iv. Staffed by either the specialist giving the lecture of the week or faculty.

b. Tuesday:

- i. Specialist lecture on the topic of the week.
- ii. Infectious Disease (9% = 7)
 1. Pneumonia
 2. Skin and Soft Tissue Infections Including Osteomyelitis
 3. HIV Infection and AIDS
 4. Sexually Transmitted Diseases
 5. Infective Endocarditis
 6. Enteric Infections
 7. CNS Infections
- iii. Pulmonary/Critical Care (10% = 8)(*Currently Specialist dividing topics among themselves*)
 1. Asthma
 2. Pleural Disease
 3. PFT
 4. COPD
 5. Sleep Apnea
 6. CXR
 7. Venous Thromboembolic Disease
 8. Hemodynamic Monitoring in ICU and Sepsis Syndrome
- iv. Cardiology (14% = 11)(*Currently Specialist deciding who will perform each lecture*)
 1. Valvular Heart Disease
 2. Pericardial Disease

3. Cardiovascular Disease Prevention
 4. Adult Congenital Heart Disease
 5. Peripheral Vascular Disease
 6. Hypertension
 7. Arrhythmias
 8. Acute Coronary Syndrome
 9. Diastolic Heart Failure
 10. Systolic Heart Failure
 11. Stress Testing
- v. Hematology/Oncology (6/7% = 5/5)
1. Breast Cancer
 2. Lung Cancer
 3. Gastrointestinal Cancer
 4. Genitourinary Cancers: Prostate, Kidney, Bladder, Testis
 5. Leukemia
 6. Non-Hodgkin and Hodgkin Lymphoma
 7. Multiple Myeloma
 8. Oncologic Emergencies
 9. Disorders of Platelets and Coagulation
 10. Anemia and Hemoglobinopathies
- vi. Gastroenterology (9% = 7)
1. Esophageal Disease
 2. Peptic Ulcer Disease
 3. Diarrhea and Malabsorption
 4. Inflammatory Bowel Disease
 5. Pancreatic Disease
 6. Liver Disease
 7. Cirrhosis
- vii. Nephrology (6% = 5)
1. Acute Kidney Injury
 2. Chronic Kidney Disease
 3. Electrolyte Disturbances
 4. Essential and Secondary Hypertension
 5. Hematuria and Proteinuria
- viii. Endocrinology (8% = 6)
1. Pituitary Disorder
 2. Thyroid Disease
 3. Adrenal Disorders
 4. Disorders of Calcium Metabolism
 5. Diabetes Mellitus
 6. Metabolic Syndrome
- ix. Rheumatology (8% = 6)

1. Laboratory Tests in Rheumatic Disorders
 2. Rheumatoid Arthritis
 3. Acute Monoarticular Arthritis
 4. Systemic Lupus Erythematosus and Related Disorders
 5. Systemic Vasculitis
 6. Common Soft Tissue Pain Syndromes
- x. Neurology (4% = 3)
 1. Stroke
 2. Dementia
 3. Headache/Migraine
 - xi. Psychiatry (4% = 3)
 1. Depression
 2. Personality Disorders
 3. Psychosis
 - xii. Allergy/Immunology (3% = 2)
 1. Testing and the workup of Allergic Reactions
 2. Common Diagnoses: Asthma, Medications, Hereditary
 - xiii. Obstetrics/Gynecology (2% = 2)
 1. Contraception
 2. Important Cardiovascular, Endocrinology, and Oncology topics in Women
 - xiv. Ophthalmology (2% = 2)
 1. Ophthalmologic Emergencies
 2. Evaluation and Treatment of Common Infections and Reactions
 - xv. Otorhinolaryngology (2% = 2)
 1. Sinusitis and Upper Respiratory Tract Abnormalities
 2. Otitis and Hearing Abnormalities
- c. Friday:
- i. Clinical Vignette
 - ii. Cases based on the topic of the week will be presented and discussed.
 - iii. Resident will come away with an understanding of how to use the information that they have learned during the week on real cases.
 - iv. Staffed by either the specialist giving the lecture of the week or faculty.
- d. Full two years:
- i. Each class starting as a second year will get all 76 topics.
 - ii. In the last half of the third year the senior class will then start focused board preparation.
 - iii. Monday, Tuesday, Friday will be set aside for them to be one-on-one with the specialist and study topics in the specialty and do board questions.
 - iv. Topics broken down with the same ABIM percentages.
 1. Infectious Disease (9% = 7)
 2. Pulmonary/Critical Care (10% = 8)

3. Cardiology (14% = 11)
4. Hematology/Oncology (6/7% = 5/5)
5. Gastroenterology (9% = 7)
6. Nephrology (6% = 5)
7. Endocrinology (8% = 6)
8. Rheumatology (8% = 6)
9. Neurology (4% = 3)
10. General Internal Medicine: Due to a large portion of the test being on this topic the third years will have 9 board review sessions just to review general medicine topics and board questions.

2. MedSurg Conference

Objective: To expose residents to cases that involve the Gastrointestinal tract. Two cases will be presented; one from the surgical point of view and one from the medical point of view. All residents will be exposed to cases and will see how they were approached and learn from the attending physicians on how the cases should be approached.

- a. Will happen on the third Wednesday of each month.
- b. Joint effort between the surgery and internal medicine residency.
- c. Resident on GI rotation will present a case with the help of the GI attending.
- d. If no resident on GI service then presentation will be assigned.

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- a. Will occur on Thursday morning at least one time per month.
- b. A reprisal-free time to talk about issues that plague the residents.
- c. Keep open, good communication between residents and the program director.
- d. Find areas of weakness and quality and safety improvement projects.

5. Morning Report

Objective: Present interesting cases as a group and work through the differential diagnosis of admissions to the hospital.

- a. Will occur every Wednesday morning.
- b. All residents present to work through the differential diagnosis of a chief complaint.

- c. Find areas of weakness of the admission and work on improvement.
6. Morbidity and Mortality
Objective: To review cases that were difficult to manage and those that may have had unintended consequences that can be a learning point for all the residents.
- a. Will be led by chief resident or faculty.
 - b. Each case will be dissected without any individuals being blamed in the process.
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- a. Will occur on Wednesday mornings during the year.
 - b. Each resident will present one case in each year.
8. Grand Rounds
Objective: Expose residents to specialist in different fields on practice and learn from the topics that they present.
- a. Will occur on Wednesday mornings during the year.
 - b. Topics that are needed may be submitted for possible lectures.
9. Tumor Board
Objective: Expose residents to a multidisciplinary approach to malignancy.
- a. Occurs on Friday at noon.
 - b. Oncologist, Radiologist, Radiation Oncologist, Surgeons and others involved in cases meet to discuss difficult and unique cases for the betterment of patient care.
 - c. Optional lecture for all residents.
10. Summer Lecture Series
Objective: Expose residents to Graduate Medical Education topics that will be important to them in their education.
- a. Topics:
 - i. Medications and Patient Safety
 - ii. Pain Management
 - iii. Palliative Care
 - iv. QSS
 - v. Fatigue Mitigation
 - vi. Health Care Reform/Affordable Care Act
 - b. Will occur on Friday mornings at 0645 – 0730.
 - c. Topics chosen by GME staff

July 2013

~ July 2013 ~						
◀ Jun 2013						Aug 2013 ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1 PGY1: Dr. Blatt: Basics of Infections and Treatments PGY2-3: Pneumonia Reading Review	2 PGY1: Dr. Moussa: Fluid and Electrolyte Basics PGY 2-3: Pneumonia: Dr. Blatt	3 PGY 1: Dr. Moussa: ABG's: The Basics PGY2-3: Morning Report	4 Holiday: Independence Day PGY1-3: OFF	5 PGY 1: Dr. Angles: Hypotension/Sepsis: Basic Approach and Treatment PGY 2-3: Clinical Vignette Noon: Tumor Board	6
7	8 PGY1: Aaron Young: Code Blue/RRT PGY2-3: Skin and Soft Tissue Infection Reading Review	9 PGY1: Angel Mena: Chest Pain/Acute MI PGY2-3: Skin and Soft Tissue Infections Including Osteomyelitis: Dr. Friedstrom	10 PGY1: Dr. Kachoris: Syncope/Stroke/Seizure: The Work-up PGY2-3: Morning Report	11 PGY1: D.r Gandhi: HTN in the Clinic: Basic Principles and Treatment PGY2-3: CHEST Conference	12 PGY1: 0645-0730 Research: Scott Woods PGY1: 0730-0830 Angel Mena: Altered Mental Status in the Hospital PGY2-3: Clinical Vignette Noon: Tumor Board	13
14	15 PGY1: Dr. Gandhi: Atrial Fibrillation PGY2-3: HIV/AIDS Reading Review	16 PGY1: Angel Mena: CHF PGY2-3: HIV Infection and AIDS: Dr. Blatt	17 PGY1: Dr. Blatt: Immunizations and Antibiotic Prophylaxis PGY2-3: Morning Report	18 PGY1: Aaron Young: Diabeteis in the Clinic: Basic Principles and Treatments PGY2-3: MedSurg Conference	19 PGY1: 0645-0730: Effective Patient Communication PGY1: 0730-0830 Dr. Gandhi: Screening for the Clinic PGY2-3: Clinical Vignette Noon: Tumor Board	20
21	22 PGY1: Dr. Gandhi: Bronchitis and Sinusitis in the Clinic PGY2-3: Sexually Transmitted Diseases Reading Review	23 PGY1: Aaron Young: Anticoagulation PGY2-3: Sexually Transmitted Diseases: Dr. Friedstrom	24 PGY1: Angel Mena: COPD and Asthma PGY2-3: Morning Report	25 PGY1: Dr. Srivastava: Pain Management PGY2-3: Talk-It-Out with Dr. Friedstrom	26 PGY1: 0645-0730 Introduction to Pharmacy: Dr. Habedank PGY1: 0730-0830 Dr. Friedstrom: Leukocytosis and Fever: Approach in the Hospitalized Patient PGY2-3: Clinical Vignette Noon: Tumor Board	27
28	29 PGY1: Dr. Friedstrom: Scenario Absurdio PGY2-3: Infective Endocarditis Reading Review	30 PGY1: D.r Wiltse: PFT's: The Basics PGY2-3: Infective Endocarditis: Dr. Blatt	31 PGY1: D.r Gandhi: Pre-op Evaluation in the Clinic: PGY2-3: Morning Report	Notes:		

August 2013

~ August 2013 ~						
◀ Jul 2013						Sep 2013 ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1 PGY1-3: Morbidity and Mortality Conference	2 PGY1-3: 0645-0730: Medications and Patient Safety PGY1-3: 0730-0830 Clinical Vignette Noon: Tumor Board	3
4	5 PGY1:HH 4-15 Stop at Cardiac Imaging PGY2-3: Enteric Infections Reading Review	6 PGY1: OFF PGY2-3: Dr. Blatt: Enteric Infections	7 PGY1-3: Morning Report	8 PGY1-3: CHEST Conference	9 PGY1-3: 0645-0730: Pain Management PGY1: Pre-Test for Hypertension PGY2-3: Clinical Vignette Noon: Tumor Board	10
11	12 PGY1:HH: 15-28: Stop at Fick Method PGY2-3: CNS Infections Reading Review	13 PGY1: Hypertension PGY2-3: Dr. Blatt: CNS Infections	14 PGY1-3: Morning Report	15 PGY1-3: MedSurg Conference	16 PGY1-3: 0645-0730: Palliative Care PGY1:Hypertension Treatment PGY2-3: Clinical Vignette Noon: Tumor Board	17
18	19 PGY1:HH: 28-36 Stop at HOCM PGY2-3: Sleep Apnea Reading Review	20 PGY1: Post-Test Hypertension PGY2-3: Dr. Angles: Sleep Apnea	21 PGY1-3: Morning Report	22 PGY1-3: Morbidity and Mortality ICU Conference	23 PGY1-3: 0645-0730: QSS PGY1: Pre-Test Hyperlipidemia PGY2-3: Clinical Vignette Noon: Tumor Board	24
25	26 PGY1:HH: 36-44 Stop at Metabolic Syndrome PGY2-3: Pleural Disease Reading Review	27 PGY1: Hyperlipidemia PGY2-3: Dr. Wiltse: Pleural Disease	28 PGY1-3: Morning Report	29 PGY1-3: Talk It Out with Dr. Friedstrom	30 PGY1-3: 0645-0730 Fatigue Mitigation PGY1: Hyperlipidemia Treatment PGY2-3: Clinical Vignette Noon: Tumor Board	31

HH: Hitchhiker's Guide to Internal Medicine

September 2013.

~ September 2013 ~						
◀ Aug 2013						Oct 2013 ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2 Holiday: Labor Day PGY1: OFF PGY2-3: Hemodynamic Monitoring and Sepsis Disease Reading (Should read so familiar with the subject for Tuesdays Lecture)	3 PGY1: Post-Test Hyperlipidemia PGY2-3: Dr. Hayner: Hemodynamic Monitoring and Sepsis	4 PGY1-3: Morning Report	5 PGY1-3: Morbidity and Mortality Conference	6 PGY1: Pre-Test Diabetes Mellitus PGY2-3: Clinical Vignette PGY1-3: Tumor Board	7
8	9 PGY1:HH: 44-55 Stop at Atrial Flutter PGY2-3: COPD Reading Review	10 PGY1: Diabetes Mellitus PGY2-3: Dr. Kennealy: COPD/PFT	11 PGY1-3: Morning Report	12 PGY1-3: CHEST Conference	13 PGY1: Diabetes Mellitus Treatment PGY2-3: Clinical Vignette PGY1-3: Tumor Board	14
15	16 PGY1:HH: 55-64 Stop at Carotid Sinus Hypersensitivity PGY2-3: Asthma Reading Review	17 PGY1: Post- Test Diabetes Mellitus PGY 2-3: Dr. Mallick: Asthma	18 PGY1-3: Morning Report	19 PGY1-3: MedSurg Conference	20 PGY1: Pre-Test Headaches PGY2-3: Clinical Vignette PGY1-3: Tumor Board	21
22	23 PGY1: HH: 64- 71 PGY2-3: CXR Reading Review	24 PGY1: Headaches PGY2-3: Dr. Kennealy: CXR Refresher	25 PGY1-3: Morning Report	26 PGY1-3: "Talk-It- Out" with Dr. Friedstrom	27 PGY1: Headaches Treatment PGY2-3: Clinical Vignette PGY1-3: Tumor Board	28
29	30 PGY1: HH: 72- 78 Stop at Approach to Common Problems PGY2-3: Venous Thromboembolic Disease Reading Review	Notes:				

HH: Hitchhikers Guide to Internal Medicine

October 2013

~ October 2013 ~						
◀ Sep 2013						Nov 2013 ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1 PGY1: Post-Test Headaches PGY2-3: Dr. Wiltse: Venous Thromboembolic Disasse	2 PGY1-3: Morning Report	3 PGY1-3: Pharmacy Jeopardy	4 PGY1: Pre-Test Thyroid Disease PGY2-3: Clinical Vignette PGY1-3: Tumor Board	5
6	7 PGY1: HH: 78-86 Stop at Bronchiectasis PGY2-3: Interstitial Lung Disease Reading Review	8 PGY1: Thyroid Disease PGY2-3: Dr. Mallick: Interstitial Lung Disease	9 PGY1-3: Morning Report	10 PGY1-3: CHEST Conference	11 PGY1: Thyroid Disease Treatment PGY2-3: Clinical Vignette PGY1-3: Tumor Board	12
13	14 PGY1: HH: 86-98 Stop at BOOP PGY2-3: Valvular Heart Disease Reading Review	15 PGY1: Post-Test Thyroid Disease PGY2-3: Dr. Seshiah: Valvular Heart Disease	16 PGY1-3: Morning Report	17 PGY1-3: MedSurg Conference	18 PGY1: Pre-Test Back Pain, Chronic Pain, Fibromyalgia PGY2-3: Clinical Vignette PGY1-3: Tumor Board	19
20	21 PGY1: HH: 98-105 Stop at IPAH PGY2-3: Pericardial Disease Reading Review	22 PGY1: Back Pain, Chronic Pain, Fibromyalgia PGY2-3: Dr. Gandhi: Pericardial Disease	23 PGY1-3: Morning Report	24 PGY1-3: "Talk-It-Out" with Dr. Friedstrom	25 PGY1: Back Pain, Chronic Pain, Fibromyalgia Treatemtn PGY2-3: Clinical Vignette PGY1-3: Tumor Board	26
27	28 PGY1: HH: 105-109 PGY2-3: Cardiovascular Disease Prevention Reading Review	29 PGY1: Post-Test: Back Pain, Chronic Pain, Fibromyalgia PGY2-3: Dr. Hanumanthu: Cardiovascular Disease Prevention	30 PGY1-3: Morning Report	31 PGY1-3: "Talk-It-Out" with Dr. Friedstrom	Notes:	

HH: Hitchhikers Guide to Internal Medicine

November 2013

~ November 2013 ~						
◀ Oct 2013						Dec 2013 ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1 PGY1: Pre-Test Asthma PGY2-3: Clinical Vignette PGY1-3: Tumor Board	2
3	4 PGY1: HH: 110-123 Stop at Diseases of Nephrology PGY2-3: Adult Congenital Heart Disease Reading Review	5 PGY1: Asthma PGY2-3: Dr. Veldtman: Adult Congenital Heart Disease	6 PGY1-3: Morning Report	7 PGY1-3: Morbidity and Mortality ICU Conference	8 PGY1: Asthma Treatment PGY2-3: Clinical Vignette PGY1-3: Tumor Board	9
10	11 PGY1: HH:123-134 Stop at RTA's PGY2-3: Peripheral Vascular Disease Reading Review	12 PGY1: Post-Test Asthma PGY2-3: Dr. Callihan Peripheral Vascular Disease	13 PGY1-3: Morning Report	14 PGY1-3: CHEST Conference	15 PGY1: Pre-Test COPD PGY2-3: Clinical Vignette PGY1-3: Tumor Board	16
17	18 PGY1: HH: 134-147 PGY2-3: Hypertension Reading Review	19 PGY1: COPD PGY2-3:Dr. Lewis: Hypertension	20 PGY1-3: Morning Report	21 PGY1-3: MedSurg Conference	22 PGY1: COPD Treatment PGY2-3: Clinical Vignette PGY1-3: Tumor Board	23
24	25 PGY1: HH:148-157 Stop at Diseases of GI Tract PGY2-3: Arrhythmias Reading Review	26 PGY1: Post-Test COPD PGY2-3: Dr. Winner: Arrhythmias	27 PGY1-3: Morning Report	28 Thanksgiving Holiday PGY1-3: OFF	29 PGY1: OFF PGY2-3: Clinical Vignette	30

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December 2013

~ December 2013 ~						
◀ Nov 2013						Jan 2014 ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2 PGY1: HH: 157-163 Stop at Stress Ulcer PGY2-3: Acute Coronary Syndrome Reading Review	3 PGY1: Coding Class PGY2-3: Dr. Sukin: Acute Coronary Syndrome	4 PGY1-3: Morning Report	5 PGY1-3: Pharmacy Jeopardy	6 PGY1: Pre-Test Osteoporosis/Falls PGY2-3: Clinical Vignette PGY1-3: Tumor Board	7
8	9 PGY1: HH: 163-172 Stop at diseases of Bowel Causing malabsorption PGY2-3: Diastolic Heart Failure Reading Review	10 PGY1: Osteoporosis/Falls PGY2-3: Dr. Ghazi: Diastolic Heart Failure	11 PGY1-3: Morning Report	12 PGY1-3: CHEST Conference	13 PGY1: Osteoporosis/Falls Treatment PGY2-3: Clinical Vignette PGY1-3: Tumor Board	14
15	16 PGY1: HH: 172-182 Stop at Acute hepatic Failure PGY2-3: Systolic Heart Failure Reading Review	17 PGY1: Post-Test Osteoporosis/Falls PGY2-3: Dr. Shah: Systolic Heart Failure	18 PGY1-3: Morning Report	19 PGY1-3: MedSurg Conference	20 PGY1: PGY2-3: Clinical Vignette PGY1-3: Tumor Board	21
22	23 PGY1-3: OFF	24 PGY1-3: OFF	25 Holiday: Christmas	26 PGY1-3: OFF	27 PGY1-3: OFF	28
29	30 PGY1: HH: 182-192 PGY2-3: Stress Testing Reading Review	31 PGY1: PGY2-3: Dr. Biswas: Stress Testing	Notes:			

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January 2014

~ January 2014 ~						
◀ December						February ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1 Holiday: New Year's Day PGY1-3: OFF	2 PGY1-3: Morbidity and Mortality Conference	3 PGY1: PGY2-3: Clinical Vignette PGY1-3: Tumor Board	4
5	6 PGY1: HH: 193-199 Stop at Approach to Hip Pain PGY2: Breast Cancer Reading Review PGY3: ID Board Review	7 PGY1: PGY2-3: Breast Cancer	8 PGY1-3: Morning Report	9 PGY1-2: CHEST Conference PGY3: ID Board Review	10 PGY1: PGY2: Clinical Vignette PGY3: ID Board Review PGY1-3: Tumor Board	11
12	13 PGY1: HH: 199-206 Stop at Scleroderma PGY2: Lung Cancer Reading Review PGY3: ID Board Review	14 PGY1: PGY2-3: Lung Cancer	15 PGY1-3: Morning Report	16 PGY1-2: MedSurg Conference PGY3: ID Board Review	17 PGY1: PGY2: Clinical Vignette PGY3: ID Board Review PGY1-3: Tumor Board	18
19	20 PGY1: OFF PGY2: Gastrointestinal Cancer Reading (Should read and be ready for discussion on Tuesday) PGY3: ID Board Review Holiday: Martin Luther King Day	21 PGY1: PGY2-3: Gastrointestinal Cancer	22 PGY1-3: Morning Report	23 PGY1-2: "Talk-It-Out" with Dr. Fridstrom PGY3: Pulmonary/Critical Care Board Review	24 PGY1: PGY2: Clinical Vignette PGY3: Pulmonary/Critical Care Board Review PGY1-3: Tumor Board	25
26	27 PGY1: HH: 206-212 Stop at Wegener's Granulomatosis PGY2: Genitourinary Cancers: Prostate, Kidney, Bladder, Testis Reading Review PGY3: Pulmonary/Critical Care Board Review	28 PGY1: PGY2: Genitourinary Cancers: Prostate, Kidney, Bladder, Testis PGY3: Pulmonary/Critical Care Board Review	29 PGY1-3: Morning Report	30 PGY1-2: "Talk-It-Out" with Dr. Fridstrom PGY3: Pulmonary/Critical Care Board Review	31 PGY1: PGY2: Clinical Vignette PGY3: Pulmonary/Critical Care Board Review PGY1-3: Tumor Board	Notes:

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February 2014

~ February 2014 ~						
◀ January						March ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3 PGY1: HH: 212-219 Stop at Seronegative Spondyloarthropathies PGY2: Leukemia Reading Review PGY3: Pulmonary/Critical Care Board Review	4 PGY1: PGY2-3: Leukemia	5 PGY1-3: Morning Report	6 PGY1-2: "Talk-It-Out" with Dr. Friedstrom PGY3: Pulmonary/Critical Care Board Review	7 PGY1: PGY2: Clinical Vignette PGY3: Pulmonary/Critical Care Board Review PGY1-3: Tumor Board	8
9	10 PGY1: HH: 219-226 PGY2: Non-Hodgkin and Hodgkin Lymphoma Reading Review PGY3: Cardiology Board Review	11 PGY1: PGY2-3: Non-Hodgkin and Hodgkin Lymphoma	12 PGY1-3: Morning Report	13 PGY1-2: CHEST Conference PGY3: Cardiology Board Review	14 PGY1: PGY2: PGY3: Cardiology Board Review PGY1-3: Tumor Board	15
16	17 PGY1: HH: 227-235 Stop at Thyroid Gland PGY2: Multiple Myeloma Reading Review PGY3: Cardiology Board Review	18 PGY1: PGY2-3: Multiple Myeloma	19 PGY1-3: Morning Report	20 PGY1-2: MedSurg Conference PGY3: Cardiology Board Review	21 PGY1: PGY2: PGY3: Cardiology Board Review PGY1-3: Tumor Board	22
23	24 PGY1: HH: 235-242 Stop at Myxedema Coma PGY2: Oncologic Emergencies Reading Review PGY3: Cardiology Board Review	25 PGY1: PGY2-3: Oncologic Emergencies	26 PGY1-3: Morning Report	27 PGY1-2: Morbidity and Mortality ICU Conference PGY3: Cardiology Board Review	28 PGY1: PGY2: PGY3: Cardiology Board Review PGY1-3: Tumor Board	Notes:

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March 2014

~ March 2014 ~						
◀ February						April ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3 PGY1: HH: HH:242-250 Stop at Adrenal Crisis PGY2: Disorders of Platelets and Coagulation Reading Review PGY3: Cardiology Board Review	4 PGY1: PGY2-3: Disorders of Platelets and Coagulation	5 PGY1-3: Morning Report	6 PGY1-2: "Talk-It-Out" with Dr. Friedstrom PGY3: Cardiology Board Review	7 PGY1: PGY2: Clinical Vignette PGY3: Hematology/Oncology Board Review PGY1-3: Tumor Board	8
9	10 PGY1: HH: 250-255 Stop at DKA PGY2: Anemia and Hemoglobinopathies Reading Review PGY3: Hematology/Oncology Board Review	11 PGY1: PGY2-3: Anemias and Hemoglobinopathies	12 PGY1-3: Morning Report	13 PGY1-2: CHEST Conference PGY3: Hematology/Oncology Board Review	14 PGY1: PGY2: Clinical Vignette PGY3: Hematology/Oncology Board Review PGY1-3: Tumor Board	15
16	17 PGY1: HH: 255-261 PGY2: Esophageal Disease Reading Review PGY3: Hematology/Oncology Board Review	18 PGY1: PGY2-3: Esophageal Disease	19 PGY1-3: Morning Report	20 PGY1-2: MedSurg Conference PGY3: Hematology/Oncology Board Review	21 PGY1: PGY2: Clinical Vignette PGY3: Hematology/Oncology Board Review PGY1-3: Tumor Board	22
23	24 PGY1: HH: 262-272 Stop at Actinomycosis PGY2: Peptic Ulcer Disease Reading-Review PGY3: Hematology/Oncology Board Review	25 PGY1: PGY2-3: Peptic Ulcer Disease	26 PGY1-3: Morning Report	27 PGY1-2: Morbidity and Mortality Conference PGY3: Hematology/Oncology Board Review	28 PGY1: PGY2: Clinical Vignette PGY3: Hematology/Oncology Board Review PGY1-3: Tumor Board	29
30	31 PGY1: HH: 272-282 Stop at Hepatitis D Virus PGY2: Diarrhea and Malabsorption PGY3: Gastrointestinal Board Review	Notes:				

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April 2014

~ April 2014 ~						
◀ March						May ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1 PGY1: PGY2-3: Diarrhea and Malabsorption	2 PGY1-3: Morning Report	3 PGY1-2: "Talk-It- Out" with Dr. Friedstrom PGY3: GI Board Review	4 PGY1: PGY2: Clinical Vignette PGY3: GI Board Review PGY1-3: Tumor Board	5
6	7 PGY1: HH: 282- 294 Stop at PCP PGY2: Inflammatory Bowel Disease Reading Review PGY3: GI Board Review	8 PGY1: PGY2-3: Inflammatory Bowel Disease	9 PGY1-3: Morning Report	10 PGY1-2: CHEST Conference PGY3: GI Board Review	11 PGY1: PGY2: Clinical Vignette PGY3: GI Board Review PGY1-3: Tumor Board	12
13	14 PGY1: HH: 294- 304 Stop at RMSF PGY2: Pancreatic Disease Reading Review PGY3: GI Board Review	15 PGY1: PGY2-3: Pancreatic Disease PGY3: Nephrology Board Review	16 PGY1-3: Morning Report	17 PGY1- 2: MedSurg Conference PGY3: Nephrology Board Review	18 PGY1: PGY2: Clinical Vignette PGY3: Nephrology Board Review PGY1-3: Tumor Board	19
20	21 PGY1: HH: 304- 315 PGY2: Liver Disease Reading Review PGY3: Nephrology Board Review	22 PGY1: PGY2-3: Liver Disease	23 PGY1-3: Morning Report	24 PGY1- 2: Morbidity and Mortality Conference PGY3: Nephrology Board Review	25 PGY1: PGY2: Clinical Vignette PGY3: Endocrinology Board Review PGY1-3: Tumor Board	26
27	28 PGY1: HH: 316- 329 Stop at TTP PGY2: Cirrhosis Reading Review PGY3: Endocrinology Board Review	29 PGY1: PGY2-3: Cirrhosis	30 PGY1-3: Morning Report	Notes:		

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May 2014

~ May 2014 ~						
◀ April						June ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1 PGY1-2: "Talk-It-Out" with Dr. Friedstrom PGY3: Endocrinology Board Review	2 PGY1: Clinical Vignette PGY3: Endocrinology Board Review PGY1-3: Tumor Board	3
4	5 PGY1: HH:329-338 Stop at ATIII PGY2: Acute Kidney Injury Reading Review PGY3: Endocrinology Board Review	6 PGY1: PGY2-3: Acute Kidney Injury	7 PGY1-3: Morning Report	8 PGY1-2: CHEST Conference PGY3: Endocrinology Board Review	9 PGY1: PGY2: Clinical Vignette PGY3: Rheumatology Board Review PGY1-3: Tumor Board	10
11	12 PGY1: HH:338-345 PGY2: Chronic Kidney Disease Reading Review PGY3: Rheumatology Board Review	13 PGY1: PGY2-3: Chronic Kidney Disease	14 PGY1-3: Morning Report	15 PGY1-2: MedSurg Conference PGY3: Rheumatology Board Review	16 PGY1: PGY2: Clinical Vignette PGY3: Rheumatology Board Review PGY1-3: Tumor Board	17
18	19 PGY1: HH:346-356 Stop at Breast Cancer PGY2: Electrolyte Disturbances PGY3: Rheumatology Board Review	20 PGY1: PGY2-3: Electrolyte Disturbances	21 PGY1-3: Morning Report	22 PGY1-3: Morbidity and Mortality ICU Conference PGY3: Rheumatology Board Review	23 PGY1: PGY2: Clinical Vignette PGY3: Neurology Board Review PGY1-3: Tumor Board	24
25	26 Holiday: Memorial Day PGY1, 3 OFF PGY2: Essential and Secondary Hypertension, should read and be familiar for lecture on Tuesday	27 PGY1: HH: 356-364 Stop at Bladder Cancer PGY2-3: Essential and Secondary Hypertension	28 PGY1-3: Morning Report	29 PGY1-2: "Talk-It-Out" with Dr. Friedstrom PGY3: Neurology Board Review	30 PGY1: HH: 364-374 Stop at CLL PGY2: Clinical Vignette PGY3: Neurology Board Review PGY1-3: Tumor Board	31

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June 2014

~ June 2014 ~						
◀ May						July ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2 PGY1: HH: 374-382 PGY2: Hematuria and Proteinuria Reading Review PGY3: General Medicine Board Review	3 PGY1: PGY2-3: Hematuria and Proteinuria	4 PGY1-3: Morning Report	5 PGY1-2: Morbidity and Mortality Conference PGY3: General Medicine Board Review	6 PGY1: PGY2: Clinical Vignette PGY3: General Medicine Board Review PGY1-3: Tumor Board	7
8	9 PGY1: HH:383-403 Stop at Approach to Status Epilepticus PGY2: Pituitary Disorder Reading Review PGY3: General Medicine Board Review	10 PGY1: PGY2-3: Pituitary Disorder	11 PGY1-3: Morning Report	12 PGY1-2: CHEST Conference PGY3: General Medicine Board Review	13 PGY1: PGY2: Clinical Vignette PGY3: General Medicine Board Review PGY1-3: Tumor Board	14
15	16 PGY1: HH: 403-426 Stop at Polyneuropathies PGY2: Thyroid Disease Reading Review PGY3: General Medicine Board Review	17 PGY1: PGY2-3: Thyroid Disease	18 PGY1-3: Morning Report	19 PGY1-2: MedSurg Conference PGY3: General Medicine Board Review	20 PGY1: PGY2: Clinical Vignette PGY3: General Medicine Board Review PGY1-3: Tumor Board	21
22	23 PGY1: HH: 426-449 PGY2: Adrenal Disorder Reading Review PGY3: OFF	24 PGY1: PGY2-3: Adrenal Disorder	25 PGY1-3: Morning Report	26 PGY1-3: "Talk-It-Out" with Dr. Friedstrom Last Time for PGY3's	27 PGY1: PGY2: Clinical Vignette PGY3: OFF PGY1-3: Tumor Board	28
29	30 PGY1: HH: 450-461 PGY2: Disorders of Calcium Metabolism Reading Review PGY3: OFF	Notes:				

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July 2014

~ July 2014 ~						
◀ June						August ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1 PGY1: PGY2-3: Disorders of Calcium Metabolism	2 PGY1: PGY2-3: Morning Report	3 PGY1: PGY2-3: Clinical Vignette	4 Holiday: Independence Day PGY1-3 OFF	5
6	7 PGY1: PGY2-3: Diabetes Mellitus Reading Review	8 PGY1: PGY2-3: Diabetes Mellitus	9 PGY1: PGY2-3: Morning Report	10 PGY1: PGY2-3: CHEST Conference	11 PGY1: PGY2-3: Clinical Vignette PGY1-3: Tumor Board	12
13	14 PGY1: PGY2-3: Metabolic Syndrome Reading Review	15 PGY1: PGY2-3: Metabolic Syndrome	16 PGY1: PGY2-3: Morning Report	17 PGY1: PGY2-3: MedSurg Conferece	18 PGY1: PGY2-3: Clinical Vignette PGY1-3: Tumor Board	19
20	21 PGY1: PGY2-3: Laboratory Tests in Rheumatic Disorders Reading Review	22 PGY1: PGY2-3: Laboratory Tests in Rheumatic Disorders	23 PGY1: PGY2-3: Morning Report	24 PGY1: PGY2-3: Morbidity and Mortality Conference	25 PGY1: PGY2-3: Clinical Vignette PGY1-3: Tumor Board	26
27	28 PGY1: PGY2-3: Rheumatoid Arthritis Reading Review	29 PGY1: PGY2-3: Rheumatoid Arthritis	30 PGY1: PGY2-3: Morning Report	31 PGY1: PGY2-3: "Talk-It-Out" with Dr. Friedstrom	Notes:	

August 2014

~ August 2014 ~						
◀ July						September ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1 PGY1: Pre-Test Hypertension PGY2-3: Clinical Vignette PGY1-3: Tumor Board	2
3	4 PGY1: HH: 4-15 Stop at Cardiac Imaging PGY2-3: Acute Monoarticular Arthritis Reading Review	5 PGY1: Hypertension PGY2-3: Acute Monoarticular Arthritis	6 PGY1-3: Morning Report	7 PGY1-3: "Talk-It-Out" with Dr. Friedstrom	8 PGY1: Hypertension Treatment PGY2-3: Clinical Vignette PGY1-3: Tumor Board	9
10	11 PGY1: HH: 15-28 Stop at Fick Method PGY2-3: Systemic Lupus Erythematosis and Related Disorders Reading Review	12 PGY1: Post-Test Hypertension PGY2-3: Systemic Lupus Erythematosis and Related Disorders	13 PGY1-3: Morning Report	14 PGY1-3: CHEST Conference	15 PGY1: Pre-Test Hyperlipidemia PGY2-3: Clinical Vignette PGY1-3: Tumor Board	16
17	18 PGY1: HH: 28-36 Stop at HOCM PGY2-3: Systemic Vasculitis Reading Review	19 PGY1: Hyperlipidemia PGY2-3: Systemic Vasculitis	20 PGY1-3: Morning Report	21 PGY1-3: MedSurg Conference	22 PGY1: Hyperlipidemia Treatment PGY2-3: Clinical Vignette PGY1-3: Tumor Board	23
24	25 PGY1: HH: 36-44: Stop at Metabolic Syndrome PGY2-3: Common Soft Tissue Pain Syndromes Reading Review	26 PGY1: Post-Test Hyperlipidemia PGY2-3: Common Soft Tissue Pain Syndromes	27 PGY1-3: Morning Report	28 PGY1-3: Morbidity and Mortality Conference	29 PGY1: Pre-Test Diabetes Mellitus PGY2-3: Clinical Vignette PGY1-3: Tumor Board	30
31	Notes:					

HH: Hithhikers Guide to Internal Medicine

September 2014

~ September 2014 ~						
◀ August						October ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1 Holiday: Labor Day PGY1: OFF PGY2-3: Stroke Should read and be ready for Discussion on Tuesday	2 PGY1: Diabetes Mellitus PGY2-3: Stroke	3 PGY1-3: Morning Report	4 PGY1-3: "Talk-It-Out" with Dr. Friedstrom	5 PGY1: Diabetes Mellitus Treatment PGY2-3: Clinical Vignette PGY1-3: Tumor Board	6
7	8 PGY1: HH: 44-55 Stop at Atrial Flutter PGY2-3: Dementia Reading Review	9 PGY1: Post-Test Diabetes Mellitus PGY2-3: Dementia	10 PGY1-3: Morning Report	11 PGY1-3: CHEST Conference	12 PGY1: Pre-Test Headaches PGY2-3: Clinical Vignette PGY1-3: Tumor Board	13
14	15 PGY1: HH: 55-64 Stop at Carotid Sinus Hypersensitivity PGY2-3: Headaches/Migraines Reading Review	16 PGY1: Headaches PGY2-3: Headaches/Migraines	17 PGY1-3: Morning Report	18 PGY1-3: MedSurg Conference	19 PGY1: Headaches Treatment PGY2-3: Clinical Vignette PGY1-3: Tumor Board	20
21	22 PGY1: HH: 64-71 PGY2-3: Depression Reading Review	23 PGY1: Headaches Post-Test PGY2-3: Depression	24 PGY1-3: Morning Report	25 PGY1-3: Morbidity and Mortality Conference	26 PGY1: Pre-Test Thyroid Disease PGY2-3: Clinical Vignette PGY1-3: Tumor Board	27
28	29 PGY1: HH: 72-78: Stop at Approach to Common Problems PGY2-3: Psychosis Reading Review	30 PGY1: Thyroid Disease PGY2-3: Psychosis	Notes:			

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October 2014

~ October 2014 ~						
◀ September						November ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1 PGY1-3: Morning Report	2 PGY1-3: "Talk-It-Out" with Dr. Friedstrom	3 PGY1: Thyroid Disease Treatment PGY2-3: Clinical Vignette PGY1-3: Tumor Board	4
5	6 PGY1: HH: 78-86 Stop at Bronchiectasis PGY2-3: Personality Disorders Reading Review	7 PGY1: Post-Test Thyroid Diseases PGY2-3: Personality Disorders	8 PGY1-3: Morning Report	9 PGY1-3: CHEST Conference	10 PGY1: Pre-Test Back Pain, Chronic Pain, Fibromyalgia PGY2-3: Clinical Vignette PGY1-3: Tumor Board	11
12	13 PGY1: HH: 86-98 Stop at BOOP PGY2-3: Testing and Workup of Allergy Reading Review	14 PGY1: Back Pain, Chronic Pain, and Fibromyalgia PGY2-3: Testing and Workup of Allergy	15 PGY1-3: Morning Report	16 PGY1-3: MedSurg Conference	17 PGY1: Back Pain, Chronic Pain, and Fibromyalgia Treatment PGY2-3: Clinical Vignette PGY1-3: Tumor Board	18
19	20 PGY1: HH: 98-105 Stop at IPAH PGY2-3: Common Diagnoses: Asthma, Medications, and Hereditary Reading Review	21 PGY1: Post-Test Back Pain, Chronic Pain, and Fibromyalgia PGY2-3: Common Diagnoses: Asthma, Medications, and Hereditary	22 PGY1-3: Morning Report	23 PGY2-3: "Talk-It-Out" with Dr. Friedstrom	24 PGY1: Pre-Test Asthma PGY2-3: Clinical Vignette PGY1-3: Tumor Board	25
26	27 PGY1: HH: 105-109 PGY2-3: Contraception Reading Review	28 PGY1: Asthma PGY2-3: Contraception	29 PGY1-3: Morning Report	30 PGY1-3: Morbidity and Mortality Conference	31 PGY1: Asthma Treatment PGY2-3: Clinical Vignette	Notes:

HH: Hitchhikers Guide to Internal Medicine

November 2014

◀ October		~ November 2014 ~					December ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat	
						1	
2	3 PGY1: HH: 110-123 Stop at Diseases of Nephrology PGY2-3: Important Cardiovascular, Endocrine, and Oncologic Topics in Women Reading Review	4 PGY1: Post-Test Asthma PGY2-3: Important Cardiovascular, Endocrine, and Oncologic Topics in Women	5 PGy1-3: Morning Report	6 PGY1-3: "Talk-It-Out" with Dr. Friedstrom	7 PGY1: Pre-Test COPD PGY2-3: Clinical Vignette PGY1-3: Tumor Board	8	
9	10 PGY1: HH: 123-134 Stop at RTA's PGY2-3: Ophthalmologic Emergencies Reading Review	11 PGY1: COPD PGY2-3: Ophthalmologic Emergencies	12 PGy1-3: Morning Report	13 PGY1-3: CHEST Conference	14 PGY1: COPD Treatment PGY2-3: Clinical Vignette PGY1-3: Tumor Board	15	
16	17 PGY1: HH: 134-147 PGY2-3: Evaluation and Treatment of Common Infections and Reactions of the Eye Reading Review	18 PGY1: Post-Test COPD PGY2-3: Evaluation and Treatment of Common Infections and Reactions of the Eye	19 PGy1-3: Morning Report	20 PGY1-3: MedSurg Conference	21 PGY1: Pre-Test Osteoporosis/Falls PGY2-3: Clinical Vignette PGY1-3: Tumor Board	22	
23	24 PGY1: HH: 148-157 Stop at Diseases of the GI Tract PGY2-3: Sinusitis and Upper Respiratory Tract Abnormalities Reading Review	25 PGY1: Osteoporosis/Falls PGY2-3: Sinusitis and Upper Respiratory Tract Abnormalities	26 PGy1-3: Morning Report	27 Holiday: Thanksgiving PGY1-3: OFF	28 PGY1: Osteoporosis/Falls Treatment PGY2-3: Clinical Vignette PGY1-3: Tumor Board	29	
30	Notes:						

HH: Hitchhikers Guide to Internal Medicine

December 2014

~ December 2014 ~						
◀ November						January ▶
Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1 PGY1: HH: 157-163 Stop at Stress Ulcer PGY2-3: Otitis and Hearing Abnormalities Reading Review	2 PGY1: Post-Test Osteoporosis/Falls PGY2-3: Otitis and Hearing Abnormalities	3 PGY1-3: Morning Report	4 PGY1-3: "Talk-It-Out with Dr. Friedstrom	5 PGY1: PGY2-3: Clinical Vignette PGY1-3: Tumor Board	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31	Notes:		

HH: Hitchhikers Guide to Internal Medicine

Cardiology

Content Goals and Objectives:

1. Interpreted basic and advanced EKGs and use as told to make management decisions.
2. Prefer patients for appropriate cardiac imaging and correctly interpret findings on imaging reports.
3. Counseled patient on lifestyle modifications for aggressive risk factor modifications.
4. Differentiate cardiac versus noncardiac chest discomfort.
5. Diagnosis and management heart failure, differentiating between an acute, chronic, systolic, and diastolic.
6. Identifying and begin initial management plan for basic arrhythmias.
7. Interpret cardiac biomarkers.
8. Diagnosis and manage the different types of acute coronary syndrome (unstable angina, NSTEMI, STEMI)
9. Manage anticoagulant therapy and cardiac patients.

Process-Based Goals and Objectives:

1. Gathers subtle, sensitive, and complicated information that may not be volunteered by the patient.
2. Recognized the scope of his/her abilities and ask for supervision and assistance appropriately.
3. Modify the differential diagnosis and care plan based on clinical course and data as appropriate.
4. Choose the appropriate consultative services for a given clinical condition.
5. Minimize unnecessary care including test.
6. Integrate clinical evidence into decision making.
7. Age physical findings for Junior members of the health care team.
8. Use feedback to improve performance.
9. To stabilize patient's with urgent or emergent medical conditions and transferred to a higher level of care when necessary.
10. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

Resident Responsibilities:

1. Attend didactic conference each morning from 0700-0800.
2. Call attending at 0800 for new responsibilities or meet with him as planned.
3. Will be encouraged to see patients in office with attending.
4. At the half-way mark of the rotation will sit down with attending and review strengths and weaknesses. Will give a short summary to Beth Mack on this review and how resident will progress the second two weeks.
5. Will attend clinic as scheduled. Third years will have 1 half-day per week in afternoon, Second years 1 half-day per week in morning and first years 1 full day every other week.

6. No vacation will be permitted on this rotation.
7. Resident will be expected to stay with attending till he/she is done for the day.

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Hypertrophic Obstructive Cardiomyopathy

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Peripheral Vascular Disease

Carotid Endarterectomy

Guidelines for carotid endarterectomy. Circulation 1998;97:501-9.

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Stroke

Primary prevention of ischemic stroke. *Circulation* 2001;103:163-182.

Guidelines for management of acute ischemic stroke. *Stroke* 1994;25:1901-14.

Guidelines for thrombolytic therapy for acute stroke. *Circulation* 1996;94:1167-74.

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Lower Extremities PVOD

Diagnosis and treatment of chronic arterial insufficiency of the lower extremities. *Circulation* 1996;94:3026-49.

Guidelines for peripheral percutaneous transluminal angioplasty of the abdominal aorta and lower extremity vessels. *Circulation* 1994;89:511-31.

Congestive Heart Failure

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Highlights from new consensus guidelines for CHF. Cleveland Clinic J of Med 2000; 67:13-6.

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Pacemakers, AICDs, Syncope, Qte, SVT and CPR

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Management of DVT and PE. Circulation 1996;93:2212-2245.

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Anticoagulation

Management of anticoagulation before and after elective surgery. NEJM 1997;1506-1511.

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Guidelines for perioperative cardiovascular evaluation of noncardiac surgery. JACC 2002;34:910-48 (update 2002 online)

Development and validation of a Bayesian model for perioperative cardiac risk assessment in a cohort of 1081 vascular surgical candidates. JACC 1996;27:779-86.

Effect of atenolol on mortality and cardiovascular morbidity after noncardiac surgery. NEJM 1996;335:1713-20.

Exercise Testing and Training

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Benefits and recommendations of physical activity programs. Circulation 1996;94:857-62.

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Coronary Artery Bypass Grafting

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Optimal risk factor management in the patient after coronary revascularization. *Circulation* 1994;90:3125-33.

Congenital Heart Disease

Care of the adult with congenital heart disease. *JACC* 2001;37:1161-98.

Women

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Part II: Heparin vs LMWH

Part III: Fibrinolytic therapy, PCI, medical prophylaxis with LMWH

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Randomized trial of cholesterol lowering in 4444 patients with coronary heart disease: the Scandinavian simvastatin survival study (4S). *Lancet* 1994;344:1383-9.

Effect of an ACEI (ramipril) on CV events in high-risk patients (HOPE). *NEJM* 2000;342:145-53.

Guidelines for preventing heart attack and death. *Circulation* 2001;104:1577-9.

Predicting CAD

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Viagra

Use of sildenafil (viagra) in patients with cardiovascular disease. *JACC* 1999;33:273-82.

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The bedside recognition of normal jugular contours. *Resident and Staff Physician* 1987;33(6):67-71.

The bedside recognition of abnormal jugular contours. *Resident and Staff Physician* 1987;33(7):51-8.

Bedside diagnosis of systolic murmurs. *NEJM* 1988;318:1572-8.

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Valvular Heart Disease. *NEJM* 1997;337:32-41.

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Comparison of aspirin with placebo in patients treated with warfarin after heart valve replacement. *NEJM* 1993;329:524-9.

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Rheumatic Fever

Guidelines for the diagnosis of rheumatic fever. *Circulation* 1993;87:302-7.

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Infective endocarditis due to unusual or fastidious microorganisms. Mayo Clin Proc 1997;72:532-42.

Pericardial Disease

A review of pericardial diseases. Cleveland Clinic J of Med 2000;67:903-14.

Constrictive pericarditis in the modern era. Circulation 1999;100:1380-6.

Mechanism underlying Kussmaul's sign in chronic constrictive pericarditis. Am J. Cardiol 1989;64:1069-72.

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Restrictive Cardiomyopathy

Restrictive Cardiomyopathy. NEJM 1997;336:267-76.

Constrictive Pericarditis vs Restrictive Cardiomyopathy

Differentiation of constrictive pericarditis and restrictive cardiomyopathy by doppler echo.

Circulation 1989;79:357-70.

Tracings of Doppler patterns MV, TV, PV, HV, and tissue doppler

Tracings of Doppler patterns with heart diagram

Constrictive pericarditis versus restrictive cardiomyopathy: a reappraisal and update of diagnostic criteria. Am Heart J 1991;122:1431-41.

Transesophageal doppler echo pulmonary venous flow in restrictive cardiomyopathy and constrictive pericarditis. Am J Cardiol 1989;63:1286-8.

MKSAP 16

Updated June 2013

Geriatrics

Content Goals and Objectives

1. Evaluate activities of daily living, and instrumental activities of daily living.
2. Performed a focused physical exam on post hospital discharge patient.
3. Perform medication reconciliation on post hospital discharge patient.
4. Right initial admission orders on geriatric patient in the post hospital setting.
5. Provide anticipatory guidance during routine visits and a primary care setting.
6. Evaluate causes of falls and suggest initial management plan.
7. He evaluate memory loss/dementia and suggest initial management plan.
8. Evaluate urinary incontinence and suggest initial management plan.

Process-Based Goals and Objectives

1. Manage the interdisciplinary team.
2. Role model effective communication skills and challenging situations.
3. Demonstrating shared decision-making with the patient.
4. Guide and support bedside presentations that engaged the patient and focused the discussion around the patient's central concerns.
5. Gatherer subtle, sensitive, and complicated information that may not be volunteered by the patient.
6. Recognize the scope of his/her abilities and asked for supervision and assistance appropriately.
7. Modify the differential diagnosis and care plan based on clinical course and data as appropriate.
8. Choose the appropriate consult of his services for a given clinical condition.
9. Minimize unnecessary care including test.
10. Integrate clinical evidence into decision-making.
11. Use feedback to improve performance.
12. Stabilize patients with urgent or emergent medical conditions and transferred to a higher level of care when necessary.
13. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

Typical Day:

- On Monday, Tuesday, Thursday, and Friday will spend entire morning with Physician at Senior-Link.
- Morning will start at about 0815 after morning lecture at GSH.
- Senior will not miss any time due to clinic.
- Intern will miss one day every other week.
- Will attend Nursing home rounds with the physician as instruct

Attending Responsibilities:

- Please let us know as soon as possible of any deficiencies that are witnessed that we can target in our residency curriculum.
- Please communicate with us any issues you encounter at any time.
- Please tell us of any cases that would be good for Morbidity and Mortality conference for our residents' education.
- Please fill out resident evaluation in a timely manner and give good specific feedback for the furtherment of their education.

REFERENCES (optional)

NIH Consensus Development Conference Statement - Geriatric Assessment Methods for Clinical Decision-Making. J. Am Geriatr Soc 1998; 36: 342-347

Normal Aging vs Disease in the Elderly. Principles of Geriatric Medicine 2000; 38-41

Falls and Instability in the Elderly. J. Am Geriatr Soc 1998; 36: 266-78

<http://www.npaonline.org/website/article.asp?id=4>

MKSAP 16

Up To Date Online

http://www.americangeriatrics.org/education/cp_index.shtml

Clinical Practice Guidelines

Diabetes

Falls

Pain Management

http://www.acponline.org/clinical_information/guidelines/

Clinical Practice Guidelines:

Rx of Osteoporosis – Pharmacologic Treatment of Low Bone Density or Osteoporosis to Prevent Fractures: A Clinical Practice Guideline from the American College of Physicians

Dementia k- Current Pharmacologic Treatment of Dementia: A Clinical Practice Guideline from the American College of Physicians and the American Academy of Family Physicians

Palliative Care at the End of Life – Evidence-Based Interventions to Improve the Palliative Care of Pain, Dyspnea, and Depression at the End of Life: a Clinical Practice Guideline from the American College of Physicians

http://annals.org/cgi/content/full/135/8_Part_2/653

ACOVE - Assessing Care of Vulnerable Elders

Society of General Internal Medicine website modules in Ethnogeriatrics. Pain management, falls, memory assessment and urinary incontinence. www.sgim.org. You will be required to register at no cost and identify your email and password.

Updated July 2013

Gastroenterology

Content Goals and Objectives

1. Initiated cost-effective workup for iron deficiency anemia.
2. Triaged and begin initial workup for gastrointestinal bleeding.
3. Properly recommended GI procedures and imaging for specific GI conditions.
4. Initiate investigation of abdominal pain.
5. Diagnosed and managed diarrhea and a hospitalized patient.
6. Recommend appropriate route for nutritional supplementation.
7. Diagnose and manage inflammatory bowel disease.
8. Identify treatment options for patient with inflammatory bowel disease.
9. Distinguish between hepatic, cholestatic, and infiltrative patterns of liver disease.
10. Nevi as a cost effective approach to the diagnosis of chronically elevated transaminases.
11. Identify treatment options for the 8 common sequelae of cirrhosis.
12. Interpret serologic testing for hepatitis A, hepatitis B, and hepatitis C.
13. Manage pancreatitis.

Process-Based Goals and Objectives

1. Acquire accurate and relevant history.
2. Gathers subtle, sensitive, and complicated information that may not be volunteered by the patient.
3. Perform an accurate physical exam.
4. Developed prioritized differential diagnoses.
5. Development evidence based diagnostic and therapeutic plan.
6. Provide accurate, complete, and timely documentation.
7. Communicate effectively with the consulting team.
8. Modify the differential diagnosis and care plan based on clinical course and data as appropriate.
9. Minimize unnecessary care including tests.
10. Émigré clinical evidence into decision making.
11. Use feedback to improve performance.
12. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

Rotation Specifics

1. Contact Cincinnati GI at (513) 751-2255 one week before rotation begins and use this number for further needs.
2. Attend morning lecture each day from 0700-0800.
3. Round and perform consults around the lecture schedule.

4. Attend clinic with the attending whenever possible.
5. For PGY-2 clinic will happen one half day per week in the am.
6. No vacation during this rotation.
7. When on GI rotation must present case at MedSurg Conference on third Thursday of the month.
8. At two weeks sit down with attending and learn strengths and weaknesses and how to better perform your duties.
9. At end of rotation perform evaluation of the attending.

REFERENCES (latest editions)

1. Bockkus Gastroenterology, Burke. This is the most recent seven volume extensive gastroenterology textbook, which you may find helpful for specific patient problems.
2. Gastrointestinal Disease by Sleisenger and Fordtran. This is a very readable and an excellent reference
3. Disease of the Liver by Leon Schiff. Certain chapters are good; others are poor. Useful for spot reading about certain topics.
4. There are numerous journal articles that are up to date on specific topics in gastroenterology and hepatology. We encourage all residents to ask us at any time for references in our file.
5. Hepatology: A Textbook of Liver Disease. Zatini and Boyer. Excellent reference book.
6. MKSAP 16
7. Up-to-Date Online

Updated July 2013

Hematology/Oncology

Content Goals and Objectives

1. Determine cause of leukocytosis.
2. Determine cause of anemia.
3. Determine cause of thrombocytopenia.
4. Manage anticoagulation of venous thromboembolism in the cancer patient.
5. Initiate prompt plasmapheresis in the setting of TTP.
6. Differentiate between various types of hemolytic anemia and initiate work-up.
7. Initiate diagnostic work-up for suspected heparin-induced thrombocytopenia.
8. Initiate and manage direct thrombin inhibitors for heparin-induced thrombocytopenia.
9. Initiate appropriate evaluation for acute chest syndrome of sickle cell anemia.
10. Adjust long-acting and/or short-acting narcotics for cancer and sickle cell patients.
11. Initiate appropriate steroid treatment and consult appropriate services for spinal cord compression.
12. Evaluate myeloproliferative disorders, myeloma, and/or MGUS.
13. Determine when chemotherapy and biologic therapy should be used for palliative treatment, curative treatment, and adjuvant or neo-adjuvant treatment.
14. Implements supportive care agents for cancer therapies.
15. Manage the common complications of chemotherapy and other cancer treatments.
16. Order imaging and tissue studies to properly stage malignancies.
17. Initiate end-of-life discussions with patients with incurable malignancies.
18. Diagnoses neutropenic fever.
19. Choose antibiotic therapy for neutropenic fever.

Process-Based Goals and Objectives

1. Acquire accurate and relevant history.
2. Gather subtle, sensitive, and complicated information that may not be volunteered by the patient.
3. Perform an accurate physical exam.
4. Develop a prioritized differential diagnoses.
5. Develop an evidence-based diagnostic and therapeutic plan.
6. Provide accurate, complete, and timely documentation.
7. Communicate effectively with the consulting team.
8. Modify the differential diagnosis and care plan based on clinical course and data as appropriate.
9. Minimize unnecessary care including tests.
10. Integrate clinical evidence into decision making.
11. Use feedback to improve performance.
12. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

Typical Day

- 0700-0800: Mandatory Didactic session each day.
- After conference get in touch with attending and receive assignment.
- The rest of the day is devoted to rounding and working with attending.
- If at all possible seek to go to the office with attending.

Rotation Guidelines

- Contact attending the week before you will start the rotation.
- Each Friday resident on service is expected to attend Tumor Board at noon.
- No Vacation while on this rotation.
- Resident is able to be with attending from 0800 through the rest of the day.
- PGY1 will have clinic 1 day every other week, PGY2 will have clinic ½ day in am per week and PGY3 will have clinic ½ day per week in pm.

References

Internet

- 1) Up To Date Section on Hematology/Oncology
- 2) National Comprehensive Cancer Network (www.nccn.org)
- 3) Pubmed (www.ncbi.nlm.nih.gov/pubmed/)
- 4) American Society of Clinical Oncology (www.asco.org)
- 5) American Society of Hematology (www.hematology.org)
- 6) National Cancer Institute (www.cancer.gov)
- 7) U.S. National Institute of Health Clinical Trials (www.clinicaltrials.gov)

Books

- 1) Cancer: Principles & Practice of Oncology Review; DeVita, Hellman and Rosenberg.
- 2) Wintrobe's Clinical Hematology; Greer, Wintrobe, Forrester.

Journals

- 1) Journal of Clinical Oncology
- 2) Blood

Residents are urged to go to www.worldoncology.net/oncology_journas.htm for an updated list of current medically significant journals in the fields of hematology and medical oncology.

Residents should complete all of the hematology and oncology questions in the most recent version of Medical Knowledge Self Assessment Program (MKSAP) and turn these in to the program director at the end of the course.

Updated June 2013

PGY-1 ICU

Content Goals and Objectives

1. Implement the appropriate mode of ventilatory assistance for acute respiratory failure.
2. Manage ventilator changes.
3. Use low tidal volume strategy where appropriate for ARDS.
4. Identify various sources and types of shock.
5. Deliver appropriate goal-directed therapy for severe sepsis.
6. Interpret chest x-rays for common lung disorders.
7. Perform central lines.

Process-Based Goals and Objectives

1. Acquire accurate and relevant history.
2. Perform an accurate physical exam.
3. Develop prioritized differential diagnoses.
4. Develop an evidence-based diagnostic and therapeutic plan.
5. Demonstrate accurate medical reconciliation.
6. Provide accurate, complete, and timely documentation.
7. Identify the appropriate clinical question for consultative services.
8. Identify clinical questions as they emerge in patient care activities and access medical information resources.
9. Perform bedside presentations that engage the patient and focus the discussion around the patient's central concerns.
10. Minimize unfamiliar terms during patient encounters.
11. Demonstrate shared decision-making with the patient and family.
12. Use teach-back method with patients regarding medications and plan.
13. Communicate with primary care physician.
14. Recognize the scope of his/her abilities and ask for supervision and assistance appropriately.
15. Minimize unnecessary care including tests.
16. Use feedback to improve performance.
17. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

Common Rotation Specifics

1. Resident will work directly under supervising senior.
2. Senior will see each new admission and patient with the resident.
3. Resident will be on call every-other day.
4. Resident will get one day off per week.
5. Twelve hour cap is 5 new admissions and 2 transfers.
6. Maximum cap PGY-1 resident is to be responsible for is 4 patients per day.

7. If PGY-1 has 4 patients and is on call senior will attempt to give admissions to PGY-2 resident or OBGYN resident for that day. If unable to do so senior will take admissions him/herself.
8. Must attend all lectures. If an emergency arises and resident misses he/she must contact chief resident and explain reason for not being at lecture.
9. Each resident must be present at both sign-outs during the day.
10. No clinic responsibilities during this rotation.
11. No vacation during this rotation.
12. To contact Intensivists call 513-841-5864 (LUNG) and follow the prompts.

Typical Day

1. Sign-out with ICU hospitalist at 0640.
2. 0700-0800 mandatory lecture attendance.
3. 0800-0900 round on patients.
4. 0900-1200 Multidisciplinary rounds with the attending. (Firm start time, Approximate end time)
5. Afternoon: Finish notes, perform procedures, transfer/discharge patients, read about cases, and have teaching time with team.
6. 1400-1530: Didactic Session with Dr. Kennealy on Tuesday, Thursday, and Friday.
7. 1845: Sign-out to night-time ICU hospitalist.

****Special Note:** On Wednesday at 0900 ONE senior and ONE intern will attend multidisciplinary rounds instead of CPSC or other lecture of the day. This needs to be coordinated by the seniors on the team and everyone needs to be involved in the process on Wednesday during their time in the ICU.

Resources

1. The ICU Book
2. Harrison's Internal Medicine
3. Cecil's Internal Medicine
4. Textbook of Critical Care 5th Edition: Fink, Abraham, Vincent, Kochenek
5. Critical Care 4th Edition: Civetta, Taylor, Kirby
6. Intensive Care Medicine 7th Edition: Irwin, Rippe
7. Up-To-Date
8. MKSAP 16

Updated June 2013

PGY-2 ICU

Content Goals and Objectives

1. Implement the appropriate mode of ventilatory assistance for acute respiratory failure.
2. Manage ventilator changes.
3. Use low tidal volume strategy where appropriate for ARDS.
4. Identify various sources and types of shock.
5. Deliver appropriate goal-directed therapy for severe sepsis.
6. Interpret chest x-rays for common lung disorders.
7. Perform central lines.

Process-Based Goals and Objectives

1. Manage the interdisciplinary team
2. Role model effective communication skills in challenging situations.
3. Guide and support bedside presentations that engage the patient and focus the discussion around the patient's central concerns.
4. Gather subtle, sensitive, and complicated information that may not be volunteered by the patient.
5. Recognize the scope of his/her abilities and ask for supervision and assistance appropriately.
6. Modify the differential diagnosis and care plan based on clinical course and data as appropriate.
7. Choose the appropriate consultative services for a given clinical condition.
8. Minimize unnecessary care including tests.
9. Integrate clinical evidence into decision making.
10. Demonstrate shared decision-making with the patient and family.
11. Use feedback to improve performance.
12. Stabilize patients with urgent or emergent medical conditions and transfer to a higher level of care when necessary.
13. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

Common Rotation Specifics

1. 1 Second year will be present in ICU for the entire year.
2. Will rotate call on the weekend with the intern.
3. Maximum number of patients resident will carry is 6.
4. Will take admissions based on the senior's decision.
5. Will have one day off per week.
6. Twelve hour cap is 5 new admissions and 2 transfers.
7. Must attend all lectures. If an emergency arises and resident misses he/she must contact chief resident and explain reason for not being at lecture.
8. Each resident must be present at both sign-outs during the day.
9. No clinic responsibilities during this rotation.
10. No vacation during this rotation.
11. To contact Intensivists call 513-841-5864 (LUNG) and follow the prompts.

Typical Day

8. Sign-out with ICU hospitalist at 0640.
9. 0700-0800 mandatory lecture attendance.
10. 0800-0900 round on patients.
11. 0900-1200 Multidisciplinary rounds with the attending. (Firm start time, Approximate end time)
12. Afternoon: Finish notes, perform procedures, transfer/discharge patients, read about cases, and have teaching time with team.
13. 1400-1530: Didactic Session with Dr. Kennealy on Tuesday, Thursday, and Friday.
14. 1845: Sign-out to night-time ICU hospitalist.

****Special Note:** On Wednesday at 0900 ONE senior and ONE intern will attend multidisciplinary rounds instead of CPSC or other lecture of the day. This needs to be coordinated by the seniors on the team and everyone needs to be involved in the process on Wednesday during their time in the ICU.

Resources

9. The ICU Book
10. Harrison's Internal Medicine
11. Cecil's Internal Medicine
12. Textbook of Critical Care 5th Edition: Fink, Abraham, Vincent, Kochenek
13. Critical Care 4th Edition: Civetta, Taylor, Kirby
14. Intensive Care Medicine 7th Edition: Irwin, Rippe
15. Up-To-Date
16. MKSAP 16

Updated June 2013

PGY-3 ICU

Content Goals and Objectives

8. Implement the appropriate mode of ventilatory assistance for acute respiratory failure.
9. Manage ventilator changes.
10. Use low tidal volume strategy where appropriate for ARDS.
11. Identify various sources and types of shock.
12. Deliver appropriate goal-directed therapy for severe sepsis.
13. Interpret chest x-rays for common lung disorders.
14. Perform central lines.

Process-Based Goals and Objectives

14. Manage the interdisciplinary team
15. Role model effective communication skills in challenging situations.
16. Guide and support bedside presentations that engage the patient and focus the discussion around the patient's central concerns.
17. Gather subtle, sensitive, and complicated information that may not be volunteered by the patient.
18. Recognize the scope of his/her abilities and ask for supervision and assistance appropriately.
19. Modify the differential diagnosis and care plan based on clinical course and data as appropriate.
20. Choose the appropriate consultative services for a given clinical condition.
21. Minimize unnecessary care including tests.
22. Integrate clinical evidence into decision making.
23. Demonstrate shared decision-making with the patient and family.
24. Use feedback to improve performance.
25. Stabilize patients with urgent or emergent medical conditions and transfer to a higher level of care when necessary.
26. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

Common Rotation Specifics

1. 2 seniors will be on every month except May and June
 - a. One senior will be overseeing the intern and the other will oversee the OBGYN resident when they are on service.
 - b. Each third year will be able to oversee 12 patients max.
 - c. The Intern and OBGYN resident will have a cap of 4 and 6 respectively.
 - d. Patients above this cap will be seen by the senior and teaching points will be communicated to the rest of the team.
 - e. Each senior will be on call every-other day to take admissions.
 - f. Admission cap is 5 new admissions and 2 transfers per 12 hour period.
 - g. During this time the team cap will be 30 patients.
2. 1 Senior will be present in May and June
 - a. The intern and OBGYN cap will still stand at 4 and 6 respectively.
 - b. The senior will oversee both the intern and the OBGYN resident.
 - c. The max number will still stand at 12 and so they can see a total of 2 patients on their

- own.
- d. During this time the team cap will be 18 patients.
- 3. Second year will have a cap of 6 patients and will speak directly with the attending. They will come to the third year whenever they have questions or need help.
- 4. Admissions
 - a. Senior will disperse admissions and transfers between the intern on call and the second year based on patient load.
 - b. Will strive to keep patient load fairly similar and for the good of each resident's learning.
- 5. Weekend Rounds
 - a. The seniors on the rotation will alternate the weekend call for the ICU.
 - b. The call on the weekend will be a cross-coverage.
 - c. Cap will remain at 5 admissions and 2 transfers.
 - d. With the possibility of 30 patients the weekend will be a "coverage only" period and rounds will be made directly with the attending.
 - e. Residents will only write a max of 4 notes by intern and 8 by senior.
 - f. Will round with the attending and will place all orders and help rounding attending be familiar with patients he/she is cross-covering for.

Miscellaneous Notes

1. No clinic duties during the ICU month
2. Must attend all lectures. If emergency happens must tell chief resident about the occurrence and why it was necessary to miss the lecture.
3. Each resident must be present and both sign-outs each day of the week.
4. Each resident will have one day off during the week.
5. No vacation during this rotation.
6. No clinic responsibilities during this rotation.
7. To contact Intensivists call 513-841-5864 (LUNG) and follow the prompts.

Typical Day

15. Sign-out with ICU hospitalist at 0640.
16. 0700-0800 mandatory lecture attendance.
17. 0800-0900 round on patients.
18. 0900-1200 Multidisciplinary rounds with the attending. (Firm start time, Approximate end time)
19. Afternoon: Finish notes, perform procedures, transfer/discharge patients, read about cases, and have teaching time with team.
20. 1400-1530: Didactic Session with Dr. Kennealy on Tuesday, Thursday, and Friday.
21. 1845: Sign-out to night-time ICU hospitalist.

****Special Note:** On Wednesday at 0900 ONE senior and ONE intern will attend multidisciplinary rounds instead of CPSC or other lecture of the day. This needs to be coordinated by the seniors on the team and everyone needs to be involved in the process on Wednesday during their time in the ICU.

Resources

17. The ICU Book
18. Harrison's Internal Medicine
19. Cecil's Internal Medicine
20. Textbook of Critical Care 5th Edition: Fink, Abraham, Vincent, Kochenek
21. Critical Care 4th Edition: Civetta, Taylor, Kirby
22. Intensive Care Medicine 7th Edition: Irwin, Rippe
23. Up-To-Date
24. MKSAP 16

Updated June 2013

Infectious Disease

Content Goals and Objectives

1. Develop a comprehensive differential diagnosis and diagnostic plan for workup of fever of unknown origin
2. Select appropriate antibiotic therapy and duration for organisms with antibiotic resistance.
3. Diagnose and manage suspected endocarditis.
4. Diagnose and manage suspected meningitis.
5. Select appropriate type, dose, and duration of antibiotic therapy for osteomyelitis.
6. Select appropriate type, dose, and duration of therapy for complicated urinary tract infections.
7. Select appropriate type, dose, and duration of therapy for post-operative infections.
8. Determine appropriate diagnostic testing and treatment of infectious colitis.
9. Adjust type, dose, and duration of therapy for pneumonia based on historical risk factors and clinical course.
10. Select appropriate antibiotics and duration of therapy for treatment of bacteremia.

Process Based Goals and Objectives

1. Acquire accurate and relevant history.
2. Gather subtle, sensitive, and complicated information that may not be volunteered by the patient.
3. Perform an accurate physical exam.
4. Develop prioritized differential diagnoses.
5. Develop an evidence-based diagnostic and therapeutic plan.
6. Provide accurate, complete, and timely documentation.
7. Communicate effectively with the consulting team.
8. Modify the differential diagnosis and care plan based on clinical course and data as appropriate.
9. Minimize unnecessary care including tests.
10. Integrate clinical evidence into decision making.
11. Use feedback to improve performance.
12. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

Common Principles

- Patients will be distributed after lecture (0700-0800) each morning.
- Rounds with attending will occur daily on their schedule.
- Antibiotic Advisory Team will be in the afternoon. The attending will tell you when to attend.
- Clinic will be 1-2 times per week and will be at the discretion of the attending.
- **No vacation will be permitted during this rotation.**
- Will have feedback from the attending two weeks into the rotation. Will write down areas of strength and weakness, have attending sign and turn into Beth Mack.

REFERENCES

-MKSAP 16

-Harrison' Principles of Internal Medicine. 18th edition. Edited by E. Braunwald, K.J. Isselbacher, R.G. Petersdorf, J.D. Wilson, J.B. Martin, A.F. Fauci. McGraw-Hill, New York, 2012.

-Principles and Practice of Infectious Diseases by Mandell, Douglas and Bennett

-The Infectious Diseases Society of America (IDSA) website including the Practice Guideline section:

www.IDSociety.org

-Up-To-Date

Updated June 2013

Nephrology

Content Goals and Objectives

1. Initiate workup for acute renal failure
2. Manage hypokalemia and hyperkalemia
3. Initiate appropriate basic workup for disorders of sodium
4. Initiate management of hypertensive emergency
5. Identify acid-base disturbances and initiate appropriate workup
6. Recommend acute dialysis for selected patients
7. Manage kidney disease for inpatients on other services
8. Dose drugs appropriate to the level of renal function
9. Manage parathyroid abnormalities in the renal patient
10. Demonstrate appropriate use of blood products and EPO analogues in CKD and ESRD patients
11. Implement a diagnostic workup for metabolic acidosis and alkalosis

Process-Based Goals and Objectives

1. Acquire accurate and relevant history
2. Gather subtle, sensitive, and complicated information that may not be volunteered by the patient
3. Perform an accurate physical exam
4. Develop prioritized differential diagnosis
5. Develop an evidence-based diagnostic and therapeutic plan
6. Provide accurate, complete, and timely documentation
7. Communicate effectively with the consulting team
8. Modify the differential diagnosis and care plan based on clinical course and data as appropriate
9. Minimize unnecessary care including tests
10. Integrate clinical evidence into decision making
11. Use feedback to improve performance
12. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering

Common Principles

- Will start rounding on patients after didactics each morning
- Will round with attending on service at their discretion
- 1 month rotation will be split up into 2 weeks in-patient and 2 weeks out-patient
- Will have feedback from the attending two weeks into the rotation. Will write down areas of strength and weakness, have attending sign and turn into Beth Mack.

REFERENCES

Current MKSAP

Up To Date Online

Updated June 2013

Neurology

Content Goals and Objectives

1. Evaluate altered mental status.
2. Perform a comprehensive neurological examination.
3. Localize neurologic lesions.
4. Order diagnostic testing for neurologic disease.
5. Prescribe ant platelet therapy for vascular disease.
6. Prescribe medication for seizure disorder.
7. Recognize acute stroke and begin initial management.
8. Manage anticoagulation for patients with neurologic diseases.

Process-Based Goals and Objectives

1. Provide accurate and relevant history.
2. Perform an accurate physical exam.
3. Develop prioritized differential diagnoses.
4. Develop an evidence-based diagnostic and therapeutic plan.
5. Demonstrate accurate medication reconciliation.
6. Provide accurate, complete, and timely documentation.
7. Identify the appropriate clinical question for consultative services.
8. Identify clinical questions as they emerge in patient care activities and access medical information resources.
9. Perform bedside presentations that engage the patient and focus the discussion around the patient's central concerns.
10. Minimize unfamiliar terms during patient encounters.
11. Demonstrate shared decision-making with the patient.
12. Use teach-back method with patient's regarding medications and plan.
13. Communicate with primary care physicians.
14. Recognize the scope of his/her abilities and asked for supervision and assistance appropriately.
15. Minimize unnecessary care including test.
16. Use feedback to improve performance.
17. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

Daily Duties

1. Attend lecture at 0700-0800
2. Page Dr. Kachoris at 0800 for responsibilities and patients.
3. Round on patients and perform consults as directed by Dr. Kachoris.
4. May not leave the hospital till released by Dr. Kachoris
5. Please page Dr. Kachoris at 513-333-8228

6. No vacation permitted on this rotation.

READING

Principles of Neurology, Adams and Victor.

Harrison's Textbook of Medicine (Neurology section, great for stroke)

Manual of Neurologic Therapeutics, by Martin Samuels

Stroke: Pathophysiology, Diagnosis, and Management by Henry Barnett.

The Treatment of Epilepsy, Editor: Elaine Wyllie

Peripheral Neuropathy, Editor: Pete J. Dyck

The Neurological Examination, by Editor: Russell DeJong et al.

MKSAP 16

Up-to-date.

Updated July 2013

Pulmonary Disease

Content Goals and Objectives

1. Interpret pulmonary function test.
2. Refer patients for pulmonary rehabilitation.
3. Discuss a second line or third line smoking cessation plan for a patient who failed first-line therapy.
4. Initiate the basic workup for a patient with undifferentiated interstitial lung disease.
5. Provide first-line therapy to his cystic fibrosis patient presenting with a new productive cough.
6. Manage a patient on chronic home oxygen therapy who presents with the complaint of dyspnea.

Process-Based Goals and Objectives

1. Gather subtle, sensitive, and complicated information that may not be volunteered by the patient.
2. Perform an accurate physical exam.
3. Developed prioritized differential diagnoses.
4. Develop an evidence-based diagnostic and therapeutic plan.
5. Integrate clinical evidence into decision making.
6. Recognize the scope of his/her abilities and asked for supervision and assistance appropriately.
7. Minimize unnecessary care including tests.
8. Provide appropriate preventive care.
9. Evaluate complex medical patient in a timely manner.
10. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

Rotation Specifics

1. To page attending dial 513-841-5864 (LUNG) and follow prompts.
2. Will be given schedule on attending to follow each week and will need to speak with them the week before beginning the rotation.
3. Will meet with them at 0800 after didactics each morning (0700-0800).
- 4. No vacation permitted during this rotation.**
5. Will see in-patient consults and go to the office whenever possible during rotation.
6. Will sit down with attending at 2 week interval and get feedback on strengths and weaknesses, write it up and submit it to Beth Mack.
- 7.

REFERENCES

- Textbook of Respiratory Medicine 5th Edition Volume I and II. Murray and Nadel's
- Clinical Respiratory Medicine 4th Edition. Spiro, Silvestri, Augusti.
- Interpretation of Pulmonary Function Tests: A Practical Guide: Hyatt, Scanlon, Nakamura
- Fundamentals of Respiratory Care 10th Edition: Egans
- Respiratory Physiology The Essentials: 9th Edition: John B. West
- Respiratory Pathophysiology The Essentials: 8th Edition. John B. West
- Harrison's Internal Medicine
- Cecil's Internal Medicine
- Up-to-date
- MKSAP 16
- MedStudy

Updated June 2013

PGY-1 General Ward Service

PROCEDURAL OBJECTIVES

1. Arterial blood gases
2. Inserting central venous lines
3. Lumbar puncture
4. Arthrocentesis
5. Paracentesis

CONTENT GOALS AND OBJECTIVES

1. Initiate basal bolus insulin therapy and manage blood glucose over time.
2. Manage elevated blood pressure
3. Diagnose the cause of loss of consciousness and differentiate syncope from other etiologies.
4. Initiate appropriate antibiotic(s) for pneumonia.
5. Initiate appropriate antibiotic(s) for skin and soft tissue infections.
6. Choose the appropriate form of VTE prophylaxis.
7. Apply the proper diagnostic test in the workup of VTE.
8. Recognize and manage exacerbations of obstructive lung disease.
9. Initiate CIWA protocol in patients at risk for alcohol withdrawal.
10. Manage derangements of potassium.
11. Recognize delirium and identify potential causes.
12. Initiate cost-effective workup for anemia.
13. Initiate workup and proper therapy for diabetic foot ulcer.
14. Assess and treat pain as part of a daily plan.
15. Initiate fall precaution orders in patients at risk for falls.
16. Initiate workup and management of fever.

PROCESS-BASED GOALS AND OBJECTIVES

1. Acquire accurate and relevant history.
2. Perform an accurate physical exam.
3. Develop prioritized differential diagnosis.
4. Develop an evidence-based diagnostic and therapeutic plan.
5. Demonstrate accurate medication reconciliation.
6. Provide accurate, complete, and timely documentation.
7. Identify the appropriate clinical question for consultative services.
8. Identify clinical questions as they emerge in patient care activities and access medical information resources.
9. Perform bedside presentations that engage the patient and focus the discussion around the patient's central concerns.
10. Minimize unfamiliar terms during patient encounters.
11. Demonstrate shared decision-making with the patient.

12. Use teach-back method with patients regarding medications and plan.
13. Communicate with primary care physician.
14. Recognize the scope of his/her abilities and ask for supervision and assistance appropriately.
15. Minimize unnecessary care including tests.
16. Use feedback to improve performance.
17. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

RESIDENT FEEDBACK

- The second Friday and last Friday of the rotation will be reserved for resident feedback
- The attending will meet with the senior resident and discuss strengths, weaknesses, and areas of desired growth of the interns.
- Attending will also give specific feedback to the senior resident at that time.
- Each intern and student will then meet with the attending and senior resident to discuss these findings and any other issues that may be present.
- The intern is free to ask questions and bring up issues of their own.
- At the end of each rotation the attending will complete an evaluation of each resident and will discuss this with them on the last day of the rotation.
- Each resident will also complete an evaluation of the attending at that same time.

ADMISSIONS, TRANSFERS, AND CAPS

- No admission will take place from 0600 – 1200 except for clinic patients.
- If a clinic patient arrives from 0600 – 1200 then the senior will quickly go see the patient in the ER, will write basic admission orders, and then will rejoin the team for rounds.
- Team on call can take 5 new admission and 2 transfers in a 12 hour period
- Team cap is 14 patients.
- No clinic patients will be admitted over the cap.
- Night float team will also be able to admit 5 and accept 2 transfers.
- Admissions and transfers during the night will be distributed to the team as deemed best by the senior on the team.
- When students are on the team (of any level) a full History and Physical must be performed and documented by the intern or senior irrespective of what the medical student performs and documents.

CALL

- Each intern will be on call approximately every other day depending on if AI's are on the service from 0640 – 1840 Sunday through Saturday
- Night float intern will go home right after sign-out on Saturday morning.
- A second year resident will cover the census and admit patients on Saturday night from 1840 – 0640 on Sunday morning.

- For each twelve hour period that the intern is working he/she will be able to admit 5 new patients and accept 2 transfers.

DISCHARGE SUMMARIES

To be performed by the intern taking care of the patient during the patient's admission.

- Senior will oversee this process to make sure that communication to the primary care physician is complete and that care back to the primary goes smoothly for the patient.
- Senior will be responsible to read each summary, discuss with the intern, and make changes as necessary
- Discharge summaries must be completed by Intern or Senior on the team. These cannot be completed by students at any level.

TYPICAL DAY

- Sign-out and reassign patients from 0640 - 0700.
- Morning lecture from 0700 - 0800.
- Pre-round 0800 - 1000.
- Team rounds 1000-1230.
- 1230 -1330 Lunch
- 1330 – 1600 Finish notes, discharges, other patient responsibilities
- 1600-1840 Reading and team study groups
- 1840 – 1900 Sign-out to Night float

KEY CONCEPTS

- Team composed of Senior, 2 interns, and possibly medical students.
- Call is every other day from 0640 – 1840.
- May perform 5 admissions and accept 2 transfers.
- Night float is 1840 – 0640 Sunday through Friday.
- May admit 5 patients overnight.
- Team cap is 14 total patients.
- Each intern can carry 6 patients.
- Saturday night will be covered by second year resident from 1840-0640.
- Intern will have clinic one day every other week and his/her patients will be covered by the senior.

Attending Responsibilities:

- Please let us know as soon as possible of any deficiencies that are witnessed that we can

target in our residency curriculum.

- Please communicate with us any issues you encounter at any time.
- Please tell us of any cases that would be good for Morbidity and Mortality conference for our residents' education.
- Please fill out resident evaluation in a timely manner and give good specific feedback to further their education.

REFERENCES

Cecil Textbook of Medicine. 24th Edition. Edited by J.B. Wyngaarden, L.H. Smith. W.B. Saunders, Philadelphia, 2012.

Harrison' Principles of Internal Medicine. 18th edition. Edited by E. Braunwald, K.J. Isselbacher, R.G. Petersdorf, J.D. Wilson, J.B. Martin, A.F. Fauci. McGraw-Hill, New York, 2012.

Principles and Practices of Hospital Medicine. 2012. McKean, S.C., Ross, J.J., Dressler, D.D., Brotmna, D.J., Ginsberg, J.S. McGraw-Hill, New York, 2012.

Up-to-date Online Resource

Current MKSAP 16

Updated June 2013

PGY-3 General Ward Service

PROCEDURAL OBJECTIVES

Teach team members to become proficient in the following:

1. Arterial blood gases
2. Inserting central venous lines
3. Lumbar puncture
4. Arthrocentesis

CONTENT GOALS AND OBJECTIVES

1. Recognize and manage diabetic ketoacidosis.
2. Manage extremes of blood pressure.
3. Demonstrate a cost effective workup of loss of consciousness
4. Adjust type, dose, and duration of therapy for pneumonia based on clinical course.
5. Recognize deep-seated soft tissue infections.
6. Manage and escalate care in a patient with sepsis.
7. Manage anticoagulation in a patient with suspected or known venous thromboembolism.
8. Recognize and manage impending respiratory failure.
9. Manage benzodiazepines in a patient with alcohol withdrawal.
10. Manage derangement of sodium.
11. Utilize pharmacologic and non-pharmacologic methods to manage delirium.
12. Demonstrate appropriate use of blood products.
13. Use an opioid conversion table to titrate pain management.

PROCESS-BASED GOALS AND OBJECTIVES

1. Manage the interdisciplinary team.
2. Role model effective communication skills in challenging situations.
3. Demonstrate shared decision-making with the patient.
4. Guide and support bedside presentations that engage the patient and focus the discussion around the patient's central concerns.
5. Gather subtle, sensitive, and complicated information that may not be volunteered by the patient.
6. Recognize the scope of his/her abilities and ask for supervision and assistance appropriately.
7. Modify the differential diagnosis and care plan based on clinical course and data as appropriate.
8. Choose the appropriate consultative services for a given clinical condition.
9. Minimize unnecessary care including tests.
10. Integrate clinical evidence into decision making.
11. Tech physical findings for junior members of the health care team.
12. Use feedback to improve performance.
13. Stabilize patients with urgent or emergent medical conditions and transfer to a higher level of care when necessary.

14. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

RESIDENT FEEDBACK

- The second Friday and last Friday of the rotation will be reserved for resident feedback
- The attending will meet with the senior resident and discuss strengths, weaknesses, and areas of desired growth of the interns.
- Attending will also give specific feedback to the senior resident at that time.
- Each intern and student will then meet with the attending and senior resident to discuss these findings and any other issues that may be present.
- The intern is free to ask questions and bring up issues of their own.
- At the end of each rotation the attending will complete an evaluation of each resident and will discuss this with them on the last day of the rotation.
- Each resident will also complete an evaluation of the attending at that same time.

ADMISSIONS, TRANSFERS, AND CAPS

- No admission will take place from 0600 – 1200 except for clinic patients.
- If a clinic patient arrives from 0600 – 1200 then the senior will quickly go see the patient in the ER, will write basic admission orders, and then will rejoin the team for rounds.
- Team on call can take 5 new admission and 2 transfers in a 12 hour period
- Team cap will be 14 patients.
- No clinic patients will be admitted over the cap.
- Night float team will also be able to admit 5 and accept 2 transfers.
- Admissions and transfers during the night will be distributed to the team as deemed best by the senior on the team.
- When students are on the team (of any level) a full History and Physical must be performed and documented by the intern or senior irrespective of what the medical student performs and documents.
- **When the NF resident starts the shift he/she MUST call the Nocturnist and give them an accurate number of patients on the census at that time by paging 648-2010.**

CALL

- Each senior will be on call every day from 0640 - 1840
- Senior call will be on Saturday and Sunday from 0640 to 1840.
- Senior call on Saturday night 1840 to Sunday 0640 will be responsibility of a Second year resident.
- As much as possible the seniors on the service will take call on the weekend.
- Senior will be able to take the admissions and transfers that the intern takes.

DISCHARGE SUMMARIES

Will be performed by the intern taking care of the patient during the patient's admission.

- Senior will oversee this process to make sure that communication to the primary care physician is complete and that care back to the primary goes smoothly for the patient.
- Senior will be responsible to read each summary, discuss with the intern, and make changes as necessary
- Discharge summaries must be completed by Intern or Senior on the team.
These cannot be completed by students at any level.

TYPICAL DAY

- Sign-out and reassign patients from 0640 - 0700.
- Morning lecture from 0700 - 0800.
- Pre-round 0800 - 1000
- Team rounds 1000-1230.
- 1230 -1330 Lunch
- 1330 – 1600 Finish notes, discharges, other patient responsibilities
- 1600-1840 Team study group and reading about cases
- 1840 – 1900 Sign-out to Night float

KEY CONCEPTS

1. Team composed of Senior, 2 interns, and possibly medical students.
2. Call is every other day from 0640 to 1840.
3. May supervise 5 admissions and 2 transfers.
4. Night float is 1840 to 0640 Sunday through Friday.
5. Team cap is 14 patients.
6. Senior call will be Saturday and Sunday from 0640 to 1840.
7. Saturday night call 1840 to Sunday 0640 filled by second year resident.

Attending Responsibilities:

- Please let us know as soon as possible of any deficiencies that are witnessed that we can target in our residency curriculum.
- Please communicate with us any issues you encounter at any time.
- Please tell us of any cases that would be good for Morbidity and Mortality conference for our residents' education.
- Please fill out resident evaluation in a timely manner and give good specific feedback to further their education.

REFERENCES

Cecil Textbook of Medicine. 24th Edition. Edited by J.B. Wyngaarden, L.H. Smith. W.B. Saunders, Philadelphia, 2012.

Harrison' Principles of Internal Medicine. 18th edition. Edited by E. Braunwald, K.J. Isselbacher, R.G. Petersdorf, J.D. Wilson, J.B. Martin, A.F. Fauci. McGraw-Hill, New York, 2012.

Principles and Practices of Hospital Medicine. 2012. McKean, S.C., Ross, J.J., Dressler, D.D., Brotmna, D.J., Ginsberg, J.S. McGraw-Hill, New York, 2012.

Up-to-date Online Resource

Current MKSAP 16

Updated June 2013

PGY-1 Queen City Medicine Service

CONTENT GOALS AND OBJECTIVES

17. Initiate basal bolus insulin therapy and manage blood glucose over time.
18. Manage elevated blood pressure
19. Diagnose the cause of loss of consciousness and differentiate syncope from other etiologies.
20. Initiate appropriate antibiotic(s) for pneumonia.
21. Initiate appropriate antibiotic(s) for skin and soft tissue infections.
22. Choose the appropriate form of VTE prophylaxis.
23. Apply the proper diagnostic test in the workup of VTE.
24. Recognize and manage exacerbations of obstructive lung disease.
25. Initiate CIWA protocol in patients at risk for alcohol withdrawal.
26. Manage derangements of potassium.
27. Recognize delirium and identify potential causes.
28. Initiate cost-effective workup for anemia.
29. Initiate workup and proper therapy for diabetic foot ulcer.
30. Assess and treat pain as part of a daily plan.
31. Initiate fall precaution orders in patients at risk for falls.
32. Initiate workup and management of fever.

PROCESS-BASED GOALS AND OBJECTIVES

18. Acquire accurate and relevant history.
19. Perform an accurate physical exam.
20. Develop prioritized differential diagnosis.
21. Develop an evidence-based diagnostic and therapeutic plan.
22. Demonstrate accurate medication reconciliation.
23. Provide accurate, complete, and timely documentation.
24. Identify the appropriate clinical question for consultative services.
25. Identify clinical questions as they emerge in patient care activities and access medical information resources.
26. Perform bedside presentations that engage the patient and focus the discussion around the patient's central concerns.
27. Minimize unfamiliar terms during patient encounters.
28. Demonstrate shared decision-making with the patient.
29. Use teach-back method with patients regarding medications and plan.
30. Communicate with primary care physician.
31. Recognize the scope of his/her abilities and ask for supervision and assistance appropriately.
32. Minimize unnecessary care including tests.
33. Use feedback to improve performance.

34. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

RESIDENT FEEDBACK

- The second Friday and last Friday of the rotation will be reserved for resident feedback
- Attending will meet with the senior resident and discuss strengths, weaknesses, and areas of desired growth of the intern.
- He/She will also give specific feedback to the senior resident at that time.
- The intern will then meet with the attending and senior resident to discuss these findings and any other issues that may be present.
- The intern is free to ask questions and bring up issues of their own.
- At the end of each rotation EACH attending will complete an evaluation of each resident and will discuss this with them on the last day of the rotation.
- Each resident will also complete an evaluation of EACH attending that has admitted patients to the service during the month.

ADMISSIONS, TRANSFERS, AND CAPS

- Team can take 5 new admission and 2 transfers in a 12 hour period
- Team will be “capped” at 12 total patients.
- Team will only take patients under Queen City attending who give direct patient care with the residents.

CALL

- Senior and intern will be on call from 0640 to 1840.
- Neither resident will be on call from Friday at 1840 to Monday at 0640.
- On the weekend, service will be covered by Dr. Alexander or partners.
- No admissions will take place by interns or senior on night float from Friday at 1840 to Sunday at 1840.
- Coverage for service will begin again on Monday at 0640.

DISCHARGE SUMMARIES

- To be performed by the intern taking care of the patient during the patient’s admission.
- Senior will oversee this process to make sure that communication to the primary care physician is complete and that care back to the primary goes smoothly for the patient.
- Senior will be responsible to read each summary, discuss with the intern, and make changes as necessary

TYPICAL DAY

- Meet with Dr. Shetty and Dr. Cleves at 0600 to round on their specific patients. Call or text them daily to arrange time to round and discuss patient care.
- Sign-out and reassign patients from 0640 - 0700.
- Morning lecture from 0700 - 0800.

- Round with Dr. Alexander starting at 0800.
- Take admissions in hospital and go to the office from end of rounds till 1840.
- 1840 – 1900 Sign-out to Night float

KEY CONCEPTS

- Team composed of Senior and Intern
- Call is every day from 0640 – 1840.
- May perform 5 admissions and accept 2 transfers.
- Team cap is 12 total patients.
- Each intern can carry 6 patients.
- Intern will have clinic one day every other week and his/her patients will be covered by the senior on their day of clinic.
- No call from Friday at 1840 to Monday at 0640

CONTACT INFORMATION

Dr. Alexander: (513) 368-1331

Dr. Cleves: (513) 659-8989

Dr. Sawma: (513) 505-9098

Dr. Shetty: (513) 207-6633

Dr. Cleves Office: (513) 871-2340

Other Office: (513) 481-3400

REFERENCES

Cecil Textbook of Medicine. 24th Edition. Edited by J.B. Wyngaarden, L.H. Smith. W.B. Saunders, Philadelphia, 2012.

Harrison' Principles of Internal Medicine. 18th edition. Edited by E. Braunwald, K.J. Isselbacher, R.G. Petersdorf, J.D. Wilson, J.B. Martin, A.F. Fauci. McGraw-Hill, New York, 2012.

Principles and Practices of Hospital Medicine. 2012. McKean, S.C., Ross, J.J., Dressler, D.D., Brotmna, D.J., Ginsberg, J.S. McGraw-Hill, New York, 2012.

UpToDate Online Resource

Current MKSAP 16

Updated 6/2013

PGY-3 Queen City Medicine Service

CONTENT GOALS AND OBJECTIVES

14. Recognize and manage diabetic ketoacidosis.
15. Manage extremes of blood pressure.
16. Demonstrate a cost effective workup of loss of consciousness
17. Adjust type, dose, and duration of therapy for pneumonia based on clinical course.
18. Recognize deep-seated soft tissue infections.
19. Manage and escalate care in a patient with sepsis.
20. Manage anticoagulation in a patient with suspected or known venous thromboembolism.
21. Recognize and manage impending respiratory failure.
22. Manage benzodiazepines in a patient with alcohol withdrawal.
23. Manage derangement of sodium.
24. Utilize pharmacologic and non-pharmacologic methods to manage delirium.
25. Demonstrate appropriate use of blood products.
26. Use an opioid conversion table to titrate pain management.

PROCESS-BASED GOALS AND OBJECTIVES

15. Manage the interdisciplinary team.
16. Role model effective communication skills in challenging situations.
17. Demonstrate shared decision-making with the patient.
18. Guide and support bedside presentations that engage the patient and focus the discussion around the patient's central concerns.
19. Gather subtle, sensitive, and complicated information that may not be volunteered by the patient.
20. Recognize the scope of his/her abilities and ask for supervision and assistance appropriately.
21. Modify the differential diagnosis and care plan based on clinical course and data as appropriate.
22. Choose the appropriate consultative services for a given clinical condition.
23. Minimize unnecessary care including tests.
24. Integrate clinical evidence into decision making.
25. Tech physical findings for junior members of the health care team.
26. Use feedback to improve performance.
27. Stabilize patients with urgent or emergent medical conditions and transfer to a higher level of care when necessary.
28. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

RESIDENT FEEDBACK

- The second Friday and last Friday of the rotation will be reserved for resident feedback
- Attending will meet with the senior resident and discuss strengths, weaknesses, and areas of desired growth of the intern.
- He/She will also give specific feedback to the senior resident at that time.
- The intern will then meet with the attending and senior resident to discuss these findings and any other issues that may be present.

- The intern is free to ask questions and bring up issues of their own.
- At the end of each rotation EACH attending will complete an evaluation of each resident and will discuss this with them on the last day of the rotation.
- Each resident will also complete an evaluation on EACH attending that admitted patients to the teaching service during the month.

ADMISSIONS, TRANSFERS, AND CAPS

- . Team can take 5 new admission and 2 transfers in a 12 hour period
- Team will be “capped” at 12 total patients.
- Team will only take patients under attending that supplies direct patient care with the residents.

CALL

- Senior and intern will be on call from 0640 to 1840.
- Neither resident will be on call from Friday at 1840 to Monday at 0640.
- On the weekend, service will be covered by Queen City physicians alone.
- No admissions will take place by interns or senior on night float from Friday at 1840 to Sunday at 1840.
- Coverage for service will begin again on Sunday night at 1840.

DISCHARGE SUMMARIES

To be performed by the intern taking care of the patient during the patient’s admission.

- Senior will oversee this process to make sure that communication to the primary care physician is complete and that care back to the primary goes smoothly for the patient.
- Senior will be responsible to read each summary, discuss with the intern, and make changes as necessary

TYPICAL DAY

- Meet with Dr. Cleves and Dr. Shetty at 0600. When patients under their care on service text or call them and arrange specific time to meet before sign-out.
- Sign-out and reassign patients from 0640 - 0700.
- Morning lecture from 0700 - 0800.
- Round with Dr. Alexander starting at 0800.
- Take admissions in hospital and go to the office from end of rounds till 1840.
- 1840 – 1900 Sign-out to Night float

KEY CONCEPTS

- Team composed of Senior and Intern
- Call is every day from 0640 – 1840.
- May perform 5 admissions and accept 2 transfer
- Team cap is 12 total patients.

- Each intern can carry 6 patients.
- Intern will have clinic one day every other week and his/her patients will be covered by the senior.
- Each senior will have clinic one day per week in the afternoon.
- No call from Friday at 1840 to Monday at 0640

CONTACT INFORMATION

Dr. Alexander: (513) 368-1331

Dr. Cleves: (513) 659-8989

Dr. Sawma: (513) 505-9098

Dr. Shetty: (513) 207-6633

Dr. Cleves Office: (513) 871-2340

Other Office: (513) 481-3400

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Principles and Practices of Hospital Medicine. 2012. McKean, S.C., Ross, J.J., Dressler, D.D., Brotmna, D.J., Ginsberg, J.S. McGraw-Hill, New York, 2012.

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PGY-1 Night Float

Content Goals and Objectives

1. Manage hyperglycemia
2. Manage elevated blood pressure
3. Diagnose the cause of loss of consciousness and differentiate syncope from other etiologies
4. Initiate appropriate antibiotics for pneumonia
5. Initiate appropriate antibiotics for skin and soft tissue infections
6. Recognized and manage exacerbations of obstructive lung disease
7. Recognized and manage alcohol withdrawal
8. Manage derangements of electrolytes
9. Recognized delirium and identify potential causes
10. Initiate workup and management of fever
11. Manage pain complaints overnight
12. Document cross cover care

Process Based Goals and Objectives

1. Acquire accurate and relevant history
2. Perform an accurate physical exam
3. Developed prioritized differential diagnoses
4. Development evidence based diagnostic and therapeutic plan
5. Demonstrate accurate medication reconciliation
6. Provide accurate, complete, and timely documentation
7. Identify the appropriate clinical question for consultative services
8. Identify clinical questions as they emerge and patient care activities and access medical information resources
9. Perform bedside presentations that engaged the patient can focus the discussion around the patient's central concerns
10. Minimize unfamiliar terms during patient encounter is
11. Demonstrate shared decision-making with the patient
12. Recognize the scope of his/her abilities and asked for supervision and assistance appropriately
13. Minimize unnecessary care including cast
14. Use feedback to improve performance
15. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering

Rotation Specifics

1. Sign-out occurs at 1840 sharp.
2. Sign-out in the am will be at 0640.
3. Must attend morning lecture before going home for the day.
4. Will admit Hospitalist patients for the entire shift until 0600 each night of the week.

5. Will admit Queen City physician's patients from Sunday night at 1840 through Thursday night. No admissions will take place on Friday or Saturday night for the Queen City Physicians.
6. Cap is 5 admissions and 2 transfers.
7. No vacation permitted during this rotation.

REFERENCES

Cecil Textbook of Medicine. 24th Edition. Edited by J.B. Wyngaarden, L.H. Smith. W.B. Saunders, Philadelphia, 2012.

Harrison' Principles of Internal Medicine. 18th edition. Edited by E. Braunwald, K.J. Isselbacher, R.G. Petersdorf, J.D. Wilson, J.B. Martin, A.F. Fauci. McGraw-Hill, New York, 2012.

Principles and Practices of Hospital Medicine. 2012. McKean, S.C., Ross, J.J., Dressler, D.D., Brotmna, D.J., Ginsberg, J.S. McGraw-Hill, New York, 2012.

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PGY2-3 Night Float

Content Goals and Objectives

1. Supervise PGY run residence in the care of patient's overnight

Process Based Goals and Objectives

1. Manage the interdisciplinary team
2. Recognize the scope of his/her abilities and asked for supervision and assistance appropriately
3. Modify the differential diagnosis and care plan based on clinical course and data as appropriate
4. Choose the appropriate consultative services for a given clinical situation
5. Minimize unnecessary care including tests
6. Integrate clinical evidence into decision-making
7. Teach physical findings for junior members of the health care team
8. Use feedback to improve performance
9. Stabilize patients with urgent or emergent medical conditions and transfer to a higher level of care when necessary
10. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering

Rotation Specifics

8. Sign-out occurs at 1840 sharp.
9. Sign-out in the am will be at 0640.
10. Must attend morning lecture before going home for the day.
11. Will admit Hospitalist patients for the entire shift until 0600 each night of the week.
12. Will admit Queen City physician's patients from Sunday night at 1840 through Thursday night. No admissions will take place on Friday or Saturday night for the Queen City Physicians.
13. Cap is 5 admissions and 2 transfers.
14. No vacation permitted during this rotation.

REFERENCES

Cecil Textbook of Medicine. 24th Edition. Edited by J.B. Wyngaarden, L.H. Smith. W.B. Saunders, Philadelphia, 2012.

Harrison' Principles of Internal Medicine. 18th edition. Edited by E. Braunwald, K.J. Isselbacher, R.G. Petersdorf, J.D. Wilson, J.B. Martin, A.F. Fauci. McGraw-Hill, New York, 2012.

Principles and Practices of Hospital Medicine. 2012. McKean, S.C., Ross, J.J., Dressler, D.D., Brotmna, D.J., Ginsberg, J.S. McGraw-Hill, New York, 2012.

Up-to-date Online Resource

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Rheumatology

Content Goals and Objectives

1. Distinguish periarticular from particular abnormalities
2. Detect synovial swelling in joints and periarticular structures (tendons and bursa)
3. Detect muscle weakness and translate into potential functional impairment
4. Diagnosed with rheumatoid arthritis
5. Explained management goals and therapeutic options for rheumatoid arthritis 2 patient have and consult team physicians
6. Diagnose and manage gallops
7. Explained management goals and therapeutic options for gout to patient's in consultation physicians
8. Determine if lupus is active or not by history and physical
9. Order the appropriate lab test to determine if lupus is active or not
10. Recognize the urgency of treatment for the vasculopathies (particularly giant cell arteritis)
11. Prescribed nonsurgical management of osteoarthritis
12. Discuss the indications and perils of joint replacements with patients
13. Delineate the cause of low back pain into categories of disease (inflammatory, mechanical and degenerative, infection or neoplastic, referred)
14. Demonstrate a cost-effective workup of low back pain
15. Order immunologic serology accurately and cost-effectively
16. Perform knee arthrocentesis
17. Interpret the results of the synovial fluid analysis
18. Discuss treatment options for fibromyalgia with patient's and consultants

Process based Goals and Objectives

1. Gathers subtle, sensitive, and complicated information that may not be volunteered by the patient
2. Perform an accurate physical exam
3. Developed prioritized differential diagnoses
4. Development evidence based diagnostic and therapeutic plan
5. Integrate clinical evidence into decision-making
6. Recognized the scope of his/her abilities and asked for supervision and assistance appropriately
7. Minimize unnecessary care including tests
8. Provide appropriate preventative care
9. Evaluate complex medical patient's and timely manner
10. Demonstrate with the, compassion, and a commitment to relieve pain and suffering

Endocrinology

Content Goals and Objectives

1. Interpret blood glucose readings.
2. Titrate insulin based on glucose readings.
3. Recommend proper monitoring and management of diabetic microvascular and macrovascular complications.
4. Evaluate and manage thyrotoxicosis.
5. Evaluate and manage hypothyroidism.
6. Evaluate and manage pituitary adenomas.
7. Evaluate and manage hypogonadism.
8. Evaluate and manage hypercalcemia.
9. Perform and interpret a cosyntropin stimulation test.

Process-Based Goals and Objectives

11. Gather subtle, sensitive, and complicated information that may not be volunteered by the patient.
12. Perform an accurate physical exam.
13. Develop prioritized differential diagnoses.
14. Develop an evidence-based diagnostic and therapeutic plan.
15. Integrate clinical evidence into decision making.
16. Recognize the scope of his/her abilities and asked for supervision and assistance appropriately.
17. Minimize unnecessary care including tests.
18. Provide appropriate preventive care.
19. Evaluate complex medical patient in a timely manner.
20. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

Rotation Specifics

1. Each morning must attend lectures at GSH from 0700-0800.
2. On Wednesday lectures will last till 1000 a.m.
3. After lecture will spend the rest of the time with the attending in the office.
4. If in-patient consults are called to the attending will see consult with the attending.
5. No vacation will be allowed during this rotation.
6. Attending will complete evaluation of resident at end of rotation and resident will complete one for the attending.
7. Will need to contact attending week before rotation begins to get specifics of locations.

REFERENCES

Cecil Textbook of Medicine. 24th Edition. Edited by J.B. Wyngaarden, L.H. Smith. W.B. Saunders, Philadelphia, 2012.

Harrison' Principles of Internal Medicine. 18th edition. Edited by E. Braunwald, K.J. Isselbacher, R.G. Petersdorf, J.D. Wilson, J.B. Martin, A.F. Fauci. McGraw-Hill, New York, 2012.

Up-to-date Online Resources

Current MKSAP 16

Updated July 2013

Emergency Department

Content Goals and objectives

1. Develop initial evaluation and treatment plan for patients with suspected infection
2. Developed initial evaluation and treatment plan for patients with chest pain
3. Develop initial evaluation and treatment plan per patients with shortness of breath
4. Obtain a history and physical exam at time expedient manner
5. Manage multiple patients simultaneously
6. Triage patient to proper level of care
7. Communicate effectively with consultants

Process Based Goals and Objectives

1. Will model effective communication skills and challenging situations.
2. Recognize the scope of his/her abilities and asked for supervision and assistance appropriately
3. Modify the differential diagnosis and care plan based on clinical course and data as appropriate
4. Choose the appropriate consultative services for a given clinical condition
5. Minimize unnecessary care including tests
6. Integrate clinical evidence into decision-making
7. Use feedback to improve performance
8. Stabilize patients with urgent or emergent medical conditions and transfer to a higher level of care when necessary
9. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering

Rotation Specifics

1. Must contact Beth Mack or the Chief Resident 2 weeks before the rotation for your schedule.
2. Your schedule will be given to you by the ER.
3. You must communicate with Beth Mack or the chief resident to let them know your schedule so everyone will know when you will available for conferences.
4. You must make as many conferences as possible.
5. You must follow the schedule that the ER gives to you.
6. You will receive Blue Cards from the ER and you must give one of these to each physician that you work with.

Procedures

1. Orotracheal and nasotracheal intubation
2. Insertion of CVP lines
3. Fluorescein staining for corneal abrasions
4. Slit lamp examination

5. Removal of foreign bodies (ocular, nasal, and oral)
6. Nasal packing
7. laryngoscopy
8. Lumbar puncture (infant and adult)
9. Suturing of minor lacerations (optional)
10. Burn dressing
11. Splinting of soft tissue injuries fractures
12. Reduction of joint dislocations

Reading List

The curriculum for the rotation in Emergency Medicine is based on presentation rather than diagnosis. Thus, the primary chapters assigned for reading are symptom/sign based. Particular diagnosis/treatments that require special attention have been incorporated into the reading list:

The following chapters are from Rosen's "Emergency Medicine": Concepts and Clinical Practice, 7th edition, Vol 1, 2010

Shock – Chapter 4, p. 34

Brain Resuscitation – Chapter 6, p. 47

Depressed consciousness & Coma – Chapter 14, p. 106

Chest Pain – Chapter 18, pg 132

Abdominal Pain – Chapter 21, pg 159

General principles of orthopedic injuries – Chapter 46, p. 467

Wound Management principles – Chapter 56, page 698

Accidental Hypothermia, Chapter 138, pg 1868

Heat Illness, Chapter 139, pg 1882

General Approach to the Poisoned patient, Chapter 145, pg 1942

Emergency Medical Services – Overview and Ground Transport, Chapter 190, pg 2461

Updated July 2013

ICU Nights

Content Goals and Objectives

1. Implement the appropriate mode of ventilatory assistance for acute respiratory failure.
2. Manage ventilator changes.
3. Use low tidal volume strategy where appropriate for ARDS.
4. Identify various sources and types of shock.
5. Deliver appropriate goal-directed therapy for severe sepsis.
6. Interpret chest x-rays for common lung disorders.
7. Perform central lines.

Process-Based Goals and Objectives

1. Acquire accurate and relevant history.
2. Perform an accurate physical exam.
3. Develop prioritized differential diagnoses.
4. Develop an evidence-based diagnostic and therapeutic plan.
5. Demonstrate accurate medical reconciliation.
6. Provide accurate, complete, and timely documentation.
7. Identify the appropriate clinical question for consultative services.
8. Identify clinical questions as they emerge in patient care activities and access medical information resources.
9. Perform bedside presentations that engage the patient and focus the discussion around the patient's central concerns.
10. Minimize unfamiliar terms during patient encounters.
11. Demonstrate shared decision-making with the patient and family.
12. Use teach-back method with patients regarding medications and plan.
13. Communicate with primary care physician.
14. Recognize the scope of his/her abilities and ask for supervision and assistance appropriately.
15. Minimize unnecessary care including tests.
16. Use feedback to improve performance.
17. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

Rotation Specifics

- a. Will work with ICU Hospitalist during the night.
- b. Will help admit, care for patients, attend codes and rapid responses, and perform procedures when applicable.
- c. Must attend morning conference before leaving for the day.
- d. Rotation is Sunday night through Thursday night.
- e. Rotation is limited to two weeks.

Resources

25. The ICU Book
26. Harrison's Internal Medicine
27. Cecil's Internal Medicine

28. Textbook of Critical Care 5th Edition: Fink, Abraham, Vincent, Kochenek
29. Critical Care 4th Edition: Civetta, Taylor, Kirby
30. Intensive Care Medicine 7th Edition: Irwin, Rippe
31. Up-To-Date
32. MKSAP 16

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Anesthesia

Content Goals and Objectives

1. Perform preoperative evaluations
2. Obtain IV access and a preoperative patient
3. Perform bag mask ventilation
4. Intubated trachea
5. Chart the patient's course through the perioperative period

Process Based Goals and objectives

1. Role model effective communication skills and challenging situations
2. Recognize the scope of his/her abilities and asked for supervision and assistance appropriately
3. Modify the differential diagnosis and care plan based on clinical course and data as appropriate
4. Choose the appropriate consultative services for a given clinical condition
5. Minimize unnecessary clinic care including tests
6. Integrate clinical evidence into decision-making
7. Use feedback to improve performance
8. Stabilize patient's with urgent or emergent medical did conditions and transfer to a higher level of care when necessary
9. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering

Rotation Specifics

1. Must contact Beth Mack or chief resident to request rotation.
2. Must attend all morning lectures.
3. After morning lecture will report to Operating area and seek assistance to get involved in cases.
4. Rotation is Monday through Friday.

Updated July 2013

International Medicine

Content Goals and Objectives

1. Personally prepare for travel) pack team, vaccines, visas etc.)
2. Research and present topics appropriate to the region of travel during the preplanning phase
3. The liver educational activity for the destination community at large and accompanying health caregivers
4. Create and deliver on-site projects as assigned
5. Demonstrate cultural sensitivity
6. Demonstrate flexibility of on-site education and care plans
7. Utilize scarce resources and a creative and practical manner
8. Set up and break down on-site pharmacy and medical worksite

Process Based Goals and Objectives

1. Acquire accurate and relevant history
2. Perform an accurate physical exam
3. Developed prioritized differential diagnoses
4. Development evidence based diagnostic and therapeutic plan
5. Communicate effectively with the patient's and families
6. Recognize the scope of his/her abilities and asked for supervision and assistance appropriately
7. Use feedback to improve performance
8. Minimize unnecessary care including tests
9. Demonstrate empathy, compassion, and a commitment to the pain and suffering

Updated July 2013

Research

Content Goals and Objectives

1. Develop a hypothesis driven research question
2. Develop a short research proposal
3. Choose the appropriate study design for a project
4. Demonstrate proper fracture and medical research
5. Interpret the results of her research project
6. Brighter research abstracts
7. Present a poster or PowerPoint presentation on research project
8. Recognized and manage conflicts of interest (such as caring for family members and professional Associates as patients)

Rotation Specifics

1. Must get support of Dr. Gonzales for this rotation.
2. Must attend all morning conferences.
3. Must perform clinic responsibilities during this time.
4. Rotation is Monday through Friday.

Updated July 2013

Elective Rotations

- Addiction Medicine (1 week)
- Anesthesiology (2 weeks)
- Cardiology
- Emergency Unit
- Endocrinology (Dr. Collins)
- ENT (2 weeks)
- Faculty Medical Center Internal Medicine
- Gastroenterology
- General Internal Medicine
- Geriatrics & Pathology
- Hematology/Oncology
- Hospitalist Medicine
- Infectious Disease
- Intensive Care Unit (Extra)
- Intensive Care Unit Nights (2 weeks)
- Nephrology
- Neurology (extra)
- OB/GYN and Office Gynecology
- Orthopedics (Outpatient) & Sports Medicine (2 weeks)
- Pain Management (2 weeks)
- Palliative Care
- Physical Medicine and Rehabilitation
- Pulmonology
- Radiology
- Research
- Rheumatology/Muscular/Skeletal Medicine
- Surgery

RESIDENT RESPONSIBILITIES

1. Must contact chief resident or Beth Mack 3 months in advance of elective time.
2. Can only do 1 month out-elective in 3 year period.
3. Will be expected in clinic on regular day for electives that are in-network.
4. Must attend all morning conferences while on in-network electives.

Pain Management

Content Goals and Objectives:

1. Assess pain using an established pain scale
2. Diagnose a chronic pain syndrome
3. Order advanced imaging appropriately in the workup of a pain syndrome
4. Initiate inappropriate pain regimen for chronic pain syndrome
5. Communicate and monitor for side effects of pain medications
6. Titrate narcotic pain medication
7. Initiate and manage nonnarcotic adjuvant pain medication
8. Initiate nonpharmacological treatments for chronic pain
9. Uses shared decision making strategies for complicated or ambiguous pain management scenarios

Process Based Goals and Objectives:

1. Acquire accurate and relevant history
2. Calves are supple, sensitive, and complicated information that may not be volunteered by the patient
3. Perform an accurate physical exam
4. Developed prioritized differential diagnoses
5. Development evidence based diagnostic and therapeutic plan
6. Provide accurate, complete, and timely documentation
7. Communicate effectively with the consult team
8. Modify the differential diagnosis and care plan based on clinical course and data as appropriate
9. Minimize unnecessary care including tests
10. Integrate clinical evidence into decision-making
11. Use feedback to improve performance
12. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering

Resident Responsibilities:

1. Contact Beth Mack or the Chief Resident and ask for availability of doing rotation.
2. Rotation will be set up and specifics will be sent to each resident.
3. Rotation is 2 weeks in length.
4. Will be expected to work Monday through Friday with the specialist.
5. Expected to attend all morning lectures and.

Addiction Medicine

GOAL

To enhance the resident's ability as a physician to effectively care for patients with alcohol and drug disorders by:

- Increasing understanding of alcohol and drug disorders as treatable conditions
- Observing the provision of outpatient assessment and treatment services to patients
- Learning an evidenced based practice for detecting and consulting with patients about their alcohol and drug problems

To Facilitate the Achievement of this Goal,

A schedule of activities has been designed to provide an opportunity to participate in the program's primary care activities and meetings with the staff, review selected readings and to complete a training module for the evidenced based practice.

Process Goals and Objectives:

- To become familiar with the standard treatment services in the program, i.e. intake assessment, patient education, group counseling, family education, and continuing care by attending sessions and discussing them with staff.
- To understand the treatment planning and clinical team review processes by attending the clinical staff meeting.
- To recognize the medical care that is done within the scope of the program's outpatient treatment by meeting with the Medical Director and sitting in on patient appointments.
- To consult with the Medical Director on the use the inpatient detoxification protocols
- To acquire knowledge about the Screening and Brief Intervention evidenced based practice and discuss its application with Family Practice patients.
- To recognize and challenge the obstacles that interferes with applying these concepts and practices.

Updated September 2013

Faculty Medical Center

Content Goals and Objectives

1. Manage hypertension
2. Manage diabetes
3. Manage hyperlipidemia
4. Manage acute and chronic cough /Asthma/COPD
5. Manage common symptoms: Headache, Sinusitis, Fatigue, Dizziness, Insomnia, Syncope
6. Differentiate cardiac versus non-cardiac chest discomfort and order appropriate diagnostic testing.
7. Recognize the indications for anticoagulation and manage chronic therapy.
8. Manage acute and chronic back pain
9. Manage musculoskeletal, acute & chronic pain syndromes
10. Initiate workup for a new breast mass
11. Manage osteoporosis
12. Initiate anemia workup
13. Manage depression & anxiety
14. Initiate workup for hypo / hyperthyroidism and thyroid nodule.
15. Distinguish skin lesions or findings that are normal, transient, or clinically insignificant from those that warrant observation, evaluation, or treatment
16. Implement appropriate disease prevention guidelines, risk factor assessment, and health promotion.
17. Appropriately manage perioperative patients including preoperative risk stratification

Process-Based Goals and Objectives

1. Gathers subtle, sensitive, and complicated information that may not be volunteered by the patient.
2. Perform an accurate physical exam.
3. Develop prioritized differential diagnoses.
4. Develop an evidence-based diagnostic and a therapeutic plan
5. Integrate clinical evidence into decision making
6. Recognize the scope of his/her abilities and ask for supervision and assistance appropriately
7. Minimize unnecessary care including tests.
8. Provide appropriate preventive care
9. Evaluate complex medical patient in a timely manner
10. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

Procedures

1. Throat culture
2. Removal of cerumen safely and effectively
3. Breast exam
4. Pelvic/Papanicolaou smear & wet preparation of vaginal discharge
5. Perform digital rectal examination.
6. Joint aspiration and steroid injection
7. Skin Biopsy

REFERENCES

1. Primary Care Medicine: Office Evaluation and Management of the Adult Patient. Allan H. Goroll MD, Albert G. Mulley Jr. MD MPP
2. Principles of Ambulatory Medicine. L. Randol Barker MD , Nicholas H. Fiebach , David E. Kern, Patricia A. Thomas, Roy C. Ziegelstein, Philip D. Zieve
3. Harrison's Principles of Internal Medicine: Volumes 1 and 2, 18th Edition. Dan Longo, Anthony Fauci , Dennis Kasper, Stephen Hauser, J. Jameson, Joseph Loscalzo
4. Up To Date Online Resource
5. MKSAP 16
6. MedStudy

Updated July 2013

Outpatient Orthopedics

Content Goals and Objectives

- Understand the basic anatomy of the upper and lower extremity
- Recommend imaging for specific Orthopedic conditions
- Learn basic x-ray interpretation of the injured extremity.
- Understand the principles and practice of splint and cast application.
- Perform a competent examination of the major joints including the shoulder and the knee as well as the minor joints, e.g. the wrist, hand and digits.
- Learn the indications for therapeutic joint injections.
- Demonstrate proper technique in performing therapeutic joint injections of the knee, shoulder and trochanteric bursa.

Process-Based Goals and Objectives

- Perform an orthopedic evaluation including chief complaint, HPI, relevant past medical history and appropriate physical exam with particular focus on the injured or affected joint(s).
- Recognize which orthopedic conditions can be effectively diagnosed and treated by a internist and which problems require referral for specialty care.
- Develop prioritized differential diagnoses.
- Develop an evidence-based diagnostic and therapeutic plan.
- Integrate clinical evidence into decision making.
- Recognize the scope of his/her abilities and ask for supervision and assistance appropriately.
- Minimize unnecessary care including tests.
- Provide appropriate preventive care
- Evaluate complex medical patient in a timely manner
- Demonstrate empathy, compassion, and a commitment to relieve pain and suffering

Rotation Specifics

- Please contact office prior to the start of your rotation to find out the specifics of where and when to meet the attending on the first day.
- This is a rotation that is for ½ month.
- Must attend morning lectures at Good Samaritan Hospital.

References

- MKSAP 16
- MedStudy
- Uptodate.com

Outpatient ENT

Content Goals and Objectives

- Understand the basic anatomy of the upper respiratory system.
- Understand the complications and management of otitis media and externa, acute and chronic sinusitis, hoarseness, tinnitus, hearing loss and allergic rhinitis.
- Recommend imaging for specific upper respiratory tract disorders.
- Identify treatment options for a upper respiratory system infections.

Process-Based Goals and Objectives

- Gather subtle, sensitive, and complicated information that may not be volunteered by the patient.
- Perform an accurate physical exam.
- Develop prioritized differential diagnoses.
- Develop an evidence-based diagnostic and therapeutic plan.
- Integrate clinical evidence into decision making.
- Recognize the scope of his/her abilities and ask for supervision and assistance appropriately.
- Minimize unnecessary care including tests.
- Provide appropriate preventive care
- Evaluate complex medical patient in a timely manner
- Demonstrate empathy, compassion, and a commitment to relieve pain and suffering

Rotation Specifics

- Please call office prior to the start of the rotation to find out the specifics of when and where to meet the attending.
- Rotation is ½ month.
- Must attend morning lectures at Good Samaritan Hospital.

References

- MKSAP 16
- MedStudy
- Uptodate.com

Dermatology

Content Goals and Objectives

- Distinguish skin lesions or findings that are normal, transient, or clinically insignificant from those that warrant observation, evaluation, or treatment
- Describe the differential diagnoses of primary and secondary skin lesions: **Macules or papules, Vesicles or bullae, Pustules, Purpura, Hypopigmented lesions, Hyperpigmented lesions, Vascular lesions, Atrophic lesions, Associated scaling of lesions**
- Understand the effects and appropriate use of common dermatological drugs, including various topical preparations.
- Understands indications for and appropriate use of **skin biopsies** [ie. Punch, Shave], **skin excisions, KOH skin scraping preps, Skin cultures, Cryotherapy**

Process-Based Goals and Objectives

- Gather subtle, sensitive, and complicated information that may not be volunteered by the patient.
- Perform an accurate physical exam.
- Develop prioritized differential diagnoses.
- Develop an evidence-based diagnostic and therapeutic plan.
- Integrate clinical evidence into decision making.
- Recognize the scope of his/her abilities and ask for supervision and assistance appropriately.
- Minimize unnecessary care including tests.
- Provide appropriate preventive care
- Evaluate complex medical patient in a timely manner
- Demonstrate empathy, compassion, and a commitment to relieve pain and suffering

Rotation Specifics

- Please contact office prior to the start of the rotation to get the specifics of where and when to meet the attending
- This rotation is ½ month.
- Must attend morning lectures at Good Samaritan Hospital.

References

- MKSAP 16
- MedStudy
- Uptodate.com

Physical Medicine & Rehabilitation

Content Goals and Objectives

- Identify the distinction between impairments, disabilities, and community limitations.
- Identify various methods to assess and measure neuromuscular function [EMG, NCS]
- Possess a basic fund of knowledge regarding common clinical scenarios encountered in the inpatient and outpatient rehab settings:
- Spasticity: its classification, characteristics and management
- Spinal Cord injury: its classification system, rehabilitation, and associated medical complications
- Traumatic Brain Injury: characteristics and rehabilitation
- Deconditioning/Immobility and prevention/treatment of potential complications (including but not limited to basic tracheostomy care, DVT, decubitus ulcers)
- Basic Pain Management: characteristics of various types of pain and basic pain management options
- Neurogenic Bowel/bladder: the characteristics of the various types and their respective management
- Stroke Rehabilitation
- Autonomic Dysreflexia: its characteristics and management

Process-Based Goals and Objectives

- Gather subtle, sensitive, and complicated information that may not be volunteered by the patient.
- Perform an accurate physical exam.
- Develop prioritized differential diagnoses.
- Develop an evidence-based diagnostic and therapeutic plan.
- Integrate clinical evidence into decision making.
- Recognize the scope of his/her abilities and ask for supervision and assistance appropriately.
- Minimize unnecessary care including tests.
- Provide appropriate preventive care
- Evaluate complex medical patient in a timely manner
- Demonstrate empathy, compassion, and a commitment to relieve pain and suffering

Rotation Specifics

- Please call the office prior to the start of the rotation to arrange where and when to meet the attending.
- Rotation is ½ month in length.
- Must attend morning conferences at Good Samaritan Hospital.

References

- MKSAP 16
- MedStudy
- Uptodate.com

Hospitalist Medicine

Content Goals and Objectives:

1. Initial basal bolus insulin therapy and manage blood glucose over time.
2. Manage elevated blood pressure.
3. Diagnose the cause of loss of consciousness and differentiate syncope from other etiologies.
4. Initiate appropriate antibiotic(s) for pneumonia.
5. Initiate appropriate antibiotic(s) for skin and soft tissue infections.
6. Choose the appropriate form of VTE prophylaxis.
7. Apply the proper diagnostic test in the workup of VTE.
8. Recognize and manage exacerbations of obstructive lung disease.
9. Manage derangements of potassium.
10. Recognize delirium and identify potential causes.
11. Initiate cost-effective workup of anemia.
12. Initiate workup and proper therapy of diabetic foot ulcers.
13. Assess and treat pain as a part of daily plan.
14. Initiate workup and management of fever.
15. Perform History and Physical in a timely manner with timely documentation.

Process Based Goals and Objectives:

1. Acquire accurate and relevant history.
2. Perform an accurate physical exam.
3. Develop prioritized differential diagnoses.
4. Develop an evidence-based diagnostic and therapeutic plan.
5. Demonstrate accurate medication reconciliation.
6. Provide accurate, complete, and timely documentation.
7. Identify the appropriate clinical question for consultative services.
8. Identify clinical questions as they emerge in patient care activities and access medical information resources.
9. Perform bedside presentations that engage the patient and focus the discussion around the patient's central concerns.
10. Minimize unfamiliar terms during patient encounters.
11. Demonstrate shared decision-making with the patient.
12. Use teach-back method with patients regarding medications and plan.
13. Communicate with primary care physicians.

14. Recognize the scope of his/her abilities and ask for supervision and assistance appropriately.
15. Minimize unnecessary care including tests.
16. Use feedback to improve performance.
17. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

Rotation Specifics:

1. Contact Beth Mack or Chief resident to request rotation.
2. Rotation will consist of working at least 4 days per week and will try to match up with one physician to better learn the hospitalist experience.
3. When working must attend morning conferences.
4. Must communicate with Beth Mack or Chief resident when resident has a day off so that he/she can be excused from conference attendance.

References:

- Cecil Textbook of Medicine. 24th Edition. Edited by J.B. Wyngaarden, L.H. Smith. W.B. Saunders, Philadelphia, 2012.
- Harrison' Principles of Internal Medicine. 18th edition. Edited by E. Braunwald, K.J. Isselbacher, R.G. Petersdorf, J.D. Wilson, J.B. Martin, A.F. Fauci. McGraw-Hill, New York, 2012.
- Principles and Practices of Hospital Medicine. 2012. McKean, S.C., Ross, J.J., Dressler, D.D., Brotmna, D.J., Ginsberg, J.S. McGraw-Hill, New York, 2012.
- Up-to-date Online Resource
- Current MKSAP 16

Women's Health

Content Goals and Objectives:

1. Demonstrate respectful and professional manner during sensitive physical exam maneuvers.
2. Perform a routine pelvic and breast exam.
3. Initiate workup for a new breast lump.
4. Manage a patient at-risk for osteoporosis.
5. Initiate workup for a patient with amenorrhea.
6. Manage a patient with dysfunctional uterine bleeding.
7. Initiate workup for a polycystic ovarian syndrome.
8. Manage a patient with perimenopausal symptoms.
9. Provide age-appropriate cancer screening (breast, cervical)

Process Based Goals and Objectives:

1. Gather subtle, sensitive, and complicated information that may not be volunteered by the patient.
2. Perform an accurate physical exam.
3. Develop prioritized differential diagnoses.
4. Develop an evidence-based diagnostic and therapeutic plan.
5. Integrate clinical evidence into decision making.
6. Recognize the scope of his/her abilities and ask for supervision and assistance appropriately.
7. Minimize unnecessary care including tests.
8. Provide appropriate preventive care.
9. Evaluate complex medical patient in a timely manner.
10. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

Rotation Specifics:

1. Contact Beth Mack or Chief resident to request rotation.
2. Must attend morning lectures at Good Samaritan Hospital.

Primary Care Medicine

Content Goals and Objectives:

1. Recognize when to refer to specialist.
2. Initiate workup of thyroid disease.
3. Manage complicated diabetes patients.
4. Obtain thorough dermatologic history.
5. Appropriately describe rash.
6. Manage chronic sinusitis.
7. Demonstrate rehabilitation exercises for chronic low back pain.
8. Assess functional impairment as part of disability evaluation.
9. Describe resources available to hospice patients.
10. Describe resources available to elderly patients.

Process-Based Goals and Objectives:

1. Gather subtle, sensitive, and complicated information that may not be volunteered by the patient.
2. Perform an accurate physical exam.
3. Develop prioritized differential diagnoses.
4. Develop an evidence-based diagnostic and therapeutic plan.
5. Integrate clinical evidence into decision making.
6. Recognize the scope of his/her abilities and ask for supervision and assistance appropriately.
7. Minimize unnecessary care including tests.
8. Provide appropriate preventive care.
9. Evaluate complex medical patient in a timely manner.
10. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering.

Rotation Specifics:

1. Please contact Beth Mack or Chief Resident to request rotation.
2. Must attend morning lectures at Good Samaritan hospital.

Disciplinary Policy

Professionalism is the cornerstone of our most special profession. We aim to instill in each resident the highest form of conduct possible in the professional realm. If professionalism is breached then the following policies will be held to encourage daily pursuit of characteristics worthy of our calling.

- Each breach of policy will accrue one point.
- Egregious acts are always open to discipline deemed appropriate by Dr. Friedstrom.
- 3 points will cause one to accumulate an extra call day.
- The call will be taken from someone with perfect or very good conduct and given to the one not performing their duties.
- Each point after 3 gets one extra call.
- If 8 points are reached then the resident will be given an unsatisfactory evaluation on professionalism and will need to meet with Dr. Friedstrom and possibly the Resident Evaluation Committee and Graduate Medical Education if deemed necessary by Dr. Friedstrom.
- Breaches of conduct need to be reported to Beth Mack, Dr. Friedstrom, or Dr. Mena.

Policies:

1. Late to Conference
2. Late/Missing/Leaving early from rotation.
3. Not carrying pager/not forwarded to covering resident
4. Not signing out EPIC when leaving for vacation/elective
5. Not clearing EPIC in-basket within 48 hours.
6. Not answering pager in timely manner
7. Late/Missing for Clinic.
8. Late/Missing from Call
9. Unprofessional Behavior
10. Poor patient relations.
11. Poor attitude with fellow residents.
12. Poor attitude/relations with nursing staff
13. Disrespectful behavior towards attending.
14. Not reading assigned topics
15. Not finishing clinic note on day of clinic.
16. Leaving without telling those in authority.

Updated July 2013

Senior Residents by Residents and Students

Goals and Objectives

1. Provides regular feedback to other members of the team
2. Role model effective communication skills and challenging situations
3. Perform bedside presentations engage the patient in focus for discussion of around the patient's central concerns
4. Demonstrate shared decision making with the patient
5. Assist colleagues in the provision of duties
6. Demonstrate safe, accurate, and complete hand off
7. Takes leadership role of teaching healthcare team
8. Demonstrate empathy, compassion, and commitment to relieve pain and suffering

Updated July 2013

Interns by Residents and Students

Goals and Objectives

1. Provides regular feedback to other members of the team
2. Demonstrate safe, accurate, and complete hand off
3. Perform bedside presentations engage the patient in focus the discussion around the patient's central concerns
4. Demonstrate shared decision-making with the patient
5. Assist colleagues in the provision of duties
6. Respond to pages in a timely and courteous manner.
7. Demonstrate empathy, compassion, and a commitment to relieve pain and suffering

Updated July 2013

Interns and Residents by Nursing

Goals and objectives

1. Communicate the planned care to all members of the paraprofessional healthcare team
2. Recognize the scope of his/her abilities and asked for supervision and assistance appropriately
3. Maintain patient confidentiality in public setting
4. Communicate obstructive feedback to other members of the healthcare team
5. Demonstrate sensitivity to differences in patient's including race, culture, gender, sexual orientation, social economic status, c, and religious beliefs
6. Will model effective communication skills and challenging situations
7. Perform bedside presentations engage the patient in focus the discussion around the patient's central concerns
8. Demonstrate shared decision-making with the patient and team
9. Demonstrate Timothy, compassion, and a commitment to relieve pain and suffering
10. Respond to pages and timely and courteous manner

Updated July 2013

Good Samaritan Hospital
Internal Medicine
RR/Code Simulation

Anaphylactic Reaction

Scenario: A 54 y/o WM was admitted to the hospital for community acquired pneumonia. She came in with shortness of breath and was found to have leukocytosis, fever, productive cough, and an infiltrate on the chest xray. You are called to the room for a rapid response. The nurse reports that she came to check on the patient and he was gasping for breath. He has a pulse, his BP is 90/50, he is in apparent distress, he is gasping for breath and he has a very high pitched wheezing sound coming from his mouth. On auscultation he has upper airway constriction. His lips are swollen and red. They appear very puffy. His oxygen saturation has now fallen to 80%. He is using his accessory muscles to breath. On history you obtain the information that he was given Rocephin and Zirhromax for CAP. You ask for his allergies and you find out he has a Penicillin allergy listed.

Atrial Fibrillation

Scenario: You are in the ICU on call. You are trying to sleep in the call room as last night you were up all night vomiting with a stomach virus. You are called and the nurse states that the patient you admitted for a drug overdose is now tachycardic with heart rate in the 140-170 range. What should she do?

Pulseless Electrical

Scenario: You are on call lounging in the doctors lounge wanting to go home. The code blue pager goes off. You arrive at the patients room and there is a plethora of people in the room. They came to check on the patient and the patient was not breathing. You check the pulse and there is no pulse. Chest compressions are started and the patient is hooked up to the crash cart.

VFIB/VTACH

Scenario: Code pager goes off and it says to go the Dixmyth lobby parking lot. You arrive in the parking lot to find a man on the ground with his son doing chest compressions. You take over chest compressions and he tells you that he was just walking in to see their relatives new baby and he just fell face first to the ground.

Supraventricular Tachycardia

Scenario: Called to patients room due to racing heart rate. Patient is sitting up in bed and is feeling ok. She is able to talk to you and answer your questions. On the monitor it is narrow complex tachycardia that is 180-200 bpm. Her BP is stable at 100/60, no chest pain, no diaphoresis, no dizziness or lightheadedness.

Good Samaritan Hospital
Internal Medicine
RR/Code Simulation Grade Sheet

Anaphylactic Reaction Objectives: For Team Leader

Specific Points	Yes	No
Calm the situation		
Ask for History		
Ask for vital signs		
Ask about medications given		
Ask for allergies		
Listen to heart and lungs		
Check for pulse		
Diagnose Anaphylactic Reaction		
Bag Mask Patient		
Put oxygen on at 100%		
Ask nurse for Epinephrine Injection		
Order IM 1 mg/mL 0.3-0.5 mg		
Repeat in 3 minutes		
Tell nurse no we do not need Solu-Medrol		
Open fluids wide open for BP		
Put patient in Trendelenberg		
Consider Intubation		
Reconsider Solu-Medrol and give		

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Atrial Fibrillation Objectives: For Team Leader

Specific Points	Yes	No
Tell nurse you will come see patient		
Arrive at bedside and assess		
Get Vitals		
Order EKG		
Diagnose Atrial Fibrillation		
Decide patient is stable so no shock needed		
Assess vitals and BP is stable so will try to rate control		
Order Cardizem Bolus of 10-20 mg		
Order drip starting at 5 mg		
Titrate to HR <120		
Hold for SBP <90		
Start Heparin Drip		

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Pulseless Electrical Activity Objectives: For Team Leader

Specific Points	Yes	No
Check Pulse		

Start Chest Compressions		
Place pads on Patient		
Bag-Mask Ventllate Patient (1 breath q 6 seconds)		
Ask for Recorder		
Pulse/Rhythm check at 2 Minutes		
No pulse, Sinus rhythm		
Restart Chest compressions		
1 mg Epinephrine		
Diagnose PEA		
Start Discussing H's and T's		
2 minute pulse and rhythm check		
Still PEA, restart chest compressions		
EPI 1 mg 3 mintues after first dose		
Pulse/Rhythm check		
Still PEA, restart chest compressions		
Pulse/Rhythm check		
Still PEA/restart Chest compressions		
EPI 1 mg		
Pulse/Rhythm check		
Pulse with Bradycardia at 30 bpm		
Give Atropine 0.5 mg IV		
Discuss securing airway		

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H's and T's	Yes	No
Hypovolemia (wide open fluids)		
Hypoxia (give oxygen)		
Hypo/hyperelectrolytes (look up labs)		
Hypoglycemia (FSBS)		
Hypo/Hyperthermia (check Temperature)		
Hydrogen Ion (Get blood gas, look at labs)		
Tension Pneumothorax		
Cardiac Tamponade		
Thrombosis (cardiac/pulmonary)		
Toxins		
Trauma		

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Ventricular Fibrillation/Tachycardia Objectives: For Team Leader

Specific Points	Yes	No
Start Chest compressions		
Call for AED and help		
Give chest compressions and breaths at 30:2 ratio		
AED arrives and hook up		
Analyze and advise shock so shock		
Continue chest compressions		

Hook up to monitor		
Do pulse and rhythm check at 2 minutes		
Breaths at 6 second intervals		
Diagnose VTach with no pulse		
Shock at 200 Joules		
Chest compressions		
Give 1 mg EPI		
Get Amiodarone ready (300 mg)		
Rhythm and pulse check at 2 minutes		
VTach, No pulse		
Shock at 300 Joules		
Restart Chest Compressions		
Give 300 mg Amiodarone		
Check pulse and rhythm at 2 minutes		
Diagnose Torsades		
Shock at 360 Joules		
Restart chest compressions		
Order Magnesium sulfate 2 grams IV		
Recheck pulse and rhythm at 2 minutes		
No pulse sinus tachycardia		
Restart chest compressions		
Give 1 mg EPI		
Check pulse/rhythm at 2 minutes		
Pulse present with Sinus tachycardia		
Discuss intubation		
Transfer to ER		
Start Hypothermia Protocol		

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Supraventricular Tachycardia Objectives: For Team Leader

Specific Points	Yes	No
Check patient for pulse		
Talk to patient		
Ask for 3 symptoms		
Check Vitals		
Diagnose narrow complex tachycardia		
Order EKG		
Order Adenosine 6 mg		
Tell patient about affect of adenosine		
Give adenosine 6 mg		
Diagnose Narrow complex tachycardia		
Give Adenosine 12 mg		
Diagnose Atrial Flutter on EKG		
Recognize rate rising		
Order amiodarone infusion		
Bolus 150 mg		

Start drip at 1 mg/hr for first 6		
Then order 0.5 mg/hr for next 18 hours		
Consult Electrophysiologist for Atrial Flutter		

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Internal Medicine-PGY 1 June 2013-Anaphylactic Reaction

Learning Objectives	Case Presentation	Scenario Algorithm
<p>Following this simulation the participant will:</p> <ol style="list-style-type: none"> 1. Perform a rapid physical assessment 2. Identify immediate life-threatening conditions 3. Perform a thorough history that includes PMH, medications, and allergies 4. Recognize and describe S&S of anaphylactic reactions 5. Assess and manage a compromised airway 6. Defend appropriate pharmacological interventions for anaphylactic reactions 7. Discuss common patient safety measures to prevent medication errors <p>Simulator: Meti HPS</p> <p>Moulage: Urticaria on face/body</p> <p>Room Setup: Room 5, pt in bed, gowned, IV initiated, antibiotic infusion on pump, allergy bracelet with PCN label</p> <p>Equipment: Crash cart available, have Epi 1:1000 and SoluMedrol available</p>	<p>Goal: This scenario is designed to present an anaphylactic reaction as the result of an inappropriate medication administration (antibiotic administration to patient with PCN allergy). The participant is expected to begin the scenario by collecting pertinent information from bedside nurse, identify immediate the immediate life-threatening condition, and appropriately select a treatment plan.</p> <p>Past Medical History: Asthma, HTN, hyperlipidemia Medications: Albuterol (PRN), Coreg Drug Allergies: PCN</p> <p>Scenario: A 54 y/o WM was admitted to the hospital for community acquired pneumonia. She came in with shortness of breath and was found to have leukocytosis, fever, productive cough, and an infiltrate on the chest xray. You are called to the room for a rapid response. The nurse reports that she came to check on the patient and he was gasping for breath.</p> <p>Primary: Pt is alert, oriented x4. Initial visual of patient includes swollen lips, urticaria developing. Airway presents with apparent partial obstruction (due to pharyngeal/laryngeal edema), subtle stridor becoming progressively worse. Breathing is labored/rapid/shallow, one/two word sentences. Breath sounds present with wheezing.</p> <p>Secondary: The critical intervention following the primary assessment is the order of Epi IM 1 mg/mL 0.3-0.5 mg. The medication will be presented to the participant by the bedside nurse, but the nurse will be pulled back out of the room, leaving the participant to deliver the medication. Along with the Epi, airway management should be initiated via BVM with oxygen therapy. The participant should also recognize the need to discontinue the antibiotic infusion. One repeat dose the order of Epi IM 1 mg/mL 0.3-0.5 mg will be needed in 3 minutes following initial dose.</p> <p>Tertiary: Following the second dose on Epi, repeat of vital signs will indicate need for fluid administration (and possibly repositioning). The airway will remain swollen, though patent; a swollen but patent airway requires serious consideration to intubate. Continued positive response to the Epi will also allow the appropriate consideration for Solu-Medrol.</p>	<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p>Initial Presentation</p> <ul style="list-style-type: none"> • AVPU= Alert • Resp. Stridor, labored, shallow, one/two word </div> <p style="text-align: center;">↓</p> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p>Case Progression</p> <ul style="list-style-type: none"> • From the initial presentation, the symptoms will remain as such until first dose of Epi is given. • If no initial dose of Epi is given the airway will </div> <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; padding: 5px; width: 45%;"> <p>Intended Direction</p> <ul style="list-style-type: none"> • Following initial dose of Epi, pt will positively response • No change in vital signs, which warrants repeat Epi • Following second </div> <div style="border: 1px solid black; padding: 5px; width: 45%;"> <p>Alternative Direction</p> <ul style="list-style-type: none"> • Solu-Medrol admin. results in decrease in mental status, airway occlusion • No repeat Epi results in no improvement in airway/stridor </div> </div> <p style="text-align: center;">↓</p> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p>Delayed Recovery</p> <ul style="list-style-type: none"> • Respiratory arrest • Persistent hypotension </div> <p style="text-align: center;">←</p> <div style="border: 1px solid black; padding: 5px;"> <p>Case Termination</p> <ul style="list-style-type: none"> • Complaint resolution </div>

Internal Medicine-PGY 1 June 2013- Atrial Fibrillation

Learning Objectives	Case Presentation	Scenario Algorithm
<p>Following this simulation the participant will:</p> <ol style="list-style-type: none"> 1. Perform a rapid physical assessment 2. Perform a thorough history that includes PMH, medications, and allergies 3. Recall causes of tachycardia and their appropriate treatments 4. Discuss the indications and contraindications for accessing a central venous catheter 5. Describe the treatment of stable atrial fibrillation 6. Describe criteria for treating a cardiac dysrhythmia as unstable <p>Simulator: Meti HPS Moulage: None Room Setup: Standard patient care room Equipment: CVC mocked for right internal jugular placement, peripheral IV established with 125 mL/hr on pump</p>	<p>Goal: This scenario is designed to first establish the stable vs. unstable patient and then select appropriate treatment for atrial fibrillation.</p> <p>Past Medical History: Illicit drug use, Hepatitis C, asthma Medications: Oxycodone, methadone Drug Allergies: IVP</p> <p>Scenario: You are in the ICU on call. You are trying to sleep in the call room as last night as you were up all night vomiting with a stomach virus. You are called and the nurse states that the patient you admitted for a drug overdose is now tachycardic with heart rate in the 140-170 range.</p> <p>Primary: Patient presents as responsive to verbal stimuli. Airway is open, clear, and patent. Breathing is assessed as adequate; chest rise WNL, breath sounds clear bilaterally. Central and peripheral pulses present, though peripheral pulse are weaker. Skin in warm, dry, natural color.</p> <p>Secondary: Vital signs indicate the patient's status is stable and an ECG shows the rhythm is atrial fibrillation with rapid ventricular response. An order of cardizem is needed with a loading bolus of 10-20 mg followed by maintenance infusion of 5 mg. Participant will need to select CVC vs. peripheral IV for infusion.</p> <p>Tertiary: Discussion for this patient will include the continued use of the cardizem infusion with the titration for a HR < 120 bpm or SBP < 90 mmHg. Also for consideration is initiating a heparin infusion.</p>	<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p style="text-align: center;">Initial Presentation</p> <ul style="list-style-type: none"> • AVPU= (responsive to verbal) </div> <p style="text-align: center;">↓</p> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p style="text-align: center;">Case Progression</p> <ul style="list-style-type: none"> • This patient is presented as a stable dysrhythmia and pharmacological intervention is warranted • No major physiological changes will occur unless </div> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 5px; width: 45%;"> <p style="text-align: center;">Intended Direction</p> <ul style="list-style-type: none"> • Assess the patient • Obtain ECG and vital signs • Diagnose Afib with RVR • Order cardizem bolus and infusion </div> <div style="border: 1px solid black; padding: 5px; width: 45%;"> <p style="text-align: center;">Alternative Direction</p> <ul style="list-style-type: none"> • Failure to establish the patient is stable • Selects electrical or alternative drug therapies </div> </div> <p style="text-align: center;">↓</p> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p style="text-align: center;">Delayed Recovery</p> <ul style="list-style-type: none"> • Rhythm converts to pulseless VTach </div> <p style="text-align: center;">←</p> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p style="text-align: center;">Case Termination</p> <ul style="list-style-type: none"> • Dysrhythmia resolves </div>

Internal Medicine-PGY 1 June 2013-Pulseless Electrical Activity

Learning Objectives

- Following this simulation the participant will:
8. Perform a rapid physical assessment
 9. Demonstrate basic and advanced airway management techniques during a cardiac arrest
 10. Perform a thorough history that includes PMH, medications, and allergies
 11. Recall the H's and T's and apply them to a patient in PEA
 12. Discuss logistical and safety concerns commonly encountered with Code Team response.

Simulator: Meti HPs

Moulage: None

Room Setup: Standard patient care room.

Additional bystanders may be staged as family/friends visiting.

Equipment: Crash cart

Case Presentation

Goal: This scenario is designed to recall the H's and T's from the PEA algorithm.

Past Medical History: MI, CABG, CAD, HTN

Medications: Unavailable

Drug Allergies: NKDA

Scenario: You are on call in the doctors lounge wanting to go home. The code blue pager goes off. You arrive at the patients' room and there is a plethora of people in the room. They came to check on the patient and the patient was not breathing.

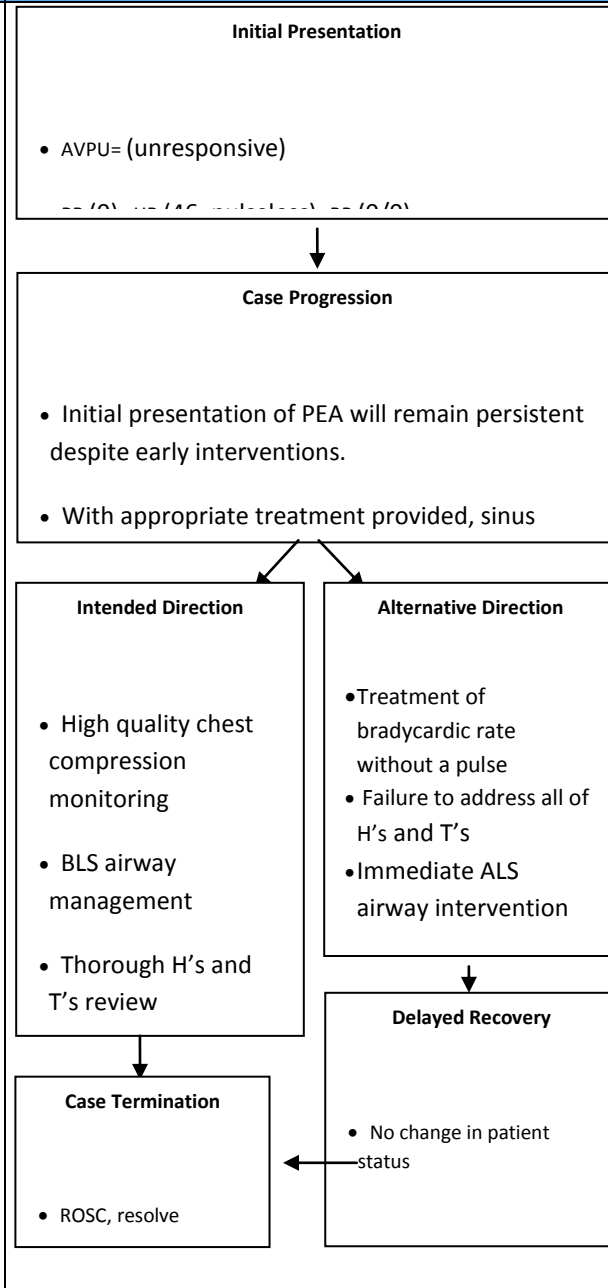
Primary: Pt is found to be unresponsive to all stimuli. Airway open, partially obstructed by tongue, free of foreign objects/fluid. Breathing is absent. No central/peripheral pulses are present. Code Team members arrive shortly after primary survey is complete.

Secondary: Chest compressions are continued, breathing is supported by BVM. Application of ECG reveals organized rhythm and no pulse, leading to diagnosis of PEA. Administration of Epi continues appropriately. Begin sorting H's and T's.

Tertiary: Following two additional rounds of Epi, rhythm check reveals organized bradycardia with a pulse. Treat bradycardia with atropine. Discuss further airway management.

Hypovolemia (wide open fluids)
Hypoxia (give oxygen)
Hypo/hypermolelectrolytes (look up labs)
Hypoglycemia (FSBS)
Hypo/Hyperthermia (check Temperature)
Hydrogen Ion (Get blood gas, look at labs)
Tension Pneumothorax
Cardiac Tamponade
Thrombosis (cardiac/pulmonary)
Toxins
Trauma

Scenario Algorithm



Internal Medicine-PGY 1 June 2013-VFIB/VTACH

Learning Objectives	Case Presentation	Scenario Algorithm
<p>Following this simulation the participant will:</p> <ol style="list-style-type: none"> 7. Perform a rapid physical assessment 8. Identify immediate life-threatening conditions 9. Perform a thorough history that includes PMH, medications, and allergies 10. Recall priorities for the cardiac arrest patient 11. Assess and manage a compromised airway 12. Manage a cardiac arrest patient according to AHA and ACLS 13. Discuss logistical and safety concerns commonly encountered with Code Team response. <p>Simulator: Laerdal SimMan Moulage: None Room Setup: Room 6, Lobby/office furniture Equipment: Provide initial participants with AED and BVM ONLY. Secondary participants will bring in the crash cart/Lifepack.</p>	<p>Goal: This scenario is designed reinforce the ventricular fibrillation (VFib) algorithm from ACLS. Limited resources and personnel in an environment that is not close to patient care facilities especially challenge the first few minutes of a resuscitation. Participants will be provided with an AED and BVM for the first four minutes of the case. After four minutes, additional Code team member (sent to the wrong lobby) will arrive with crash cart.</p> <p>Past Medical History: Unknown Medications: Unknown Drug Allergies: Unknown</p> <p>Scenario: Code pager goes off and it says to go the Dixmyth lobby. You arrive in the lobby to find a man on the ground with his son doing chest compressions. You take over chest compressions and he tells you that he was just walking in to see their relatives' new baby and he fell face first to the ground.</p> <p>Primary: Pt is found supine on floor. Pt is unresponsive to all stimuli. Airway is obstructed by tongue, no foreign objects/fluid appear to be present. Breathing is absent. No central or peripheral pulses are present. Skin is pale, warm, dry. Participants will be provided with an AED and BVM for the first four minutes of the case. Emphasis of quality chest compressions and 30:2 delivery will be made during this time.</p> <p>Secondary: After four minutes, additional Code team member (sent to the wrong lobby) will arrive with crash cart, ECG can be applied and pulseless VTach will be identified. Additional defibrillations will be delivered at the appropriate time intervals. Epi and amiodarone will also be delivered at their respective time intervals.</p> <p>Tertiary: After approximately 7-10 minutes into arrest, ECG converts to Torsades for Mag sulfate 2 grams delivered. After two minutes ECG rhythm changes to sinus tachycardia without a pulse. Repeat one additional Epi. ROSC is then presented. Discussion of intubation/hypothermia protocol/transfer to ED.</p>	<div style="text-align: center;"> <p>Initial Presentation</p> <ul style="list-style-type: none"> • AVPU= (Unresponsive) </div> <p style="text-align: center;">↓</p> <div style="text-align: center;"> <p>Case Progression</p> <ul style="list-style-type: none"> • VFib with AED • Pulseless VT when Lifepack arrives </div> <div style="display: flex; justify-content: space-around;"> <div style="width: 45%;"> <div style="text-align: center;"> <p>Intended Direction</p> <ul style="list-style-type: none"> • Torsades and mag sulfate • PEA (tachycardia) • ROSC </div> <p style="text-align: center;">↓</p> <div style="text-align: center;"> <p>Case Termination</p> <ul style="list-style-type: none"> • Transfer to ED </div> </div> <div style="width: 45%;"> <div style="text-align: center;"> <p>Alternative Direction</p> <ul style="list-style-type: none"> • Persistently inadequate chest compressions result in asystole • Inappropriate airway management </div> <p style="text-align: center;">↓</p> <div style="text-align: center;"> <p>Delayed Recovery</p> <ul style="list-style-type: none"> • No change in patient status-asystole </div> <p style="text-align: center;">←</p> </div> </div>

Internal Medicine-PGY 1 June 2013- Supraventricular Tachycardia

Learning Objectives	Case Presentation	Scenario Algorithm
<p>Following this simulation the participant will:</p> <ol style="list-style-type: none"> 14. Perform a rapid physical assessment 15. Perform a thorough history that includes PMH, medications, and allergies 16. Differentiate various underlying rhythms while treating SVT 17. Demonstrate safe and appropriate use of synchronized cardioversion 18. Describe the treatment of stable atrial flutter 19. Describe criteria for treating a cardiac dysrhythmia as unstable <p>Simulator: Meti HPS</p> <p>Moulage: None</p> <p>Room Setup: Room 5, pt sitting up in bed, gowned, IV initiated</p> <p>Equipment: Crash cart available</p>	<p>Goal: This scenario is designed to assess the patient with cardiac dysrhythmias and differentiate the stable vs. unstable patient.</p> <p>Past Medical History: HTN, skin cancer, GERD</p> <p>Medications: HCTZ, Prilosec</p> <p>Drug Allergies: NKDA</p> <p>Scenario: Called to the patient's room for nurse reporting "racing heart rate". Onset of symptom is sudden. No immediate pain is associated with complaint; no chest pain/diaphoresis/dizziness/lightheadedness.</p> <p>Primary: Pt is alert, oriented x4. Pt complains of racing heart rate. Airway is open, clear, and patent. Breathing is slightly labored; tidal volume is within normal limits (WNL), rate may be slightly elevated, breath sounds are clear bilaterally. Peripheral and central pulses are present/equal. Skin is warm, dry, natural color. Pt is not in an immediately life-threatening state.</p> <p>Secondary: Detailed physical examination will reveal no further significant findings. ECG should be ordered and narrow complex tachycardia should be confirmed. Initial dose of Adenosine is administered with fluid bolus, though no effect will be observed. Repeat dose of Adenosine administered with fluid bolus will reveal atrial flutter on ECG.</p> <p>Tertiary: Pt's status deteriorates from initial presentation with complaints to now include "heaviness in chest", decreased blood pressure, and altered mental status. A synchronized cardioversion will be required (one shock if immediately administered, two shocks if delayed). Following cardioversion, the patient's status returns to stable atrial flutter. To treat the atrial flutter, an amiodarone bolus of 150 mg/10 minutes will be delivered followed by an infusion (1 mg/hour for the first six hours, 0.5 mg for the next 18 hours). The case will terminate when the appropriate amiodarone dose for bolus/infusion is identified by participants.</p>	<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p style="text-align: center;">Initial Presentation</p> <ul style="list-style-type: none"> • AVPU= (alert, oriented x4) </div> <p style="text-align: center;">↓</p> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p style="text-align: center;">Case Progression</p> <ul style="list-style-type: none"> • From the initial presentation the patient's status should not change unless life-threatening treatment is delivered </div> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 5px; width: 45%;"> <p style="text-align: center;">Intended Direction</p> <ul style="list-style-type: none"> • Identify stable SVT • Attempt loading dose of adenosine • Repeat adenosine • Synchronized cardioversion </div> <div style="border: 1px solid black; padding: 5px; width: 45%;"> <p style="text-align: center;">Alternative Direction</p> <ul style="list-style-type: none"> • Inappropriately diagnoses ECG • Attempts alternative drug/electrical therapies </div> </div> <p style="text-align: center;">↓</p> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p style="text-align: center;">Case Termination</p> <ul style="list-style-type: none"> • Complaint resolution </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p style="text-align: center;">Delayed Recovery</p> <ul style="list-style-type: none"> • ECG falls into V-Fib-case termination </div> <p style="text-align: center;">←</p>

Good Samaritan Hospital
Internal Medicine
Central Line Simulation Evaluation

Name: _____

Date: _____

Verbal Checklist

Technique	Yes	No
Consent patient		
Obtain Kit		
Get Gloves		
Get Ultrasound		
Visualize Target		
Mark Site		
Wash hands		
Perform Timeout		
Open Package		
Put on hat and mask		
Put on gloves		
Open Line kit		
Place drape to side		
Cap blue and white ports		
Flush all 3 ports		
Prepare needle		
Draw lidocaine		
Check guidewire		
Cover ultrasound probe		
Place all instruments in order		
Drape patient		
Clean site		
Apply gel		
Visualize target		
Inject Lidocaine		

___/25

Procedural Checklist

Skill	Yes	No
Apply gel		
Hold ultrasound probe in non-dominant hand		
Visualize vein and maintain in center of screen		
Know which direction ultrasound points		

Insert needle bevel up at arrow on probe		
Visualize needle into vein		
Withdraw fluid		
Take off syringe and insert guidewire		
From here on NEVER leave go of guidewire		
Withdraw needle		
Nick skin		
Dilate vessel		
Insert catheter		
Remove guidewire		
Cap red port		
Draw back fluid and flush all ports		

____/16

Procedure Mastery

Performed procedure correctly and efficiently

- Cannot perform procedure without Direct Assistance
- Can perform procedure with proactive, on-going, full supervision
- Can perform procedure with direct supervision
- Can perform procedure acting independently
- Can perform procedure and act as a supervisor/instructor

Line in vessel visualized on Ultrasound

- Yes
- No

Guidewire status

- Perfect
- Minimally bent
- Severely bent
- Mangled beyond reuse

Final Score: _____/41 = _____%

Level of Training:

- Cannot perform procedure without Direct Assistance
- Can perform procedure with proactive, on-going, full supervision
- Can perform procedure with direct supervision
- Can perform procedure acting independently
- Can perform procedure and act as a supervisor/instructor

Lumbar Puncture Simulation

Objective: To expose the resident in a 3 step approach to lumbar puncture. First resident will have a lecture on the indications, complications, risks, and general principles on how to perform the procedure as well as watching a video of the procedure. Secondly, the residents will perform the procedure on the mannequin with their tactile senses and become familiar with the procedure in the simulation lab. Lastly, the residents will then practice the technique of using the Ultrasound to guide the entry site of the needle. They will be encouraged to practice this both on the mannequin and on each other in the simulation lab. The end goal is that they will show competence in this procedure in the simulation lab, will be given a passing grade when they have achieved competence on the mannequin, and then will be able to take this to the bedside under supervision of the attending till they have shown enough skill at the bedside to do it independent of supervision.

Procedure Checklist

Action	Yes	No
Perform Timeout		
Palpate Iliac Crest		
Find L4		
Find L3-L4 Interspace		
Clean area		
Apply Drape		
Anesthetize Area		
Insert Spinal Needle		
Obtain CSF Fluid		
Obtain opening pressure		
Insert Stylet		
Remove needle		

Procedure Mastery

Performed procedure correctly and efficiently

- Cannot perform procedure without Direct Assistance
- Can perform procedure with proactive, on-going, full supervision
- Can perform procedure with direct supervision

Ultrasound Checklist

	Yes	No
Place transducer in transverse axis		
Find L3, L4, L5 Spinous Processes		
Mark the above Spinous Processes		
Place transducer in Sagittal Plane		
Find L3-L4 and L4-L5 Spinous Interspace		
Mark the above interspaces		
Have marking at correct site for needle entry		

Procedure Mastery

Performed procedure correctly and efficiently

- Cannot perform procedure without Direct Assistance
- Can perform procedure with proactive, on-going, full supervision
- Can perform procedure with direct supervision
- Can perform procedure acting independently
- Can perform procedure and act as a supervisor/instructor