Harborview Medicine Service - Expectations for Students on the Required Medicine Clerkship

Our goal is to promote a learning environment conducive to outstanding patient care and an outstanding educational experience. Our philosophy is expecting talented learners to assume primary responsibility for patient management – with appropriate supervision – is the best way to achieve this goal. We value the stimulation of working with highly motivated students eager to improve their knowledge and skills, take advantage of learning opportunities, and participate actively in care. These are our expectations for students on the HMC wards:

Educational Attitude

- Enthusiastic participation in clinical and teaching activities.
- Make it possible for your patients to receive better care simply because you are following them:
  - Know your patients better than anyone else on your team: medical issues, living situation, core beliefs, hobbies, etc.
  - Thoroughly review the history (present illness, PMH) and physical exam to gather a complete database.
  - Read actively about patient problems, differential diagnosis, and management so you understand care decisions and can ensure your team’s plan of care is the best possible.
  - Advocate for plans that make the most sense given a patient’s individual circumstances; plans often appropriately differ from ‘textbook’ care.
  - Assume personal responsibility for care outcomes.
  - Contribute to a collaborative team spirit and effective work environment.
- Attempt to learn something from every patient on your team. Ask questions, examine patients, and educate your team. The HMC wards offer ample opportunity to gain practical, hands-on experience with patient evaluation and management.
- Hang out with your team and contribute to patient care, learning, and team spirit.
- Attend as many Student didactic sessions with Dr. Sheffield and your chief resident as possible (see “Weekly Educational Conference” schedule). We do not take attendance and understand these sessions conflict with your team’s patient care activities and occur after you’ve left post-call or have a day off, etc.

Professionalism

- Respect Harborview’s mission to provide outstanding care for all.
- Professional demeanor; HMC Photo I.D. required at all times.
• Professional behavior:
  o Follow Dr. Copass’s advice:
    ▪ Treat everyone with respect.
    ▪ Work hard.
    ▪ Ask for help as soon as you need it.
  o Complete clinical work in a timely and reliable manner.
  o Act with integrity and accountability.
  o Document your clinical work in the electronic medical record in an accurate, timely, thoughtful and professional manner.
  o Answer CORES and other pages promptly (see below).
  o Receive feedback with an open mind and motivation to improve.
  o Collaborate effectively with all members of our multidisciplinary care teams, including Nursing, Pharmacy, Social Work, Therapists, Continuity of Care Nurses, consultants, and ward administrators.

Clinical Care

You will be assigned to one of our five housestaff ward teams (Med A-E) and share direct patient care responsibility with interns while working a 5-day admitting cycle that includes overnight call in hospital every 5th night. You will be expected to:

• Admit 2 new patients per 5-day work cycle.
• Follow a personal daily census of 1-3 patients.
• Complete all charting and record-keeping for your patients:
  o Admission notes should be completed before morning rounds the following day.
  o Daily progress notes should be completed before you sign out each day.
  o Patient problems and sign-out plans entered in CORES and updated daily.
• Strive toward primary responsibility for patient care:
  o Review primary patient data: medical record, radiographs, lab, smears, etc.
  o Participate in diagnostic, treatment, and discharge planning discussions.
  o Represent (and speak for) your team whenever your patient is discussed.
  o Sign in as your team’s Primary Contact for your patients on CORES and keep your team informed of new problems, questions and events in a timely manner (e.g., immediately for major changes in patient status).
  o Enter as many electronic orders as possible, mandating careful communication with your interns. (You will receive separate orientation to ORCA and its Computerized Physician Order Entry (CPOE) function.)
  o Be your team’s expert regarding pathophysiology, diagnosis, and management for patient problems.
• Pre-rounding: allow 15-20 minutes per patient before work rounds to review ORCA and overnight events; perform directed interviews and exams; and discuss plans with your interns. (Work Rounds start at 7:30 or 8 AM daily, depending on the work cycle.)
• Present patients in a focused and well-organized manner, ideally from memory (see below).
• Please copy primary care physicians on your Admit Notes. Please also copy Dr. Sheffield on one of your admission notes weekly so he can give you feedback.

Work Schedule

This is a hard-working rotation. On your first day, we will provide an overview of the 5-day admitting cycle. Please see monthly “Medicine Service Schedule” and “call schedule” to determine your team assignments and admitting cycle.

• You will work the same schedule and hours as every other team member totaling ≤ 80 hours/week averaged over the full rotation. (Some weeks will exceed 80, others less. Interns generally work low 70s/week; your hours will be about that.)
• You will have 1 day off each week, ultimately to be determined by you and your Senior Resident. On your last day, you will NOT be admitting a new patient, and you will be scheduled to meet with Dr. Sheffield for feedback.
• MAJOR holidays (e.g., Thanksgiving, but not Black Friday or President’s Day) are additional days off for all students.
• On work days, you will arrive in time to pre-round and leave when your work is done: progress notes completed; CORES updated; patients signed out; and/or your team blesses your departure. On Long Call, you will remain in hospital overnight with your team. We will provide call room assignments when you arrive; unfortunately, the hospital does not have enough call rooms to guarantee a private room for every student. On the Post-Call Day, you will sign out by 10 AM and leave the hospital by 11 AM. On the Short Call Day, you will probably be here until ~8 PMish.
• The last day of 4-week rotations is Friday except that the last clinical day of the clerkship before the Final Exam is Wednesday. 6-week rotations end on Thursdays except for the last week of the clerkship.
• For other schedule requests, you must communicate with us as early as possible and follow the official UW Time-Off Policy: https://depts.washington.edu/medclerk/drupal/pages/AbsenceTime-Policy. No more than 2 days are allowed for time off during a clerkship. These days should be reserved for illness and emergency. Whenever you are absent, you should contact your inpatient team and also inform Carmelita Mason-Richardson in the Medicine Student Program Office: carmelit@uw.edu.

Requirements

The following list is a summary of requirements for the clerkship as a whole and a recap of the big items from above.

• 2 Admit/Transfer work-ups per 5-day cycle.
• Shared primary patient care responsibility with your interns.
• Overnight call with your team every 5th night.
• Not more than 80 hours/week, averaged over 4 weeks. 1 day off/week.
- Nutrition Seminar.
- Clerkship requirements:
  - Simple cases
  - Patient logging
  - Palliative Care exercises
  - Thursday AM didactics at UW

**Suggestions for Presentations and Write-Ups**

(See "Suggested Readings for Perspective on the Student Experience":
“Medicine as a Second Language” NEJM, May 12, 2005
“Clear Writing, Clear Thinking and the Disappearing Art of the Problem List” Kaplan, Daniel M. Journal of Hospital Medicine, July/Aug 2007
“A Piece of My Mind: John Lennon’s elbow.” JAMA, August 1, 2012

**Oral Presentations**

**New Admissions**

- Goals of a Works Rounds presentation of a new patient are to introduce the patient to your team, discuss major problems, and outline a management plan for each major problem. Because these rounds must move swiftly, you have to be highly selective regarding the content of your presentations. You should only include information crucial for management decisions. Some important information (secondary PMH issues, FH, some SH, and all ROS) must be omitted.
- If you are able to give concise, well-organized presentations summarizing crucial information and omitting less important data, your team will conclude you have done an excellent job. If your attending has questions, it does not necessarily mean you should have provided more information.
- The goal for the rotation is 5-7 minutes in length, delivered from memory (but not memorized). Practice out loud to yourself, fellow students, or your senior.
- Make eye contact. Presenting from memory makes this easier. **DO NOT READ YOUR WRITE-UP.** A very useful technique is to prepare a 3x5 card containing bulleted historical information, vital signs, lab data, and plan.
- Suggested outline (subject to vary with input from your resident and attending):
  - Chief Concern: (Identifying information, problem, duration)
  - HPI (include relevant FH, SH, and pertinent negatives)*
  - Active/Relevant PMH (can omit if mentioned in CC or first line of HPI)
  - Medications and Allergies
  - Physical Exam – general appearance, vital signs, pertinent findings
  - Labs – only pertinent results
Summary – your one-line diagnostic statement

Assessment and Plan, by problem. Problem 1 is always the most important reason the patient is in the hospital. For each major problem, diagnose the condition with the greatest degree of precision possible, briefly state what you think is going on and why, give a realistic differential diagnosis (if there is one), and outline your specific management plan, using bullets. Then go on to problem 2, etc. Only address major problems.

* Special situations:

1. For patients newly admitted through the Emergency Department, ED data and treatment course provide a special challenge for presentations (and notes). **Most attendings and residents will ask you to give the ED course as part of your HPI, but you must be highly selective** and your default approach should be to give exam and lab information in their proper sections. Major exceptions to this rule include: seriously-ill patients for whom the history of their being found and resuscitated is the only story you can tell; unexpected lab findings demanding additional history. However, if you routinely give all the ED exam, lab and treatment course in your HPI, you will usually deliver a highly redundant presentation and cannot possibly do so in 5 minutes. (Practice and time yourself.)

2. For patients transferred from outside hospitals or other services (e.g., MICU), the Chief Concern and HPI differ in these ways:

   - CC/ID: Give ID and announce the transfer and its rationale. For example: “This is a 45 yo F with DM2 and COPD accepted in transfer from the MICU for ongoing management of community-acquired pneumonia.”
   - HPI: Follows this outline:
     - Usual state of health.
     - Acute events leading up to seeking medical care.
     - Presenting findings: vitals, exam, and labs carefully selected to provide information regarding diagnoses and severity
     - Hospital course, including treatment interventions and response.
     - Patient status on transfer. (For example: “On transfer, Ms Jones reports her breathing is almost back to normal. Her cough….)
     - If diagnostic uncertainty remains for any problem, give additional pertinent history here along with pertinent negatives.

Subsequent Care/Daily Progress

- 1-3 minutes in length
- Suggested outline:
  - Intro: “This is hospital day #4 for our 34-year-old woman now responding well to treatment for cellulitis.”
- Overnight Events: key symptoms, signs, input from consultants, procedures, etc. (Note: “No events is NOT ENOUGH INFO.)
- Interval Exam – vital signs, pertinent findings
- Labs
- Assessment and Plan for the Day, by problem

**Note:** it is very important to revise your one-line introduction, problem definition and problem order every day based on evolving clinical information and patient treatment course.

### Recommendations for Charting in ORCA

- All of your notes will be typed into ORCA. Please use the “Admission Note” or "Medicine – Inpatient Record" template.
- Copy and Paste as little as possible. When you copy the work of others, you must cite your source and confirm the accuracy of what you chart. To do anything less is sloppy at the very least, and plagiarism is a serious professionalism issue. When you copy your own work, be sure to reread it entirely and revise it for accuracy and precision. Pay attention to font and time references.
  - Only document history you have confirmed and exams you have performed yourself. Documenting history or exam elements you did not perform constitutes fraud.
  - For new admissions, the only element you might copy and paste would be PMH found in clinic or prior chart notes. Even this should be expanded, revised, and updated.
  - For daily progress notes, it is common practice to copy and paste the prior day’s A/P. Doing so saves key strokes and time but can also diminish time devoted to achieving mental and documentation clarity. Control-C’d A/Ps often show little revision from day to day and may not reflect the most precise and up-to-date thoughts regarding patient status. We STRONGLY recommend you actively revise your assessments daily (see below).
- Sign your notes and refer them to your intern to sign and attending for review ("cc").
- Please send admission notes to clinic primary care providers for review. Please also send admit notes to Dr. Sheffield so he can give you feedback.

### Admission Notes

- Your note should be the most complete account in the record of your patient’s acute illness, prior history, exam, and management plan. CONSULTANTS, NURSES, AND YOUR TEAM WILL READ YOUR NOTES. Your notes are integral to patient care.
- **HPI:** use a consistent time reference (usually “prior to admission” – PTA) when outlining chronology. Tell the story of your patient’s illness. At the end, list
pertinent negatives relevant to the differential diagnosis. (It can be very helpful to outline your A/P first before writing the HPI.)

- **Problem List** (optional): list active issues pertinent to the current hospitalization only. Note that in the hospital, the PL is a ‘spoiler alert’ for your A/P section whereas in the clinic the PL and PMH are basically the same.
- **PMH**: outline complete details of clinical events, prior diagnostic test and imaging results, etc. so readers fully understand the scope of each problem. For example, a history of COPD could mention GOLD staging, PFTs, baseline ABGs, prior use of corticosteroids, etc.
- **PFSH**: Please note that for billing purposes a Family History lacking in pertinent information should be charted as “Negative” rather than “Non-Contributory.” (If this makes sense to you, perhaps you have a future as a billing coordinator.)
- **Review of Systems**: every patient deserves a complete review of all 14 systems (not necessary to repeat symptoms listed in HPI)
- **Physical Examination** – every patient admitted to the Medicine Service deserves a complete screening physical exam, including neurological. For systems relevant to the presenting problems, a more detailed exam is appropriate. (The only way to master the PE and earn full trust of your patients is to perform complete exams. Stethoscopes should touch skin.)
- **Lab**: if you use an ORCA template, many will be imported for you but you should type in additional new laboratory key to diagnosis and management. (Note that old imaging and test results belong in the HPI or PMH.) With imaging studies, it is preferable to give a brief summary of key findings rather than pasting the entire radiography report.
- **Summary**: one-line, diagnostic statement. This is similar in structure to CC/ID but reflects how you've digested all the data and provides your synthetic overview to frame the problem-based A/P that follows.
- **Assessment and Plan** – give A & P for each problem separately, beginning with the most important problem. For example:
  1. **Problem** (diagnosis, symptom, sign, or lab result, being as precise as possible, based on available information). Your discussion should be a concise prose-form review of the problem outlining what you think is going on, why you think that, and severity. For problems with a differential diagnosis, you should mention the most likely explanation first then review realistic or do-not-miss alternatives. You may want to discuss the rationale for the diagnostic and therapeutic plan briefly. For unusual or especially interesting problems, you may also include references or educational information from your reading here. Not every problem requires the full treatment, but the “full nine yards” assessment includes:
     - Characterization of the problem
     - Etiology and differential diagnosis (most likely, realistic alternatives, do not miss conditions)
     - Complications to anticipate and monitoring required
     - Diagnostic work-up required
     - Treatment options
Plan:
- List your diagnostic and therapeutic plan in bullets, and be specific
- This makes your note easier to read and more accessible for people in a hurry (i.e., everyone).

2. **Problem the next.** Ditto above. As you move to less important problems, you won't have as much to say. For very chronic problems, you may simply say:
   **Plan:** Continue current outpatient management with …..

3. **Any problem** requiring orders should be addressed in your admission note A/P.

**Daily Progress Notes**

- The "Medicine-Inpatient Record" template is preferred.
- Hospital Day – automatically imported
- Chief Concern: age, sex, major problem(s) being addressed in hospital (revised daily, as above in Daily Work Rounds presentations)
- Interval History: Bulleted mix of content, including overnight events, status of major ongoing symptoms, pertinent ROS. NOTE: “No events” is NOT acceptable.
- Meds/Infusions/PRN: accurately imported from CIS for you.
- Exam: Problem-focused.
- Labs: routine chemistries and heme results are automatically imported. Avoid a daily repetition of old labs and imaging studies.
- A/P: Begin with a revised one-line diagnostic summary statement to convey a synthetic overview and perspective on the hospitalization including your sense of clinical trajectory (i.e., improving, deteriorating, or stable awaiting discharge). Then give your revised A/P, by problem. Ideally, your A/P should be steadily more accurate, and (generally) shorter. What you call problems should become more precise, and differentials can be deleted as indicated by the work-up. Resolved problems should be moved to the bottom of the section, but can retain key diagnostic or procedural interventions performed to facilitate cross-cover and Discharge Summary preparation. To help you improve your thinking about problems and demonstrate your growing mastery of their management, we strongly recommend you copy and paste the previous day's A/P as little as possible.

**Primer for HMC medical information systems**

**ORCA**

Electronic medical record, containing all clinic and ward notes. You will chart and draft orders here.
Rounding (CORES)

Found in the Tool bar of ORCA. Providers assign patients to their team here and use CORES to sign in and out. This alerts Nursing regarding the primary physician contact and facilitates direct text paging of that person. CORES imports medications, vital signs and lab results, but you have to input (and update) problem lists and sign-out plans. You will use CORES to sign on as your team’s first contact for patient care calls and generate printouts for rounding and sign-out.

MINDscape

Found among the “Menu-Inpatient” choices in ORCA patient charts. MINDscape duplicates ORCA, is easier to navigate, and contains Cardiology test results (esp. ECHO).

Epic Web

Found among the “Menu-Inpatient” choices in ORCA patient charts, Epic contains outpatient notes from most clinics.

Paper Chart

Contains loose papers from the ER (e.g., ambulance sheets, etc.) before they are scanned.

Contact Us if You Encounter Problems

We expect the Harborview wards to be a challenging but highly stimulating and fun work environment. If you are encountering problems with the educational or work environment, please alert your Resident, Attending, Chief Resident, John Sheffield, or Eva Crist to problems as early as possible.

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