
FOR RESIDENTS AND STUDENTS

How to use this book:

→ Read the **Introduction**, **Perioperative Medication Management**, **PACU Tips**, **Cardiovascular Risk Stratification**, and **Pulmonary Risk Stratification** chapters. Read other sections as needed. For specific surgeries, read **Surgery Notes** in the back of the book.

Medicine Residents on the Medicine Consult Elective:

Goals

- Evaluate patients in both the preop and postop settings.
- Evaluate new inpatient consults.
- Learn the art and science of being an effective consultant.

Expectations

- See 1-2 patients per day in the outpatient preoperative clinic.
- Dictate or directly enter notes the same day the patient is seen.
- Follow up on all studies ordered (e.g. stress tests, labs) and communicate with other providers in a timely fashion.
- See your patients postoperatively.
- Learn, and have fun! *Be an educator* for the requesting services.

Medicine ward residents (ward team and night float):

Goals

- Evaluate new inpatient consults.
- Become adept at being an effective consultant.

Expectations

- Respond in a timely fashion to other services who request a medicine consultation.
- Document new consults in the chart and staff with Medicine Consult attending the following morning, or with your Medicine attending if urgent staffing needed.
- Triage appropriately—some patients are better served with the MICU team involvement, or with specialty services. Occasionally the consultation can wait until morning.

THE MEDICINE CONSULT HANDBOOK

Introduction

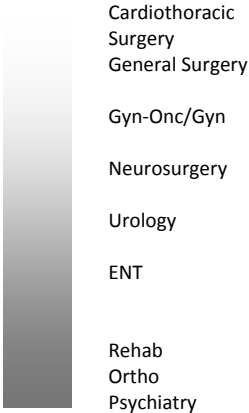
Medicine Consultation is an evolving field. At UWMC, medically complex patients undergo surgeries of varying levels of risk. We believe that teamwork between internists, surgeons, and anesthesiologists improves patient care. This handbook was created to provide useful information, advice, and guidelines, based on a combination of clinical experience and evidence-based medicine. It is designed with a medical resident in mind, but may very well prove useful to others.

As with any handbook, this is simply a guide, and is no substitute for clinical judgment and appropriate supervision.

Overview of the service

- We see patients at the request of another provider
- Our role is to:
 - (1) Risk stratify patients prior to surgery. (AVOID the term “cleared for surgery”).
 - (2) Provide preoperative recommendations to optimize a patient’s condition prior to surgery and to anticipate perioperative events.
 - (3) Provide postoperative advice with regard to a patient’s medical problems.
 - (4) Perform consultations for nonsurgical services to address problems pertaining to general internal medicine.

- Level of involvement: Recommendations only



The style of consultation is not uniform, and highly dependent upon the requesting service and physician (the figure to the left is only a rough guide based on our UWMC experience).

In general, we are a consulting service and make recommendations to the primary team. On occasion, we will write orders to assist a team that may be unavailable, e.g. in the OR—these orders still must be discussed with the primary team.

Ultimately, the level of assistance depends on you and the primary service, and good communication is essential to define this balance.

Direct assistance
e.g. writing orders

- Transfers:
 - Medicine inpatient service: Must contact the Medicine F attending from 8 am to 11 pm and the inpatient chief medical resident from 11 pm to 8 am.
 - MICU: Evaluated by the MICU pulmonary fellow.
 - SICU: The primary surgical service should contact the SICU service for transfer.

Documentation

Initial consults:

- Dictate or directly enter new consults.
- Make sure consult request and reason for consult is documented in the chart. (e.g. "Medicine Consult requested for diabetes recommendations.")
- Format for initial consult notes, both inpatient and outpatient:

<p>Requesting Physician (avoid the word "referral")</p> <p>Chief Complaint</p> <p>Date of Surgery (if applicable)</p> <p>PCP name (phone # is helpful)</p> <p>HPI: Summarize but do not go into the exquisite detail that you would for a medical presentation. The work-up has already been done. You are being asked to help with the next step.</p> <p>Active and Past Medical Problems: Focus on the ones requested, e.g. diabetes and hypertension, but be complete.</p> <p>Past Surgical History:</p> <p>Past Surgical Complications:</p> <p>Drug Sensitivities:</p> <p>Medications:</p>	<p>Family History:</p> <p>Social History:</p> <p>Habits:</p> <p>Review of Systems:</p> <p>Exercise Tolerance:</p> <ul style="list-style-type: none"> • No. of blocks • No. of flights of stairs <p>Physical Exam:</p> <p>Studies:</p> <p>Assessment: Include:</p> <ul style="list-style-type: none"> • Problem List • Risk Stratification e.g. "2 Clinical risk factors for high risk surgery" <p>Recommendations:</p> <ul style="list-style-type: none"> • Be specific (doses of drugs, etc) and concise. • Include preventative measures, e.g. DVT prophylaxis and incentive spirometry, etc.
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*** Tip: You can save time when performing inpatient consults by dictating your note, then entering only your **Assessment & Recommendations** online so that they are immediately available.

Initial postop note:

- Your first postop note should start "Follow up of preop consultation", to distinguish it from a new consultation. (See "**PACU Tips**" for further suggestions).

Follow up notes:

- In general, a note should be written every day in the chart.
- If you plan to follow the patient less frequently than daily, you should communicate this in the chart: "I will follow up with the patient after the chest CT is done" or "My colleagues will be on call this weekend and will see the patient if called. I will follow up with the patient on Monday."
- Assessments should be by diagnosis, not organ system: e.g. "Diabetes", not "Endocrine." Start with the most important medical diagnosis first, e.g. "Atrial fibrillation", instead of "Postop AAA repair".
- In most cases, you should also communicate with the team verbally. A note is no substitute for good communication.

FINAL TIPS

- Keep up a dialogue with the surgical team, and always call with critical recommendations. Don't wait for them to discover an important recommendation you made on morning rounds when they make evening rounds at 10 PM.
- Although much information in this handbook is tailored to the postoperative patient, many questions can be answered by simply asking yourself, "How would I ideally manage this patient were he/she on my medicine service?"
- Avoid recommendations on these subjects except in unusual circumstances:
 - Type of anesthesia or use of PA catheters (let the anesthesiologist decide)
 - Per rectum (PR) meds in any surgery with bowel manipulation (including cystectomy, gyn surgery)
 - Diet orders in patients with abdominal surgery
- Think carefully before making recommendations or writing orders on these subjects—the services tend to feel strongly about them for various reasons (ask your attending for details):
 - DVT prophylaxis (good to recommend, but not to write as an order—bleeding risk needs to be discussed with the surgery team)
 - Anticoagulation (same reasoning)
 - Pain medications (often handled by APS)
 - Transfusions
 - Antibiotics
 - Postop fever workup, especially within the first 48 hrs. (See **"Postoperative Fever"**)