I. Educational Purpose

The internal medicine inpatient ward rotation is a rigorous and rewarding comprehensive patient care experience. Residents will learn how to evaluate and manage numerous patients with diverse and complex pathophysiology under the close supervision of dedicated faculty. This experience offers a multidisciplinary team approach to the care of these patients.

II. Principal Teaching Methods

a. Direct Supervised Patient Care: Interns and residents evaluate patients independently and develop their initial impressions and evaluation and treatment plans. The patients are then presented to the attending during rounds and the treatment plan is adjusted as needed. All residents are closely supervised by attending physicians. The attending will provide daily supervision of patient care. Daily attending rounds are scheduled to occur from 10 AM to 12 noon except on the on-call and post call days as noted in the schedule below. The attending will provide teaching at the time of new patient presentations as well as during daily rounds. Additional teaching outside the context of management rounds is to occur by the attending and this is to include bedside physical exam skills. Total teaching time is to be at least 4.5 hours weekly

b. Didactic or Seminar Education: Residents are provided educational opportunities during the rotation in a variety of formats including:
   • Morning Report which occurs Tuesday through Friday 9:00-10:00 AM
   • Monday Academic conferences 10:30-12:30 (interns); 1-3pm (res)
   • Grand Rounds on Thursday Morning at 8:00 AM
   • Chairman’s rounds (w/ Dr H) occur on Fridays for Jeopardy day#2 team
   • Monthly Clinical Grand Rounds (3rd Wednesday per month at noon)
   • Interaction with consultative services

III. Educational Content

a. Mix of Diseases: By the end of the inpatient medicine rotations, the resident will have the skills and knowledge to care for patients with a vast array of disease processes including but not limited to:
Syncope
Pneumonia- community acquired and healthcare associated
Alcoholism and its complications
Gastrointestinal bleeding (upper and lower)
Asthma/COPD
Congestive heart failure
Diabetes Mellitus and its complications (including DKA, Hyperosmolar Hyperglycemia)
Cellulitis
Acute Renal failure
Dementia/Delirium/Altered level of consciousness
Substance abuse
HIV and its complications
Liver disease (ascites, encephalopathy, variceal bleeding)
Venous Thromboembolic disease
Hypertension
Diabetes
Shortness of Breath
Chest Pain
Abdominal pain
Pancreatitis
Endocarditis
Pyelonephritis
Meningitis
Osteomyelitis
Catheter related bacteremia
Disorders of sodium
Disorders of calcium
Disorder of potassium
Acid-base disturbances
Acute and chronic pain management
Anemia

b. Venue: The UC Wards Service is entirely at the UC Davis Medical Center. It comprises floor patients only. The ICU and CCU are separate services. The hospital is a state of the art medicine facility with a full ancillary support staff. It offers highly skilled and diverse array of consultative and technologic services.

c. Patient Characteristics and types of encounters: The patient population at UC Davis Medical Center is very diverse, ranging in age from 18 to 100, with multiple ethnic and socioeconomic groups represented. The spectrum of these encounters will be from primary presentation of new disease processes to the tertiary care for the patient who is referred for subspecialty care. The care for these patients will occur on either general medicine floors or telemetry floors. Any patient requiring ICU level care will be transferred to the ICU teams who will assume care of the patient. Once patient stabilized and can be transitioned out of the ICU, the care for this patient can be reassumed by the general medicine ward service.

Under our current system all potential patients from the emergency room, clinics, and transfers from outside facilities are screened by a hospitalist attending to ensure that they are appropriate. The hospitalist attending will then notify the housestaff of the admission.
Additionally, patients can be transferred to the general medicine teaching service from the medical intensive care unit, cardiac inpatient service, and other non-medical services. The protocol for such transfers is that the MICU and CCU teams place patients on the transfer list and one patient each day can be transferred to the long call team. The non medical service transfers are seen by the general medicine consult service and if the attending of that service approves, the patient is transferred to the general medicine long call team.

d. Procedures: In addition to acquiring knowledge to manage above mentioned disease processes, residents will acquire the skills to perform basic procedures including but not limited to: lumbar puncture, thoracentesis, paracentesis, arterial blood gas, and venipuncture. The residents will also have the opportunity to acquire the skills to perform central line placement under the supervision of competent faculty during this and other rotations (MICU, ER) in their residency training.

e. Structure of the Rotation: There are 5 inpatient general medicine ward teams at the University. Each team consists of one upper level resident (PGY 2 or 3) and two interns (mostly from internal medicine but includes psychiatry, emergency medicine, OB-Gyn). Additionally, depending on the time of year there can be 2 third year medical students and a fourth year medical student (sub intern). There is one attending for each of the teams and they are assigned to the service for two continuous weeks. The housestaff is expected to use this attending as the primary resource for issues regarding patient care.

In addition, there is a hospitalist attending physician who is in the hospital 24 hours/7 days a week. This attending serves as an additional resource to housestaff, especially at night for the night float intern and resident for any questions or concerns that arise regarding patient care including supervision of procedures.

The Ward service has a 5 day call cycle. It consists of a long call day, followed by a post call day, then 2 jeopardy days and a pre-call day. Teams can assume care of new patients on 3 of the 5 days of this cycle. Patients defined as bounce backs to teams can be assumed on any day in the call cycle (except post call). The ward service has a night float intern and resident. The intern is scheduled 5 nights a week and the resident is scheduled 5 nights a week. See the curriculum for this night float service for complete description.

Long Call: Teams can begin admitting patients at 12 PM on this day. The team caps new admissions at 8 patients or 12 AM, whichever comes first. The entire team will be remaining in house overnight and will be responsible for completing their work on the new patients, providing cross coverage on the patients on their service, and preparing for morning rounds and the next day.

There is a staggered system for arrival on the long call day. Interns will arrive between 6:30 AM and 7 AM to review in person any overnight events or issues with the night float intern who provided cross coverage. They will proceed with their own work rounds. If there are any issues prior to the residents arrival at 0900, they should be discussed with the attending directly. Interns then meet with their resident at 0900 where the team will present a morning report case.

The senior resident of the service will not arrive until around 9 AM, in time for morning report. Immediately after report (10 AM) the whole team, including the attending will round together. Rounds will conclude by 11 AM-12pm.
Post Call: Post call rounds will occur at the mandatory start time of 7 AM. These rounds will be attended by all members of the team and the assigned senior day float resident. Rounds are mandated to end no later than 10:00 AM. By 10:00 AM the interns will meet with both residents (day float resident and senior team resident) to review their sign-out. This is to ensure the 30 hour maximum work limit is not violated.

Since the senior resident arrived at 9 AM the previous day, they are able to remain a few more hours to provide ongoing care, along with the day float resident and attending to the patients. It is expected that the senior resident leave the hospital by noon on the post call day. The process is they sign-out in the morning report room documenting the time they leave the hospital. Additionally the resident must update the attending about progress of the patient care at noon.

The day float resident remains after the senior resident leaves to help with the remaining work under the guidance to the service attending physician (see the Day Float Curriculum). The day float resident will perform an updated computerized sign-out for the each patient on the service and review this with the appropriate cross cover intern.

Jeopardy Days: These days occur on day 3 and 4 of the call cycle. These are days where patients who were admitted the previous evening by the night float team are transitioned to the ward teams. On most days up to 4-5 patients need to be reassigned to one of the ward teams. This is done based on the ledger system to allow for as even distribution of work as possible. These patients have admission orders and a written history and physical. This allocation of patients occurs at 7 AM daily in D6 conf room. The teams are expected to review the admission with the admitting resident in the designated conference room, and then evaluate the patient themselves. These patients are then to be discussed during attending rounds.

Precall day: No new patients are to be assigned on this day of the call cycle unless they are bouncebacks.

Days off: It is an expectation that each member of the team average 1 in 7 days off (free of all clinical duty) during the rotation except the attending, who will be available for 14 days consecutively. Days off are managed by the resident and is discussed with the attending so teaching rounds can be scheduled appropriately. Interns and Residents will be expected to attend their outpatient continuity clinic as scheduled, which will usually be 2-3 sessions per month.

Transfers: patients can be transferred to the general medicine teaching service from the medical intensive care unit, cardiac inpatient service, and other non-medical services. The protocol for such transfers is that the MICU and CCU teams place patients on the transfer list and one patient each day can be transferred to the long call team. The non medical service transfers are seen by the general medicine consult service and if the attending of that service approves, the patient is transferred to the general medicine long call team.

Bouncebacks:
- Based on the resident, NOT the intern, having the patient for 24 hours.
- Count towards the ledger.
- Patients admitted to gen med team initially, and then transferred to MICU/CCU/other service, that eventually come back to the gen med team ARE NOT BOUNCEBACKS!!
Please continue to track the progress of these patients while on other services and communicate routinely with other MDs about these patients (ie: how are they doing, when are they coming to the floor, etc.)

- Bounceback patients do not count towards the admission cap of 8 on long call, but are added to the ledger.
- If admit a bounceback patient for another team...admitting resident can keep the patient (and get ledger credit) or transfer back to the bounceback team. If they transfer, they will not get ledger credit.

**Typical Daily schedule (excluding long call and post call day)**

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<thead>
<tr>
<th>Monday</th>
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<tr>
<td>7:00 AM</td>
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Individual roles defined:

**Students**

- Each patient must be seen and examined prior to work rounds.
- Carefully review cross cover issues from the previous evening.
- Know the results of all the recent lab tests/radiographic studies/telemetry.
- Review any consulting service’s recommendations from the previous day.
- Review all medication cardex daily to ensure you have an up-to-date list including start dates for all antibiotics.
- The intern must review your patient with you prior to work rounds. This includes seeing the patient with you at the bedside.
- Review care plan from previous day to see if accomplished and if not, why?
- Formulate your own management plan for each patient to discuss with the intern and resident.
- Have your questions ready for the intern and resident.
- Your admission history and physical is not to be placed in the medical chart. The intern is expected to place their own H&P in the chart.
- Your daily progress notes are allowed to be part of the official medical record. You are expected to complete them early in the day. The intern and resident must review your note with you, edit them accordingly and add an addendum to the end of the note. Your note should not be placed into the chart until this review process occurs.
- Inform the interns, residents, and attendings of your other educational responsibilities during the rotation so they can optimize your educational experience.

**Intern**

- Each patient must be seen and examined prior to work rounds. The only exception is if you are managing an unstable patient.
- Carefully review cross cover issues from the previous evening.
- Know the results of all the recent lab tests/radiographic studies/telemetry.
- Review any consulting service’s recommendations from the previous day.
- Review all medication cardex daily to ensure you have an up-to-date list including start dates for all antibiotics.
- Medical student patients must be seen with them prior to work rounds. Their findings do not substitute for your exam.
- Prepare the medical students for the resident and attending.
- Review care plan from previous day to see if accomplished and if not, why?
- Formulate your own management plan for each patient to discuss with the resident.
- Have your questions ready for the resident.
- Review the medical students daily progress notes with them editing them accordingly and add an appropriate addendum prior to the note being placed in the chart.
- Regularly meet with discharge planning and social services to facilitate the discharge needs of each patient.

**Resident**

- He/she is the leader of work rounds and provides the framework for the team.
- Sets the meeting time – key point is to allow enough time to discuss...
adequately all patients and to physically see and examine all the sick patients with the
interns and students before Morning Report. Card flipping does NOT constitute work
rounds
. Must make it an expectation that all patients be seen and students &
interns be prompt to rounds
. Review all radiology studies/labs from the previous day
. Make sure all the little details/questions are answered (i.e. how to replace
K+) so these issues are not discussed in attending rounds
. With the intern, develop the care plan for the day (any difference of
opinion is settled here before attending rounds) for each patient
. Formulate any questions for the attending
. Prepare the intern and students for attending rounds
. Review any sub intern’s daily progress note and add an appropriate
addendum to it prior to it being placed in the chart
. Take the opportunity to provide teaching to interns and students without
the attending
. Identify learning issues for the team that the attending can then focus on
in teaching rounds
. Provide continued supervision of interns and students throughout the day
in all aspects of patient care including procedures and ongoing management
. Regularly meet with discharge planning and social services to facilitate
the discharge needs of each patient
. Arrange the schedule so that the students, interns, and yourself average
1 day off in 7 over the 4 week rotation

IV. Educational Goals and Objectives

a. Overall Goals

. Develop the basic clinical skills of caring for hospitalized patient
. Understand the process of admission from the outpatient and emergency
settings, in addition to transfers from outside hospitals.
. Continue to expand on history taking skills and physical exam skills
. Learn appropriate use of laboratory and other diagnostic tests in evaluate
of patients and their disease processes
. Become familiar with the social, economic, cultural and ethical issues
unique to inpatient medicine
. Understand the appropriate disposition of patients upon discharge from
the acute care setting
. Develop the interpersonal and communication skills to be able to work
effectively within the health care system and with all members of the health care team
. Understand appropriate use of subspecialty consultation, social work,
discharge planning, therapists, nutritionists, etc.
. Acquire and further develop skills to become an effective
educator/teacher
. Acquire and develop skills that allow resident to become an effective
leader/supervisor of a health care team
. Develop critical thinking skills and ability to practice evidence based
medicine

At the conclusion of the inpatients medicine rotations, residents should be
familiar with other aspects of inpatient medicine including:
- End of life discussion and decision making including code status
- Inpatient and outpatient hospice
- Appropriate use and limitations of home infusion therapy, sub acute nursing facility, acute rehab facility, chronic care facility, home health
- Discharge planning including role of PT/OT, medications, instructions, appropriate follow up, communication with family, primary care provider

b. Rotation Specific Competencies: Residents rotate through the UCW rotation in each academic year. PGY-year specific competencies are outlined below. These are cumulative -- it is expected that residents in each year will have mastered the competencies outlined for the previous training year.

Patient Care

Goal: Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

PGY-1 Residents are expected to:
- Demonstrate respect, compassion and empathy for patients and their families.
- Be able to obtain a complete and accurate patient history using interviews of patients and families/friends, thorough review of the medical records, and review of outside records when applicable.
- Be able to perform a general physical exam and to tailor the exam according to clinical situation. This should include appropriate exam components depending upon on the presentation, such as performing a neurologic, mental status, rectal, and pelvic exams on appropriate patients.
- Correctly delineate normal from abnormal findings, and understand the relevance of abnormal findings.
- Integrate information obtained from the history and physical exam to develop a pertinent and prioritized problem list and an initial differential diagnosis with supervision.
- Select initial diagnostic studies and therapeutic interventions based on the initial differential diagnosis.
- Integrate the results of diagnostic studies to refine the differential diagnosis.
- Select additional diagnostic studies and therapeutic interventions based on the refined differential diagnosis, with some supervision.
- Incorporate patient preferences into the care plan.
- Counsel patients/families about their medical conditions including the diagnostic and treatment plan.
- Show sound clinical judgment and ask questions or for help when clinical uncertainty exists.
- Work toward completing the requirements for technical and cognitive proficiency for invasive procedures. Perform invasive procedures under supervision until those requirements are met.
- Recognize the role of healthcare providers from other disciplines and services, and work in cooperation with those providers to provide comprehensive, patient-centered care.
PGY-2 Residents are also expected to:
. • Ensure that the intern obtains an adequate history and to fill in blanks where necessary.
. • Ensure that interns have complete problem lists, adequate differential diagnoses, and treatment plans.
. • Demonstrate the ability to elicit subtle findings from the history and physical exam, or to augment the physical exam with additional maneuvers as needed to support or refute a diagnostic hypothesis.
. • Integrate all information from history, physical exam and diagnostic studies to develop a diagnostic and therapeutic plan with minimal supervision.
. • Begin to incorporate consideration of risks, benefits, and costs into patient management plans.
. • Effectively communicate the management plan to patients/families and modify that plan based on their values and preferences.
. • Begin to utilize information technology to retrieve and apply current medical evidence (e.g. guidelines, original literature) to refine the patient management plan.
. • Initiate and coordinate the involvement of healthcare providers from other disciplines and services to provide comprehensive, patient-centered care.

PGY-3 Residents are also expected to:
. • Integrate all information from history, physical exam and diagnostic studies to develop a diagnostic and therapeutic plan at the level of a general internist without need for supervision.
. • Consistently incorporate consideration of risks, benefits, and costs into patient management plans.
. • Consistently utilize information technology to retrieve and apply current medical evidence (e.g. guidelines, original literature) to patient management.
. • Complete the requirements for proficiency in invasive procedures

Medical Knowledge

Goal: Residents must demonstrate 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.

PGY-1 Residents are expected to:
. • Have a basic understanding of the mechanism of diseases commonly encountered in internal medicine (such as acute coronary syndrome, pneumonia, urinary tract infection, abdominal pain, chest pain, edema, shortness of breath, and alcohol withdrawal).
. • Display an attitude of inquisitiveness and a desire to continuously expand their knowledge base.
. • Utilize reference materials (e.g. textbooks, Up-To-Date®, pocket references) to correct deficits in knowledge related to the diagnosis and treatment of the patients for which they are providing care.

PGY-2 Residents are also expected to:
Have more in-depth understanding of diseases commonly encountered in internal medicine, as demonstrated by the ability to develop an appropriate initial diagnostic and treatment approach to these conditions, with minimal supervision.

Utilize current medical evidence (e.g. guidelines, original literature) to correct deficits in knowledge related to the diagnosis and treatment of the patients for which they providing care.

Teach the team on common medical conditions.

Develop a plan of independent study to expand their knowledge of internal medicine and its subspecialties.

PGY-3 Residents are also expected to:

- Have an understanding of diseases encountered in an internal medicine practice that is appropriate for a general internist, as demonstrated by the ability to develop a comprehensive diagnostic and treatment approach to these conditions without supervision.
- Have a basic understanding of unusual or complex diseases commonly encountered in the subspecialties of internal medicine.

Practice-Based Learning and Improvement

Goals: Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

PGY-1 Residents are expected to:

- Be able to supervise and teach 3rd year medical students. Seek and accept feedback from students and use that feedback to improve their teaching and supervisory skills.
- Seek and accept feedback from attendings, fellows and supervising residents, and utilize that feedback to improve their clinical performance.
- Set short-term learning goals. Evaluate and critiques their own performance relative to those goals at the beginning and end of the rotation.
- Learn from errors and use errors to improve patient care on both a personal and system-wide level.
- Be able to formulate clinically relevant questions related to the diagnosis and treatment of their patients’ medical conditions.
- Be familiar with common medical databases and common search engines (e.g. OVID, PubMed, etc.) and to use these information sources effectively to support patient care decisions and to educate self, patients and other physicians.

PGY-2 Residents are also expected to:

- Be able to supervise and teach 4th year medical students and interns. Seek and accept feedback from students and interns, and use that feedback to improve their teaching and supervisory skills.
- Seek and accept feedback from attendings and fellows, and utilize that feedback to improve their clinical performance. Be able to critique own performance.
- Set longer-range learning goals for their training. Develop learning plans to help achieve those goals and a method of evaluation to determine their success in meeting them.
- Know basic methods for searching the medical literature and be able to find original medical literature related to the diagnosis and treatment of their patients’ conditions, and then to incorporate that knowledge into the treatment plan.
- Be able to critically appraise literature related to diagnosis and treatment, and
appropriately apply the results of that literature to their clinical practice.

PGY-3 Residents are also expected to:

• Understand basic principles and methodology of Clinical Quality Improvement (CQI) and how it affects the inpatient practice of physicians and staff.

### Interpersonal and Communication Skills

**Goals**: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families, and professional associates.

PGY-1 Residents are expected to:

• Provide verbal presentations that are thorough, yet succinct and pertinent, and that reflect understanding of the patients' condition and/or support a differential diagnosis.
• Maintain comprehensive, timely and legible medical records in the EMR.
• Provide electronic and verbal sign-out of patients that is efficient, pertinent, and explicit.
• Be open and receptive to questions and recommendations from members of the nursing and ancillary staff.
• Develop a good working relationship and rapport and communicates clearly with other physicians, health professionals and patients.
• Be proactive about contacting discharge planning and social workers for discharge care planning.
• Develop a therapeutic relationship with patients and their families, regardless of their background.
• Be able to explain a patient's condition and plan of care to the patient and family in terms that are understandable and appropriate.
• Be able to discuss the risks and benefits of procedures or interventions with patients and families, and obtain informed consent.
• Be able to discuss resuscitation status with patients and families, answer their questions regarding this issue, and elicit the patient's wishes in regard to cardiopulmonary resuscitation.
• Communicate expectations to 3rd year students and provide them with feedback.

PGY-2 Residents are also expected to:

• When appropriate, provide written senior admission notes that succinctly summarize the patient's condition, reason for admission and management plan.
• Ensure that discharge summaries succinctly summarize and convey the pertinent details of the patient's hospitalization and post-hospitalization follow-up needs.
• Effectively communicate verbally with consulting physicians. Be able to succinctly summarize the patient's condition and the explicit reason(s) why consultation is being requested.
• Effectively communicate and coordinate the plan of care with nursing staff and members of ancillary healthcare services.
• Engage patients and their families in shared decision-making, especially in situations whether there is clinical uncertainty and/or ambiguity.
• Lead family/team meetings, with some support from the attending physician, including discussions of end-of-life care.
• Be able to resolve conflicts with patients/families, staff, or within the team, with some involvement of the attending physician.
Communicate expectations to 4th year students and interns and provide them with feedback.

PGY-3 Residents are also expected to:

- Effectively communicate with physicians as a consultant, and be able to provide succinct, explicit recommendations both verbally and in writing.
- Lead family/team meetings, with minimal or no support from the attending physician, including discussions of end-of-life care.
- Be able to resolve conflicts with patients/families, staff, or within the team, with minimal or no involvement of the attending physician.

Systems Based Practice

**Goal:** Residents must 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.

PGY-1 Residents are expected to:

- Work within the UC and local health care systems to ensure continuity of care between inpatient and outpatient arenas.
- Complete all charting/documentation/dictations in a timely manner (H&Ps at the time of admission and discharge summaries within 48 hours).
- Learn the role of other members of the healthcare team, including case managers, social workers, physical/occupational/speech/respiratory therapists, nutritionists, clinical pharmacists, and others.
- Recognize when their patients may benefit from the involvement of other healthcare providers, and invoke their assistance when appropriate.
- Learn what evidence-based guidelines and standardized order sets are available in our institution. Know how to find these resources, and utilize them when appropriate for patient care.
- Work within the UC system in quality improvement initiatives

PGY-2 Residents are also expected to:

- Effectively coordinate the involvement of healthcare providers from other disciplines and physicians from other specialties to provide comprehensive, patient-centered care.
- Learn to anticipate patients’ discharge needs (e.g. transportation and medication assistance; need for placement, home health care, and durable medical equipment; etc.), and begin discharge planning early in their hospitalization, with some prompting by the attending physician.
- Participate effectively in Interdisciplinary rounds, and to take a leadership/advocacy role for patients when necessary.

PGY-3 Residents are also expected to:

- Consistently anticipate patients’ discharge needs and begin discharge planning early in the hospitalization, with minimal or no prompting by the attending physician.
- Describe the basic systems of payment for health care, and the principal types of payers for health care.

Professionalism
Goal: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

PGY-1, PGY-2, and PGY-3 Residents are expected to:

- Treat all patients, regardless of background, with respect, compassion and empathy.
- Treat everyone else – nursing staff, ancillary healthcare providers, program personnel, students, residents from our own and other programs, attending physicians in all specialties, others – with respect and courtesy, and in a way that reflects positively on them as individuals and the medical profession as a whole.
- Respect patients' autonomy and their right to make informed decisions about their own health care.
- Commit to advocating for their patients' needs in the healthcare system, and be willing to place the patients' needs above their own.
- Commit to providing the highest quality, most effective and most efficient care that their experience and level of training permit.
- Understand and safeguard patient confidentiality and protected health information.
- Be honest in all aspects of their professional life, including documentation of patient information, disclosure of medical errors, and acknowledgement of mistakes and of deficiencies in medical knowledge and skills.
- Be committed to self-directed learning, self-evaluation, and self-improvement.
- Comply with the policies and expectations of the residency program, and complete administrative tasks (e.g. evaluation forms) on time.
- Adhere to principles of confidentiality, scientific and academic integrity and informed consent.
- Be willing to assist their colleagues and the program with patient care and service coverage when needed.

V. Reading Lists/Educational Materials

The University of California, Davis offers a vast array of medical educational material free through its online Clinical Resource Center. Residents have access to Harrison’s *Principles of Internal Medicine*, *Scientific American Medicine*, Up to Date, multiple drug reference databases, CDC guidelines, MD Consult, Cochrane Library, Pub Med search engine, and UC Davis' electronic journal database. There are computer terminals in every location that residents provide care to patients that allow access to this and other educational material. Also the residents can access this information from home if they have a computer with internet access.

We have an internal medicine library located on the sixth floor of the hospital that has a large variety of relevant general medicine and subspecialty textbooks in addition to the computer based materials. Residents have access to this area 24 hours a day.

The medical center campus contains the School of Medicine which has a very large state of the art medical library which grants full access to all students,
VI. Feedback and Evaluation

a. Evaluation and Feedback for Residents: Although sometimes difficult, feedback is essential to the learning process. Residents are given continuous feedback on a daily basis by faculty. In addition, it is expected that there be two scheduled formal feedback sessions with each resident: a formative feedback session at the midpoint of your teaching block and a summative feedback session at the end of your block. Formative evaluation is a method of judging the worth of the learner while the program activities are happening; it focuses on process, and this feedback allows the teacher to reinforce appropriate behavior and to provide suggestions for improvement. Summative evaluation occurs at the end of the activity and focuses on outcome. Although written feedback is only required in the end of rotation E-value evaluation, we encourage adding written feedback to your midpoint session. Feedback is best when it results from directly observed behavior.

Remember, feedback is most effective when it:
1. contains specific goals
2. is linked to teaching
3. is given in a respectful, non-threatening way
4. is timely
5. refers to a specific observed behavior
6. is limited in amount
7. includes positives and negatives
8. Ends with an action plan.

The summative evaluation is based upon the faculty assessment of competency for each resident on the 6 ACGME Core Competencies in E-Value.

Upper level residents fill out E-Value assessments of interns and students. Interns fill out evaluations on their supervising resident and students.

b. Program and Faculty Performance: all residents on the UC Wards rotation are expected to complete an evaluation of the rotation and of their supervising faculty, all in the E-Value system. These are confidential evaluations, and are sent to the residency office for review.