CURRICULUM for GENERAL MEDICINE INPATIENT FLOOR ROTATIONS

INTRODUCTION

Bridgeport Hospital's Internal Medicine Residency Program provides physician-trainees with patient-care experiences and instruction to become exemplary internists. This categorical residency includes a minimum of three years of training, characterized by increasing levels of responsibility. The detailed curricula for this program are described herein.

The curriculum addresses all of the requirements of the Residency Review Committee for Internal Medicine, and will include:

I. **Minimal objectives of the rotation** – These are the minimal requirements for successful completion of the rotation. These objectives also correspond to those for promotion.
II. **Educational purpose of rotation** – One or two sentences that describe the overall goal of the rotation.
III. **Principal teaching methods**
IV. Patient characteristics and types of clinical encounters
V. Procedures
VI. **References** – A list of selected references. A *attached to a reference will designate that it is mandatory reading during the rotation.
VII. Methods of evaluation

The Accreditation Council for Graduate Medical Education (ACGME) has endorsed 6 competencies for medical practitioners. These are described in greater detail at http://www.acgme.org/Outcome/, and include:

Patient Care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

Medical Knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care

Practice-Based Learning and Improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

Interpersonal and Communication Skills that result in effective information exchange and teaming with patients, their families, and other health professionals

Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population

Systems-Based Practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value

Global Objectives of the Internal Medicine Residency at Bridgeport Hospital

A. Knowledge :
Over the course of three years, the resident will develop an increasingly in-depth understanding of the pathogenesis, clinical manifestations, natural history, diagnosis, and management of most common and many uncommon medical problems. Residents will learn about these illnesses in a variety of settings, including inpatient, ambulatory, emergency medicine, geriatric, adolescent medicine, and critical care settings. Incremental knowledge is gained experientially. For every patient admitted or evaluated in the outpatient setting, the resident is expected to learn, through the teaching of more senior residents, attending staff, and readings, as much detail as possible about the disease processes and the patient's experience of disease. Repeated exposures to the same disease allows the trainee to master the pathophysiologic foundations of disease and appreciating each patient's experience creates the potential for empathy and engagement with patients to team for their health. Accordingly, as this repertoire of knowledge, skills and experience build, trainees will assume increasing responsibility for patient care, commensurate with their knowledge, level of training, intrinsic abilities, and experiences. At the completion of the program, residents will be able to function independently as general internists to provide exemplary care of patients.

B. Skills and procedures:

1. Mastery of medical history-taking and physical diagnosis using Bayesian analysis to analyze problems.
2. Mastery of medical synthetic reasoning – using Bayesian reasoning to formulate differential diagnoses for patients' problems and create efficacious, evidence-based and cost-effective diagnostic and therapeutic plan.
3. Mastery of medical communication:
   a. Full detailed case presentation

  b. "5 minute" case presentation – the essential elements of the presentation, examination, work-up and problem-based progress to date of any given patient
  c. "Sign-outs" – Ensuring that the verbal and written hand-offs of patients to other physicians on the team are complete and anticipate problems based on prior knowledge of patients' histories.
  d. Written communication – Detailed history/physical/plan ("H&P"), daily progress notes, transfer/off-service notes, discharge notes and consultative notes.
4. Mastery of medical procedures
  a. Mandatory: BLS/ACLS (annual certification required), bi-manual gynecologic examination with PAP smear, arterial blood gas, nasogastric intubation, central venous catheterization, electrocardiography (including ambulatory interpretation).
  b. Highly recommended (depending upon career aspiration): paracentesis, thoracentesis, arthrocentesis, arterial catheterization, lumbar puncture
  c. Optional: elective cardioversion, endotracheal intubation, sigmoidoscopy, pulmonary artery catherization, skin biopsy, temporary pacemaker placement,

C. Professionalism/Attitudes

The qualities and ethical behaviors that constitute the medical professional will be taught, reinforced and evaluated. These are highlighted in the ABIM project "Medical Professionalism in the New Millennium: A Physician Charter," (*Ann Intern Med* 2002; 136: 243) and include:

1. Respect of patient autonomy and the primacy of patient welfare
2. Vigorous patient advocacy – doing whatever is necessary to master an understanding of the patients' illness so as to promote health.
3. Respect of justice – ensuring that patients' rights are respected, guarding against all types of discrimination and advocating for fair distribution of healthcare resources.
4. Commitment to professional competence i.e. the lifelong pursuit of medical knowledge (continuing medical education) for the sake of patients.
5. Commitment to patient confidentiality
6. Guarding against conflicts of interest that can interfere with 1-5 above

In addition, trainees will learn his/her own personal limitations and those of internists in general. The program will cultivate in the trainee humanistic qualities that foster rich and beneficial patient/physician relationships.

D. The 6 Competencies – In addition to *Medical Knowledge* and *Professionalism*, graduates of the program will master application of the other 4 competencies to provide exemplary, humane, evidence-based *Patient Care*, hone their *Communication* skills with patients and allied health providers, using their experiences and facile circumnavigation of the medical literature to pursue the best plan for patients (*Practice-Based Learning*), and utilize in- and outpatient resources to provide most cost- and outcome-effective care (*Systems-Based Learning*).

GENERAL MEDICINE INPATIENT FLOOR ROTATIONS
(Team Care, Private Ward Service, Hospitalist Service):
Trainee's Name _____________________ **Month** ______________

<table>
<tr><th>Time</th><th>Monday</th><th>Tuesday</th><th>Wednesday</th><th>Thursday</th><th>Friday</th><th>Sat/Sun</th></tr>
<tr><td>06:00-07:00</td><td colspan="5">INTERN PRE-ROUNDS</td><td>Intern pre-rd</td></tr>
<tr><td>07:00-08:00</td><td colspan="5">WORK ROUNDS WITH INTERNS & RESIDENT</td><td>(Hosp)AR</td></tr>
<tr><td>08:00-09:00</td><td colspan="2" rowspan="2">MANAGEMENT ROUNDS WITH ATTENDING</td><td>AR</td><td colspan="2" rowspan="2">MANAGEMENT ROUNDS WITH ATTENDING</td><td rowspan="2">(TC)AR
AR</td></tr>
<tr><td>09:00-10:30</td><td>MR</td></tr>
<tr><td>11:00-12:00</td><td colspan="2">MORNING REPORT</td><td>TAR</td><td>MORNING REPORT</td><td>TAR</td><td>ptcare</td></tr>
<tr><td>12:00-13:00</td><td colspan="3">NOON CONFERENCE</td><td>GRAND ROUNDS</td><td>NOON CONFERENCE</td><td>ptcare</td></tr>
<tr><td>03:00-17:00</td><td>ptcare</td><td>ptcare</td><td>ptcare</td><td>ptcare</td><td>ptcare</td><td>ptcare</td></tr>
<tr><td>17:00-18:00</td><td>Sign-out</td><td>Sign-out</td><td>Sign-out</td><td>Sign-out</td><td>Sign-out</td><td>ptcare</td></tr>
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PGY1 Objectives for Wards Medicine

Patient Care
- Gathers pertinent and accurate patient data including old and EMS records
- Written work is complete and organized in a problem-centered format
- Careful follow-up of patient's problems
- Begins to develop appropriate problem-based diagnostic and therapeutic plans
- Organized long and 5-minute oral presentations
- Provides clear instructions about plans of care and follow-up
- Procedures – Competently performs basic procedures[1] (ABG, bladder catheterization, gynecologic exam) and practices proper sterile technique.

Knowledge
- Commitment to CME
- Demonstrates adequate knowledge for common inpatient and outpatient medical conditions
- Begins to apply knowledge appropriately and effectively

Communication
- Caring, respectful behaviors
- Uses effective listening, questioning, and non-verbal communication skills
- Works well with team and consultants; follows and acknowledges all disciplines' input
- Works and communicates effectively and collegially with nursing and ancillary staff
- Teaches medical students

Practice-based learning
- Appreciates the limitations of his/her medical knowledge and asks for help when needed
- Independent study and learns from mistakes
- Responsive to constructive criticism
- Able to use the computerized patient database (Powerchart) effectively to obtain information
- Capable of performing a literature search to obtain some medical information

Professionalism
- Vigorous patient advocate
- Honesty, reliability, responsibility, cooperativeness and timeliness
- Shows respect, compassion, and integrity in working with patients, peers and attendings, and hospital staff
- Follows the rules of the residency program (e.g., work hour regulations)
- Attends the formal educational venues within the residency (60% attendance)

Systems-based practice
- Actuates care and discharge plans expeditiously and completely
- Participates constructively with disposition planning

☐ has successfully achieved the above-listed objectives of this rotation OR
☐ has not successfully achieved the objectives highlighted above.

Electronic Signature of Attending Physician ________________________

☐ I had the opportunity to review my evaluation objectives form with the attending physician. I had sufficient opportunity to meet the above objectives during the rotation.

____

Electronic Signature of Resident _______________________

GENERAL MEDICINE INPATIENT FLOOR ROTATIONS
(Team Care, Private Ward Service, Hospitalist Service):
Trainee's Name ______________________ **Month** _______________

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PGY2 Objectives for Wards Medicine
The PGY2 will demonstrate mastery of the objectives outlined for the PGY1 rotation AND additionally:

Patient Care
- Identifies, prioritizes and synthesizes patient's problems appropriately
- Appreciates and considers alternatives for diagnoses and treatment
- Able to independently develop and carry out management plans in in-patient and out-patient settings
- Orders appropriate tests and interprets results of tests and procedures properly
- Triages patients to appropriate location
- Procedures - Knowledge of procedural indications, complications, and contraindications; obtains informed consent; receives supervision of procedure when skill level requires; documents a complete procedure note in chart and procedure log[1]

Knowledge
- Commitment to CME
- Integrates progressive knowledge in Bayesian synthesis
- Understands and responds to social and behavioral issues

Communication
- Effective counseling for informed decision-making and behavior change
- Increasing leadership of the team to create an educational dynamic and coordinate care
- On in-patient service, ensures that the primary care physician (including clinic residents of staff patients) is kept apprised of the patient's status and is aware of the discharge plans

Practice-based Learning
- Appreciates limitations of his/her medical knowledge and asks for help when needed
- Continues to seek to improve self as a physician
- Addresses and uses evidence from primary scientific studies to guide patient care

Professionalism
- Completes duties in medical records
- Understands ethical principles pertaining to medical care
- Sensitive to patient's culture, age, gender, and disabilities

Systems-based Learning
- Appreciates the resources within the hospital and clinic and able to mobilizes them efficiently to serve the needs of patients
- Shows awareness of cost and length of stay issues and the need to be prudent in utilizing resources
- Working with peers, participates in a Quality Improvement project within the Primary Care Center

______________________ □ has successfully achieved the above-listed objectives of this rotation OR
□ has not successfully achieved the objectives highlighted above.
________________________ (Electronic Signature of Attending Physician)
I had the opportunity to review my evaluation objectives form with the attending physician. I had sufficient opportunity to meet the above objectives during the rotation. (Electronic Signature of Resident)

GENERAL MEDICINE INPATIENT FLOOR ROTATIONS
(Team Care, Private Ward Service, Hospitalist Service):
Trainee's Name ____________________ **Month** _____________

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17:00-18:00	Sign-out	Sign-out	Sign-out	Sign-out	Sign-out	ptcare

PGY3 Objectives for Wards Medicine
The PGY3 will demonstrate mastery of the objectives outlined for the PGY1&2 rotation AND additionally:

Patient Care
- Shows reasonable judgement in ambiguous situations and with critically ill patients (i.e., calls for help appropriately).
- Thoughtfully adjusts management plans according to information obtained in follow-up
- Directs and supervises patient care and teaching of junior residents/students.
- Procedures – Demonstrates facility with invasive procedures and teaches proper techniques.

Knowledge
- Commitment to CME
- Applies progressive knowledge sufficient to manage with minimal supervision
- Demonstrates analytical thinking and ability to develop well-formulated differential diagnoses for patients with multiple problems; independent Bayesian synthesis
- Communication

Practice-based Learning
- Effectively discusses end of life care issues with patients and their families
- Acts as a consultant in internal medicine to other clinical services

Professionalism
- Appreciates the limitations of his/her medical knowledge and asks for help when needed
- Contributes to the medical educational environment of the residency
- Analyzes personal practice pattern in continuity clinic systematically and seeks to improve it

Systems-based Learning
- Aware of community resources that can assist and enhance patient care objectives
- Actively balances quality of patient care with costs and length of stay

☐ has successfully achieved the above-listed objectives of this rotation OR
☐ has not successfully achieved the objectives highlighted above.

Electronic Signature of Attending Physician ______________________

☐ I had the opportunity to review my evaluation objectives form with the attending physician. I had sufficient opportunity to meet the above objectives during the rotation.

Electronic Signature of Resident ______________________

II. Educational Purpose of Rotation:
The purpose of the inpatient Wards rotation is to expose and instill a thorough knowledge and skill-set required to optimally care for patients requiring hospitalization for acute medical illnesses.

A) Knowledge -Over the course of three years, the resident will develop an increasingly in-depth knowledge with regard to the pathogenesis, clinical manifestations, natural history, diagnosis, and management of a wide variety of medical problems. On the general medical inpatient service, this will include problems involving, but not limited to: infectious diseases, the cardiovascular, respiratory, gastrointestinal, endocrine, genitourinary, musculoskeletal, and neurological systems. The incremental knowledge gained is experiential. For every patient admitted to the resident's service, he/she is expected to know all the facts about and learn (through the teaching by more senior residents, attending staff, and readings), in detail, about all of the medical and related psychosocial problems experienced by that patient.

B) Skills: From the experiences gained during the rotation, the resident will:

1) Refine his/her skills in medical history taking and physical diagnosis, 2) Learn to prioritize tasks 3) Use time efficiently , 4) Learn the principles of medical decision making, 5) Learn to cost-effectively order diagnostic studies and provide therapeutic interventions

C) Attitudes: Desirable attitudes in the trained internist. He/she should:

1) Assume primary responsibility for patients' welfare – knowing every detail of their history (including old records), physical examination,
laboratories, diagnostic/therapeutic plan, 2) Access the opinions of attending physicians and consultants ONLY AFTER thinking about a case and offering their best effort at synthesis and a plan, 3) Appreciate the role of the general internist, his capabilities as well as limitations with respect to caring for hospitalized patients on a general medical inpatient service, 4) Value helping each patient to achieve the best attainable level of physical, mental, and social functioning, 5) Value cost-effective medicine, 6) Value the role of medical ethics in the medical decision making process

III. Principal Teaching Methods: Residents will learn by having progressively increasing responsibilities for the care of the inpatients on the medicine teaching services. The PGY-1 will perform admission history and physicals, write all orders on his/her patients, formulate a problem list with appropriate differential diagnosis and management plans. But his/her primary role is "reporter" – to gather the evidence and begin thinking about synthesis. PGY-2 and –3 residents are expected to formulate comprehensive differential diagnoses, diagnostic plans and therapeutic plans THEN share these with attending physicians-of-record for approval/fine-tuning. In addition to these constant, daily interactions (resident-intern, resident-attending), trainees will also learn through:

1. Attending Management Rounds - Daily (8-10:30) on Team Care and Hospitalist Service; twice weekly on Private Service – emphasizing 5-minute case presentations, care discussions and bedside validation of history and/or physical examination data.
2. Teaching attending rounds – Thrice weekly for 1.5 hours (Tuesday, combined with Attending Work Rounds, and most Wednesdays and Fridays with Yale faculty members except one Wednesday/month with PD and one Wednesday/month for Geriatrics Teaching Attending Rounds). These rounds emphasize case presentations (full and 5-minute), followed by a visit to the bedside of the patient to allow one trainee to test his/her history-taking and/or physical examination skills observed and assessed/modeled by faculty.
3. Morning Report – 4 sessions per week for PGY2/3s: the themes of morning reports vary from 2-3 new general medicine cases, to Geriatrics (Fridays), Cardiology (Wednesdays) or other subspecialty cases. Morning report always includes case-based discussions in which presenting residents come prepared to present cases comprehensively, succinctly and armed with either review articles or primary medical literature to inform proper diagnosis or management. Interns are invited only if their patient census and care responsibilities allow.
4. Intern Report - there will be one intern report per month, modeled after the morning report format. The emphasis is to examine and strengthen the reporting and interpretative skills of the interns.
5. Noon conference lecture series – 5 days/week, July-September is a repeating course of core topics, while October-June includes specialty and sub-specialty lectures comprising a 2-year cycle that covers most fundamental topics for each discipline.

A detailed description of teaching methods, in University of Rochester format (i.e. competency-specific) is included toward the end of this curriculum.

IV. Patient Characteristics – All patients admitted to the inpatient Medicine Teaching Services (Team Care, Hospitalist Teaching, Private) with the exception of critically ill patients. These patients include nearly equal numbers of men and women, ranging in age from 18 to over 100 years and of average age in the early 60's. Team Care patients are mainly uninsured or Medicaid-insured; predominantly poor with a greater number of ethnic minorities. Private and Hospitalist patients are mainly those with insurance – predominantly White middle class. Patients are admitted with a broad array of multiple and complex medical illnesses. In addition, the Medicine Services also inherit primary inpatient care of postoperative patients if surgical issues are quiescent and Surgery and Medicine physicians agree. Rarely, patients with active surgical issues will be admitted to Medicine Services primarily with Surgery consultation and follow-up. The only training site for Wards rotations is Bridgeport Hospital.

V. Procedures - Residents will have the opportunity to perform all procedures on their patients including: arthrocentesis, paracentesis, thoracentesis, placement of central vein catheters, lumbar puncture, bone marrow aspirates and biopsies. All will be performed under the supervision of residents or attendings who are certified in these procedures (see Institutional Procedures Credentialing Policy).

VI. References – Harrison's, *Principles of Internal Medicine*; Computerized data-bases available throughout the hospital at every terminal: *Up-to-Date* and *MD-Consult.* Chapters in Harrison's "Approach to . . . " should be read by every intern. All trainees are expected to use one of these or similar resources to master topics that are germane to their patients every day. In addition, PGY-2's and –3's are expected to support the teams with ***original articles***, using Pub-Med, Ovid, or google scholar searches (also available hospital-wide), that are applicable to and inform patients' care.

V. Methods of Evaluation

Residents and interns are evaluated by their teaching and work-rounds attending physician. Residents will also evaluate each other.

Residents and interns will evaluate each other, the quality of the rotation, their work-rounds attending physician and the degree to which they had the opportunity to meet objectives (listed above). When students are on-service, residents and interns will provide timely evaluations of the students' performance.

DETAILED CURRICULUM

FACULTY (for Wards Medicine):

George Abdel-Sayed, MD
Rubie Adam-Aldien, MD
Yaw Amoateng-Adjepong, MD, MPH, PhD
Vivian Argento, MD
Peter Bartelloni, MD
Marina Blagodatny, MD
Doru Bordea, MD
Angela DeGirolamo, MD
Nicholas Dainiak, MD
Pawan Dhawan, MD
Manisha Gupta, MD
Sheikh Hoq, MD
Karen Hutchinson, MD
David Kaufman, MD
Gilead Lancaster, MD
Ryan O'Connell, MD
Wigneswaran Paramanathan, M.D.
Pasquale E. Perillie, MD
Beata Skudlarska, MD
Michael Smith, MD
Gerald Valletta, MD
Stuart Zarich, MD

ORGANIZATION OF THE TEAMS

The in-patient ward services consist of one Private, one Hospitalist, and two Staff Team Care Teaching Services. Each PGY-1 resident spends a total of 7 months, PGY2s spend 3 months (one of which is night float) and PGY3s spend 3 months on these rotations.

Each resident team consists of one supervising resident (PGY2 or PGY3) and one or two interns (PGY1). A medical student is generally assigned to each Team Care team. The two Staff Team Care teams care primarily for patients from the hospital's medical clinic as well as uninsured patients (see below), one Private Team Care team provides care to patients admitted by community-based (private) internists and the fourth team cares for patients on the Hospitalist Service.

The resident teams develop diagnostic and therapeutic management plans in collaboration with the attending physician of record through daily discussions and/or rounds. During these rotations, residents gain experience in managing patients from a variety of backgrounds and with a broad array of medical problems. They gain this experience by assuming direct patient care and primary order-writing responsibilities under the supervision of Attending Physicians trained in Internal Medicine and with the aid of medical and surgical consultants.

Nurses on the medical-surgical floors contribute substantially to the team's work by providing daily updates on individual patient's status. Clinical pharmacists are regularly available to provide the team with information on pharmacotherapy. The case management team, consisting of a discharge planning nurse and a clinical social worker, assists the team in coordinating a host of social and medical services especially in preparing patients for discharge or transfer.

Staff Team Care : The attendings of record for patients on Staff Team Care include hospital-based faculty who supervise the care of hospitalized patients who are followed in the hospital's medical clinic and uninsured patients admitted from the emergency room.

Hospitalist Service: The Attendings of record for patients on the Hospitalist Service are full time hospital-based faculty. Patients are admitted on the Hospitalist service at the request of their community-based physicians. Patients' community-based physicians relinquish general medical care to the Hospitalist attending during the hospital stay and resume care of their patients on discharge. Patients treated on the

Hospitalist Teaching Service are seen with the Teaching Service Team (1 resident/2 interns) who assume levels of responsibility similar to that of the Staff Team Care patients. Primary communication with the community-based physician is handled by the Hospitalist attending.

Patients: Patients are admitted directly to the medical/surgical wards from the hospital's medical clinic or community-based physicians' offices or are admitted from the emergency room. The number of patients followed by each team is based on the number of patients under the care of the individual PGY1s. Optimally, each PGY1 follows between 8 and 10 patients; the goal is 8 patients. Individual case-loads do not exceed 10 patients. PGY1s may not admit more than 5 patients in a 48-hour period. When patient numbers threaten to exceed these limits, patients are reassigned to PGY1s below these "caps." Alternatively excess patients may be managed by the supervising senior resident alone provided he/she is below the cap of 24 patients overall per resident (and no more than 10 admissions in a 48 hour period). If patient numbers remain excessive, stable medical patients are removed from Wards Teaching Services and care is assumed directly by the attending physicians. The attending physician must be notified and agree to taking patients off service. Disagreements are resolved by the Chief Resident with the aid of the Program Director.

In addition to above prescribed ratios, no intern on the Private Service shall have more than 8 patients with more than 8 different attending physicians. Any additional patients admitted up to the resident's cap of 24 will be admitted and cared for by the resident working with the attending physician of record.

A hospitalized patient who is in a resident's continuity clinic should be assigned to the resident's team whenever possible. If the continuity clinic resident is not on Team Care rotation at the time, then he/she should be notified of the patient's hospitalization. The resident is expected to follow the patient along with Team Care, including providing written background information on the patient's medical problems in the chart. The patient should be referred back to the resident's clinic on discharge.

RESIDENTS' RESPONSIBILITIES

PGY1 Responsibilities

PGY1s are expected to take an independent and comprehensive history and perform a thorough physical examination on each patient at the time of admission. If they are assigned a patient after initial admission (through redistribution), they MUST repeat an abbreviated history and perform/document a complete physical examination with problem list that includes differential diagnoses of each problem, diagnostic plan and therapeutic plan. They must document their findings in writing and provide an assessment of the patient's problems. A problem list should be formulated that includes ALL documented medical problems (active and inactive). Assessments are documented in the chart after being discussed with the supervising senior resident and/or attending physician. The PGY1 should write all admission orders based on plans discussed with the resident and attending physician. In subsequent follow-up of their patients, PGY1s are expected to be knowledgeable about the details of their patients' problems and the results of diagnostic studies and therapeutic interventions. ALL NOTES MUST BE DATED AND TIMED.

Interns will write the daily ("***SOAP***") notes that MUST include:

1. ***S***ubjective description of the patient/last 24 hours,
2. ***O***bjective data including vitals, inputs-outputs, daily weights, oxygen saturation, physical examination, laboratory and radiologic tests,
3. ***A***ssessment and ***P***lan: For Wards patients, must list all active problems followed by differential diagnosis, diagnostic plans and therapeutic plans. Some very ill patients (and those in special care units) warrant "systems-oriented" assessments/plans to ensure systematic and robust consideration of all patient issues.

Interns must master oral presentations of the full History/Physical/Lab/Assessment/Plan (for presentation of new cases) and the SOAP elements for daily rounds. They should be able to present this information orally in a concise manner in work rounds and in discussions with attendings and consultants. Interns are also expected to perform all procedures on their patients (with appropriate supervision as necessary). They participate in discussions with the patients and their families about the patients' status and plans. They are expected to read in detail about their patients' medical problems using standard medical texts, review articles, and current medical literature (see references). A critical PGY1 responsibility is to provide careful sign-out of patients to the on-call team for night and weekend coverage, emphasizing possible problems that may arise and suggestions for how to deal with them.

Individual PGY1s are assigned to specific nursing units only for urgent and emergent needs of medical patients not followed by Team Care and are expected to respond in a prompt and appropriate manner when called to evaluate these patients. In responding to an acute off-Team Care patient problem, they respond, discuss their evaluation with the patient's attending physician and write a note describing the evaluation/ discussion in the medical record. If the census on the team is not near the cap and it is mutually agreed, such patients can be transferred to Teaching Services.

On-call duties for PGY1s include one month of night float. The intern presents new cases admitted between 8 PM and 6 AM with the incoming Ward Service Team and to the attending physician of record before leaving the following day. Wards Service Night Float interns are evaluated by Wards Team attending physicians and night-coverage attending physicians as appropriate.

PGY2 and 3 Responsibilities

PGY2s and 3s are the supervising residents on all Wards Teaching Services. They are responsible for leading the team in work rounds and supervising PGY1s and students in all patient care activities. Residents provide initial evaluations of patients admitted to Wards services. They take (and document) their own careful history from the patient and perform a physical examination. The senior residents take responsibility for assuring that timely communication occurs with patients' attending physicians, consultants and family members. Residents supervise procedures performed on patients and they help assure that sign-out to the on-call team is complete and thorough. They are also responsible for overseeing patients' discharge and promptly dictating a discharge summary.

PGY2s and PGY3s scheduled to work short-call evenings (5:30-8:00 PM) sign out to the Night Float (PGY3) resident at 8:00 PM. The Night Float resident (PGY2) supervises the PGY 1 night float in admitting patients,

and assists in the evaluation and management of medicine inpatients with urgent problems. The Night Float resident leaves the hospital by 10 AM the following morning (to comply with work rules).

Attending Supervision

Each patient has an attending of record who provides daily supervision. There are three hospital-based attending physicians assigned to the resident teams (2 on Team Care and one on the Hospitalist service) each month. Administrative oversight and supervision of the fourth team is shared by the Chief Resident and community-based physicians with patients on the service.

Each hospital-based attending makes daily management rounds on his/her patients with the entire team between 8:00 and 10:30 each morning. One of the hospital-based attendings is on-call at night to assist in managing any problems with these patients.

Community-based attendings also make regular management rounds on their patients and discuss daily management with at least one member of the team. They (or a member of their Group) are available 24 hours/day. As stated above, it is the responsibility of the senior residents on Team Care to assure that the attending physician is updated regularly and at least daily on all important changes in each patient's clinical status. Medical and surgical subspecialty consultants are frequently involved in Team Care patients' care. In addition, one community-based attending is assigned to the team per month. This attendings provides supervision and teaching, and formally rounds with the team two or three times per week.

PRINCIPLE TEACHING/LEARNING ACTIVITIES

PATIENT-BASED ACTIVITIES

Morning Work Rounds (MWR)– Led by the senior resident, the Team makes bedside rounds on patients from 7:00–8:00 AM. In work rounds, PGY1s learn to present succinctly their patients. There is appropriate questioning and examination of each patient with development of plans for all active problems, including implementing effective communication with the patient and family members and members of the health care team. Residents are also responsible for performing literature searches (to promote education of the Team regarding patients' problems). Work Rounds also include team sign-outs.

Hospital-based Faculty Attending Management Rounds (HFAMR) – Led by a hospital-based faculty member, teams make bedside management rounds on patients from 8:00-10:30 AM each weekday. The goal of management rounds is for residents and interns to work with experienced attendings to devise cost-effective, appropriate and practical management plans for hospitalized patients. As in morning work rounds, reading assignments may be discussed as they relate to the specific patient care issues.

Private Attending Management Rounds (PAMR) – Community-based attendings who choose to remain as the attendings of record for their patients on Team Care round with the resident team caring for their patients in the mornings between 7:00-10:30 AM.

Morning Report (MR) – Currently morning report convenes four times a week, each Monday through Thursday. Except for Wednesdays, the morning report convenes from 11:00AM to 12:00 noon. On Wednesdays, it is from 9:00-10:00 AM. The morning report is designed mainly for PGY2 and PGY3 residents. Interns are encouraged to attend if they have completed their immediate patient care responsibilities. Team Care residents present selected new admissions or transfers for group discussion. Morning Report is run by the Chief Resident. Many primary care and subspecialty attendings are present. Goals of Morning Report include learning to provide succinct oral presentations, reviewing pertinent laboratory and imaging studies, discussing differential diagnosis and management decisions, and applying evidence from the medical current literature to common medical problems. Formats other than case-based discussion may be employed at times in morning report.

Teaching Attending Rounds (TAR) – Formal teaching rounds are conducted each Wednesday and Friday from 10:30–12:00 noon by selected Teaching attending physicians. In addition, there is a combined Attending Management/Teaching round, at least once a week, usually on Tuesdays. All the Teaching attendings are faculty members of the Yale University School of Medicine (at least 50% of rounds) or Bridgeport Hospital attending staff. Goals of teaching rounds include development of history-taking and physical examination skills, case-presentation skills, and analytic skills. Medical fund of knowledge is improved by detailed discussions of the diseases encountered in the patients on Team Care or the Hospitalist services. Teaching attendings are expected to observe and/or demonstrate bedside skills as well as guide discussion of clinical and basic science issues related to the patients presented, review the medical record. They provide immediate feedback (by optimal modeling of behaviors). Additionally, the teaching attending provides both verbal and written feedback to the residents on their clinical bedside skills (via mini-CEX and then more globally in the end-of-month evaluation). Attendings are asked to give reading assignments or assist residents in finding articles on the problems discussed and to promote evidence-based medical practice. Tuesday's TAR are conducted simultaneously with HFAMR with an emphasis of getting to patients' bedsides to observe residents' skills.

Geriatric Attending Rounds (GAR) : One Wednesday morning per month, from 10:30 to 12:00 noon, all resident ward teams meet with one of the full time Geriatricians. A single case is presented, the group goes to the bedside and a comprehensive discussion of the case is led by the attending.

Program Director's Rounds: One Wednesday of each month, between 10:30 and noon, the program director performs Teaching Rounds with all members of Team Care and the Hospitalist Service. These sessions center on three facets of performance: 1. Succinct case presentation, 2. Medical reasoning, 3. Medical documentation.

DIDACTICS/CLINICAL CONFERENCES –

Team Care residents attend the following departmental conferences (in addition to those listed above) unless responding to an emergency or working in their weekly continuity clinic:

Noon Conferences (NC) - The Residency Program Noon Conference Lecture Series is held daily every day of the week except Thursday (when Grand Rounds occurs at noon). The core curriculum (available at the office of the program director) will be covered. The core curriculum includes reviews of topics in every sub-specialty of Internal Medicine. Topics are recycled and updated every two years. All residents on inpatient floor teams, as well as those on ambulatory block rotations and electives are expected to attend. Once/month a "joint conference" occurs for residents of all specialties. Topics include issues of interdisciplinary interest including medical ethics, systems-based learning, medical biostatistics, and approach to the impaired physician.

Morbidity & Mortality Conferences (CPC) – monthly.
A Medicine resident presents the clinical case of a patient who died on service and who went to autopsy or a living patient with important pathological findings. The pathophysiologic and practical patient care teaching points are made by invited faculty (and by many faculty who attend out of interest). A faculty member from the Department of Pathology at Yale University finishes the conference with a review of the gross and microscopic findings.

Medicine Journal Club (JC)/Research in Progress - The Journal Club alternates with research in progress every month. For journal club, a senior resident (PGY2 or PGY3) presents a thorough critique of an article, assessing its validity and the applicability of the findings to our patient population. This is followed by group discussion. For research in progress, residents present their ongoing clinical research projects for critical review and advice by their peers. All residents and attendings are encouraged to attend.

Weekly Grand Rounds (GR) – All but one Thursday each month, at noon, Medical Grand Rounds reviews State-of-the-Art issues of basic or clinical medical science. Topics for Grand Rounds are chosen by Division Chiefs and generally complement the Noon Conference Lecture Series.

EVALUATIONS OF PERFORMANCE

Attendings' Written Evaluations (AWE) (of trainees): Both Teaching Attendings and Management Rounds Attendings provide written feedback for each month of Team Care and Hospitalist services using the ABIM 6-competency evaluation tool (attached).

Residents Written Evaluation (RWE): All trainees on Team Care and the Hospitalist Services provide written evaluations of one another.

Nurses survey (NS): Floor nurses where most of the team care/hospitalist patients are cared for are surveyed annually. They are asked to rate their satisfaction with each residents' professionalism and interpersonal/ communication skills.

Discharge Planning Evaluation (DPE): Discharge planners provide monthly written assessments of each resident on Team Care and the Hospitalist services. They rate the residents on their skills in identifying discharge planning issues, their promptness in filling the required paper work, and their understanding/knowledge of systems-based resources.

Patient surveys (PS): Patients are periodically surveyed to assess satisfaction with the hospital care received from each resident. The questions (in an ABIM form) address satisfaction with general aspects of the physician's care (e.g., amount of time spent with the patient, courtesy, interest or empathy). The Chief Resident chooses randomly from trainees' panels of inpatients whom will be chosen for surveys.

Clinical Evaluation Exercise (CEX): All residents perform a full clinical evaluation exercise (CEX) annually. In the CEX, a faculty member observes the resident doing a bedside evaluation on a hospitalized patient. The resident receives structured feedback on his/her performance and all of the residents' performances are discussed in a faculty meeting.

Mini-Clinical Evaluation Exercise (MCEX): During Teaching Attending Rounds, the attending physician assesses one or two trainees regarding specific competencies (e.g. history taking, examination of a specific

system, family meeting, etc). Trainees are chosen to perform a particular exercise on a patient under the direct observation of the entire Team. The attending provides immediate feedback, through appropriate modeling, then individual verbal and written feedback. Each evaluation lasts 10-15 minutes.

Record Review (RR): In addition to the frequent informal reviews of each residents written notes and dictated discharge summaries by Ward and Teaching attendings, the Program Director, during his monthly rounds, reviews medical documentation of interns and residents. These are compared to accepted patient care standards as defined and posted on the website of the Agency for HealthCare Research and Quality (http://www.ahrq.gov/). Missing or incomplete documentation of care is interpreted as not meeting the accepted standard. Additionally, attending physicians assess discharge summaries for comprehensiveness and cohesiveness.

Written Examination (ABIM-MCQ)**:** All residents take the ABIM-APDIM in-training examination annually. Residents can use the results to improve their knowledge base in selected areas.

Procedure Logs (PL): Procedure logs documenting the date, number and type of procedures performed are to be kept by the resident. These are periodically reviewed by the program director.

Records of all of these formal evaluations are kept in the program director's files and are available for the residents to review. Formal feedback is provided to each resident by the program director at a minimum of twice/year.

Informal evaluations:

Informal evaluations are done on an almost daily basis by the supervising attending. These encompass direct observation and periodic chart review of the broad range of the residents activities, including history taking, presentation, and documentations. In addition, the Program Director and/or Chief Resident conducts occasionally unannounced, spot chart reviews and chart stimulated recall. In chart stimulated recall, the Program Director/Chief Resident probes for reasons behind the work-up, diagnoses, interpretation of clinical findings and treatment plans. Immediate feedback is provided to the resident.

Faculty Evaluation:

At the end of the rotation, the Team Care/Hospitalist residents complete written evaluations of the hospital-based faculty who conducted management rounds with them. These evaluations are given to the program director and remain anonymous. The program director compiles these evaluations and then provides individual attendings summative feedback at least yearly, and sooner if there are significant problems in the attending's performance that need to be addressed. Teaching attendings are similarly evaluated. Teaching attendings who are deemed to be very effective are strongly encouraged to schedule another rotation the following year. Residents also provide summative evaluations of all attendings once/year by committee.

Curriculum Evaluation:

The Medicine Curriculum Committee reviews and updates, every 2-3 years, the inpatient medicine curriculum using specific input from attendings and residents. To some extent, the knowledge base of the residents for inpatient medicine topics can be tracked by reviewing their performance on the intraining examination. The performance of graduates on the ABIM certifying examination is also monitored as a determinant of the success of the inpatient rotation.

Principle Educational Goals and Evaluation Tools by Relevant Competency

In the tables below, the principle educational goals for the in-patient (Team Care/ Hospitalist) rotation are indicated for each of the six ACGME competencies. The second column of the table indicates the most relevant principle teaching/learning activity for each goal, and the third column identifies the evaluation tool used. The Attending and resident end of rotation written evaluations address all of the competencies. They (AWE & RWE) are therefore not individually listed at every evaluation cell (except where they are the main evaluation tools).

*Legend for learning activities and evaluation tools (See above for descriptions)

AWE: Attending written Evaluation
ABIM-MCQ: ABIM annual in-training examination
CEX: Clinical Evaluation Exercise
DPC: Direct Patient Care
CSR: Chart stimulated recall
DO: Direct Observation
GAR: Geriatric Attending Rounds
GR: Grand Rounds
HFAMR: Attending rounds by hospital-based faculty
RR: Record review
JC: Journal club
MR Morning Report
MWR Morning Work Rounds
NC: Noon Conference
NS: Nurses survey
PAMR Attending Rounds with privates
PS: Patient surveys
PL: Procedure Logs
TAR: Teaching Attending Rounds
DPE: Discharge planning evaluation

1) Patient Care

PRINCIPLE EDUCATION GOALS	LEARNING ACTIVITIES	EVALUATION TOOLS
Gather essential and accurate information about patient	DPC; HFAMR; PAMR; MWR; TAR	CEX; CSR;
Examines patients skillfully	DPC; HFAMR; PAMR; MWR; TAR	CEX; IE: ;
Defines Problems		
Make informed diagnostic and therapeutics decisions	DPC; HFAMR; PAMR; MWR; MR; TAR; DPC;	CEX; RR; CSR;
Carry out patient management plans	DPC;	RR; CSR;
Prescribe and perform competently medical procedures	DPC; MWR; HFAMR; PAMR	CEX;
Write appropriate and informative notes: H &P, SOAP, DC summaries	DPC	RR
Counsel patients and families	DPC; HFAMR; PAMR; MWR;	PS

2) Medical Knowledge

PRINCIPLE EDUCATIONAL GOALS	LEARNING ACTIVITIES	EVALUATION TOOLS
Expand knowledge & application of basic sciences	DPC; HFAMR; PAMR; MWR; MR; TAR;NC; GR	ABIM-MCQ; CEX; CSR
Access and recall current medical information relevant to patient care	JC; MR; GR; DPC; HFAMR; PAMR; MWR; TAR	CEX; CSR
Analytic thinking and application of information to the specific patient	TAR; MR; DPC; HFAMR; PAMR; MWR; TAR	**ABIM-MCQ; CEX; CSR**
Teaches other residents and students in an organized, enthusiastic, and effective manner on a regular basis	TAR; DPC; HFAMR; MR; MWR	AWE; RWE

3) Practice-Based Learning and Improvement

Principle Educational Goals	**Learning Activities**	**Evaluation Tools**
Identify and acknowledge gaps in personal knowledge and skills in the care of hospitalized patients	TAR; HFAMR; PAMR; MR; SRR	RR; CSR; CEX; ABIM-MCQ
Develop and implement strategies for filling gaps in knowledge and skills	TAR; SRR; ; HFAMR	**CSR; RR; ABIM-MCQ**
Facilitate learning of others	DPC; MWR	MiniCEX; RWE;
Use of evidence from scientific studies	JC; MR; TAR; NC	RR; CSR; ABIM-MCQ
Use of Information technology to guide care	MWR; JC	RWE

4) Interpersonal Skills and Communication

Principle Educational Goals	**Learning Activities**	**Evaluation Tools**
Listening skills	DPC	CEX, MCEX
Communicate effectively with physician colleagues at all times	MWR, HFAMR, PAMR, MR, SRR	RWE, AWE
Communicate effectively and respectfully with patients and families	DPC, MWR, HFAMR	PS, NS
Communicate effectively with non-physician members	DPC, DPR	**NS, DPE**
Sensitive to cultural, gender, disability, age, and sexual orientation issues	DPC	NS, PS, CEX, MCEX
Present patient information concisely and clearly, verbally and in writing	MWR, TAR, HFAMR, SAR	CSR, CEX, RR

5) Professionalism

Principle Educational Goals	**Learning Activities**	**Evaluation Tools**
Timeliness	MWR, TAR, HFAMR, SRR	AWE, RWE
Respectful towards patients, families, colleagues and all members of the health team	DPC, MWR, HFAMR, PAMR	**NS, PS, RWE, AWE, DPE**
Respects patient autonomy and patient's rights	DPC, MWR, HFAMR, PAMR	NS, PS,
Ethically sound practice	DPC, MWR, HFAMR, PAMR,NC	AWE, NS, PS

6) Systems-Based Practice

Principle Educational Goals	**Learning Activities**	**Evaluation Tools**
Recognizes the need for and serves as patient advocate in ensuring the optimum care of patients	DPC, HFAMR, PAMR	NS, DPE
Uses evidence-based, cost-conscious strategies in the care of hospitalized patients	DPC, HFAMR, PAMR, TAR	**RR, CSR**
Utilizes system resources effectively	DPCMC, DPC, TAR, HFAMR, PAMR	RR, CSR, DPE
Collaborate with other members of the healthcare team to assure comprehensive patient care	DPCMC, DPC	DPE, NS