

Primer to the Internal Medicine Subinternship

A Guide Produced by the Clerkship Directors in Internal
Medicine

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INTRODUCTION

Welcome to your internal medicine subinternship. We are delighted that you have joined us for this short period when you will have your first taste of what internship will be like and will experience more of what internal medicine has to offer. Regardless of your future career path, we wish you the most stimulating, rewarding, and transforming experience possible over the coming weeks.

The information in this booklet has been produced through the collaboration and consensus of internal medicine subinternship directors across the country, most of whom have spent many years teaching, evaluating, and advising students. It should help fill in some common gaps in the formal medical curriculum as you begin your internship. A complimentary resource for your subinternship is the *CDIM Internal Medicine Subinternship Curriculum and CDIM Internal Medicine Subinternship Training Problems*, which cover more traditional medical topics commonly encountered during the internal medicine subinternship. It is available free of charge online at:

www.im.org/Resources/Education/Students/Learning/CDIMsubinternshipCurriculum/Pages/default.aspx

Please note information provided by your subinternship director should take precedence over these suggestions.

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SECTION 1: MAKING THE MOST OF YOUR SUBINTERNSHIP

“It is a daring and transforming experience to attempt to heal another person.”
— *Edmund Pellegrino, MD*

For many of you, the subinternship will be your first real taste of autonomous patient care. Although you will of course be supervised, you are expected to be the first person evaluating your patients and generating assessments and action plans. You will be an integral part of the team, working directly with nurses, therapists, consultants, and other health care providers. Patients’ post-hospital care will be determined largely by how well you anticipate and facilitate their discharge needs. You will also be actively involved in the kinds of difficult discussions you may have only observed up to this point. With these increased responsibilities, efficiency will now be of paramount importance to your success. You will feel the potentially competing pressures of patient care, proper documentation, early discharges, and conferences. The tips and resources in this guide were developed to prepare you for many of the practical, day-to-day issues you will face when caring for hospitalized patients. They are intended to direct you to strategies that improve both the efficiency and quality of patient care.

SECTION 2: WORKING IN HEALTH CARE TEAMS

Given the diversity of backgrounds and complexity of patients in the 21st century, medicine has become a team sport and no one appreciates that more than a busy intern. Facilitating communication among the increasingly large health care team is a critical skill that will help you care for your patients. A new intern quickly learns that one of the best resources is the nurse. If you have not yet asked a nurse, “What do we usually do in this situation?” chances are you will. Even with nursing shortages and increased nurse to patient ratios, the nurses still have the greatest opportunity to pick up subtle changes in your patients while also ensuring that the orders are carried out.

Consultants also play a key role in the care of most patients, whether it is the physical therapist helping the patient walk or the transplant nephrologist managing a complex cocktail of immunosuppressants. Conveying complex data to patients and their families in a way that they understand while encouraging their participation in decisions about care is an essential duty for a physician. This section will provide strategies to maximize your communication with both the health care team and the patient.

CHAPTER 1: CONSULTATIONS

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Physicians commonly request consultations to:

- Get expert advice on diagnosis.
- Get expert advice on management.
- Get assistance in scheduling or performing a procedure or test.
- Arrange follow-up.

If you and your team already understand what is going on with a patient and are able to provide the care with your attending, there is little use in calling for a consult. Before calling, consider how the consultant may change your management. If a consultant would add to the case, then make sure you are very clear on what it is you and your team are asking the consultant to do before calling. “Curbsiding,” or asking consultants for an opinion without formally seeing the patient, may seem convenient but is discouraged.

HOW TO MAXIMIZE YOUR CONSULT

Perform the initial work up and have test results ready

For most stable patients, obtain and wait for the results of relevant diagnostic tests before contacting the consultant. For example, a stable female patient with a chief complaint of abdominal pain will typically have a urinalysis, serum amylase/lipase, and serum or urine

pregnancy test performed; these test results should be available prior to contacting the consultant.

For unstable patients or those with suspected unstable conditions (e.g., bleeding varices, dissecting aortic aneurysm, etc.), it is certainly indicated to contact the appropriate consultants before any definitive diagnostic tests have been performed. As for all patients, be sure that your upper level supervisors (i.e., senior resident or attending) are in agreement with your clinical impression and plans and are actively helping you manage the patient until definitive specialty help arrives.

Call consults early in the day

Most consult services have a resident or fellow see new consults first, and then round with the attending in the mid to late afternoon unless the problem is urgent. Therefore, it is most effective for patient care to call your consults early (as soon as you decide with your team a consult is needed, typically right after morning rounds). If you wait to call your consult until the afternoon, a member of the consulting team will either have to break away from consult rounds or may just wait to see your patient at the end of the day, which means the attending consultant most likely would not see your patient until the next afternoon.

Be professional

Prior to requesting a consult, be sure that you have discussed your plans with your supervising resident or attending so that she can:

- Approve these plans.
- Ensure that all pertinent data are available.
- Help coach you on what to say, including the level of urgency of the consult.

Some faculty and upper level fellows do not think it is appropriate for students to call consultations. If you experience this attitude, do not take it personally. Simply apologize and have your resident call.

Develop the capacity to handle disagreements professionally and to compromise appropriately. (See Chapter 5 on negotiating conflict.) In the academic setting, the person requesting a consult is commonly the least experienced caregiver on the primary team (e.g., medical students or interns), while the consultant taking the call is also typically the least experienced member of the consult team (e.g., medical student, resident, or first-year fellow). If there are any misunderstandings, it is best to involve your supervisors (resident or attending) immediately so that they can directly communicate with their counterparts on the consulting team to facilitate patient care.

HOW TO REQUEST A CONSULT: A STEP-BY-STEP APPROACH

The purpose of this guide is to help you communicate more effectively and systematically (either via telephone or in person) when requesting a consult from another service.

- Make sure you have **contacted the right person** before going any further with the conversation.
 - “Hello, Dr. _____. Are you the consulting resident/fellow/attending for the _____ (e.g., GI, Renal, General Surgery, etc.) service this month?”
- Clearly **identify yourself** and the service you are on.
 - “My name is _____ and I’m the subintern on the _____ (e.g., Medicine, etc.) service at _____ (Hospital name) this month, and I would like to request a consult.”
- **State your question** (or reason) for the consult *up front*—be as specific as you can. This crucial step immediately captures your consultant’s attention and helps him/her focus in on the presentation you are about to give.
 - “Our team is requesting your help for:
 - Advice on management of our patient who has a small bowel obstruction.”
 - Advice on diagnosis for our patient who we suspect has systemic lupus.”
 - Scheduling/performing a colonoscopy for our patient who is having persistent rectal bleeding.”
- Give **relevant clinical information** (in standard SOAP format to help you and your listener follow a systematic framework).
 - “Mr. _____ is a ___ year-old man with a history *significant* for (don’t report the whole PMH, only what that particular consultant needs to know) _____ who was admitted from the ED yesterday after he presented with _____ (chief complaint and *abbreviated* HPI) and was found to have _____, _____, etc. on physical exam and _____, _____, etc. on labs/radiology/ECG.”
- Give your **clinical impression** and brief hospital course.
 - “Based on his presentation, our working diagnosis is _____.”
 - “This is what we’ve done for him thus far: _____.”
- State the **urgency** of the clinical situation to let your consultants know if this is a patient they need to see now or a patient who can wait until later in the day or even until the following day to be evaluated. Be prepared to give additional details to back up your clinical impression, particularly in urgent situations.
 - “This man is still actively bleeding and his systolic BP has remained in the 90s despite aggressive volume resuscitation. We’d appreciate it if you would see him now.”
 - “Volume status, serum potassium, and acid-base status are all stable. She has no clinical evidence of uremia at this time, and she is not oliguric or anuric. Therefore, this consult can likely wait until later today or even tomorrow.”
- Consider **re-iterating your question** (or reason) for the consult if the steps above have taken longer or necessitated a more involved conversation.
 - “So again, we would like you to evaluate this patient for _____ so that you can give us some advice on _____.”

- Have the patient's medical record number and location ready to provide and make sure you obtain the name of the attending physician who will staff the consult. (A written request for consultation that includes the names and specialties of the attending physicians requesting and performing the consult along with the question or reason for the consultation may be required for reimbursement and possibly other logistical reasons.)

Ideally, total consult time should be less than one minute.

Example: Putting it all together

Hello, Dr. Green, are you on for neurosurgery consults? (Yes) Great, I'm Jane Eager, the subintern working with Dr. Smart on the medicine service, and we would like a neurosurgery consult to evaluate whether a subdural needs draining. The patient is Morris Trip. MR number is 234765 in room 721, and the attending is Dr. Smart from Medicine. Mr. Trip is an 82 year-old man with early Alzheimer's disease admitted for confusion and found to have a UTI. He was clinically improving on antibiotics but fell last night trying to go to the bathroom. His mental status is unchanged this morning but the cross-cover team ordered a head CT as a precaution, and we just got the report that it shows a moderate subdural hematoma but no sign of active bleeding. He has no change on neurologic exam and is at his baseline. We suspect this is chronic and not related to his initial mental status changes as he has been improving so it's not urgent to see him right away. But given its size we wanted your formal opinion about whether it should be drained. Who will be staffing this consult? Do you need any contact information from me? Thanks.

CHAPTER 2: EFFECTIVE USE OF AN INTERPRETER

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Approximately 18% of the US population speaks a language other than English at home, and about one-half of these individuals are considered Limited English Proficient (LEP). An LEP person is defined as an individual who speaks a language other than English at home and has a limited ability to speak, read, write, or understand English. Studies have shown that LEP patients, when compared with the English-speaking population, have limited access to primary care and are less likely to receive recommended preventive services. Additionally, because of their limited ability to communicate quickly and efficiently with health care providers, these patients have an increased risk for adverse events related to hospitalization or medication use and also are less satisfied with their own health and health care. You will certainly care for LEP patients in a variety of hospital settings. Title VI of the 1964 Civil Rights Act legally mandates that health care providers provide language assistance to these patients. Thus, it is important to understand the options for obtaining an interpreter and limitations.

Seek Professional Help

Professional medical interpreters are the recommended and most effective method of providing linguistically competent care to LEP patients. These professionals positively impact patient comprehension, health care utilization, clinical outcomes and patient satisfaction when compared with ad hoc interpreters (e.g., family members or bilingual office/hospital staff). In fact, the quality of care of LEP patients approaches that for English-speaking patients and there is a measured reduction in medical errors when professional interpreters are used.

Know Your Options: Types of Interpreters

Chance and untrained interpreters have no formal training in interpreting or interpret on an ad-hoc basis. Chance interpreters include the patient's family members or friends, but can also be a bilingual individual who just happens to be available and in the vicinity. Untrained interpreters are bilingual support personnel (e.g., nurses, technicians) or bilingual individuals hired as interpreters who lack formal training in medical interpretation.

Onsite medical interpreters are hired by the hospital or health care facility and have specific training in medical interpretation. These individuals have experience in health care-related cultural issues and medical terminology that allows them to play an active and more productive role in health communication.

Telephone interpreters are usually trained in medical interpretation and often more readily accessible (including after hours) than onsite interpreters. Telephone interpreters are especially useful in interpreting languages that may not be commonly spoken at your institution. AT&T Language Line Service is one of the pioneers in providing telephone interpretation; however, other private corporations (CyraCom or Language-Line) also provide similar services. It is best to request a medical interpreter because telephone interpreters can vary in expertise.

Remote Simultaneous Medical Interpreting (RSMI) is an innovative method that allows a remotely located trained interpreter to communicate with the physician and the patient in real time using audiovisual teleconferencing equipment.

INTERPRET™ Mnemonic

(Developed by Martha A. Medrano, MD, University of Texas Health Science Center at San Antonio and Alison Dobbie, MD, University of Texas Southwestern Medical Center at Dallas)

When using an ad hoc, chance, and untrained interpreter to interview a patient, the INTERPRET™ mnemonic can assist the physician/interviewer to obtain a linguistically and culturally appropriate history:

- I** – **Introduction:**
Introduce and identify all participants (physician, patient, and interpreter).
- N** – **Negotiation:**
Negotiate exact role for interpreter (especially if chance interpreter). Clarify if interpreter will also act as the “culture broker” (one who can provide insights about the patient’s culture and how it might affect their health care).
- T** – **Trust:**
Establish atmosphere of mutual trust by, for example, greeting the patient in his or her language.
- E** – **Engagement:**
Speak directly to and maintain eye contact with the patient, not the interpreter. Refer to the patient as “you.” (Ask the patient, “Do you have pain?” instead of asking the interpreter, “Can you ask the patient if he has pain?”) Use short, simple sentences. Allow time for patient to speak and interpreter to interpret before proceeding.
- R** – **Room setup:**
Position the interpreter slightly behind the patient. Sit directly facing the patient.
- P** – **Patient-centered:**
Establish and address the patient’s agenda. Ensure that the patient understands and agrees to treatment plan and follow up. Ask if there are any other questions or concerns.
- R** – **Respect cultural beliefs:**
Elicit and acknowledge the patient’s cultural/religious beliefs.
- E** – **Ethical considerations:**
Address ethical issues such as confidentiality and gender issues. Avoid using children as interpreters whenever possible.
- T** – **Time management:**
Be time efficient without rushing the patient or the interpreter.

CHAPTER 3: ANSWERING A NURSE PAGE

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Most calls from nurses involve a relatively simple question or need for clarification. It is important to recognize that for even the simplest of calls, asking the nurse for his or her advice and suggestions is often helpful, particularly when the nurse has personal knowledge of the patient in question and years of experience. Furthermore, recognizing when and how to initiate simple laboratory studies or initial treatment prior to seeing the patient will often aid you in caring for the patient. Responding to pages quickly and collaborating with the nurse is professional and insures the best patient care.

Guidelines for Answering a Nurse Page: A Step-by-Step Approach

(Ideally, total time communicating with the nurse should be less than a few minutes.)

Answer the page in a timely fashion, within one to two minutes.

- If you are unable to answer the page when you receive it, have someone on your service answer the page and identify what the nurse needs.

Clearly identify yourself as a medical student and the service you are on.

- “My name is _____ and I’m the senior medical student working with _____ (e.g., Dr. Smith on Medicine, etc.). I was paged.”

Confirm you, along with the resident or intern, have responsibility for the patient.

- When possible, help the nurse identify who is caring for the patient.
- Even if the question or point of clarification from the nurse may be relatively simple, you should not authorize an order or study unless you are directly responsible for the patient and the intern/resident is immediately available for co-signature

If the nurse is concerned, you should be concerned.

- For nurse pages that relay a change in the patient’s status, you will need to see the patient.

Ask the nurse for his or her initial assessment.

- Nurse: “...the patient has a history of significant coronary artery disease and I am concerned that the ‘epigastric pain’ could be cardiac.”
- Nurse: “...the patient has a history of dementia and frequently is confused at this time of night...the mental status is not new.”

Identify if there is something that can be done or initiated prior to seeing the patient

- A patient with chest pain will likely need an EKG and cardiac enzymes, for example, and these can be initiated as you are on your way to see the patient.
- A patient with shortness of breath may benefit from checking a pulse oximeter reading and beginning oxygen.

Ask if there are additional questions or concerns before you hang up.

Collaborate with the nurse on an acceptable time to see the patient if you are occupied.

Remember as the subintern you are not able to give orders so make sure the nurse does not interpret anything you say as a direct verbal order, which must come from a physician. It is your

responsibility to communicate with your team members and ensure that the orders are given by the appropriate person in a timely fashion.

CHAPTER 4: TIPS FOR TRIAGING CROSS-COVER

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The first time you receive a phone call from a nurse on a patient you are covering but have never seen before can provoke anxiety. Here are a few tips that may help you with the cross-coverage process.

- Always be courteous, no matter how late or how unnecessary the call may seem.
- If there are simultaneous patient emergencies/urgencies, call for back-up.
- When the nurse states the patient looks sick and needs to be seen, go and see the patient as soon as possible.
- When a nurse calls you with a patient concern, ask for a current set of vital signs to help you triage.
- When in doubt, always err on the side of going to the bedside to see the patient.
- Some common conditions require bedside assessment (in parentheses are things for the nurse to address as you proceed to the bedside):
 - Chest pain (have nurse get ECG)
 - Shortness of breath (ask for pulse oximetry)
 - Hypotension (ask if the patient is alert and making urine)
 - Mental status change (have nurse get ECG, pulse oximetry, and chemstick glucose)
 - Fall
 - New symptoms not addressed on your sign out

When you physically see the patient, you need to document it in a cross-coverage note (see Chapter 10). If you do not document it, the primary team may not know what happened and legally the encounter did not happen.

SECTION 3: ADVANCED COMMUNICATION SKILLS

Given the acuity, complexity, and uncertainty surrounding most patients on an inpatient medical service, challenging communication issues will arise and, as the subintern, you may be the first person present to address them. Some of these issues, such as delivering bad news or discussing an adverse event, can have important consequences for patients and therefore you should treat such delicate interactions as you would an advanced procedure. **You should not attempt them unsupervised (other than conflict negotiation) as they require the presence of an experienced physician.** However, you are encouraged to play an active role in these conversations, even taking the lead with supervision.

This section will highlight some of the most frequent challenges to communication that arise in the inpatient setting and provide practical and proven strategies to prepare you to negotiate them successfully.

CHAPTER 5: NEGOTIATING CONFLICT

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The subinternship marks a transition where your success, both as a student and as a clinician, is measured by getting things done for your patients. The key to getting things done is to work effectively with people in the hospital. However, when such a diverse group of people are working together (residents, fellows, faculty, nurses, family members, social workers, etc.) conflicts are bound to happen. Interestingly, the business world does a much better job training for conflict management than we do in medicine, where the stakes are so much higher. The following principles were derived from the works of Steven Covey, Roger Fischer, and Dale Carnegie and should provide you with practical strategies to negotiate conflicts.

Principle 1: See things from the other person's point of view.

Our first inclination in any difference of opinion is to assume that we are right and the other person is wrong, or that we have the best of intentions and the other person is operating from a less noble perspective (e.g., laziness).

Why didn't the GI fellow agree to do an endoscopy on this patient who has a clear GIB?

An ability to see the other person's perspective will allow you to understand why differences exist and then move toward a common solution. Rather than express frustration or bewilderment, a better strategy is to assume nothing about the other person and probe for their underlying reasons without challenging or undermining their role.

You may be thinking: *She's just trying to get out of the EGD because it is 5:00 p.m.*

But you might say: *I'm sorry, but I wasn't clear on why this patient should not get an EGD.*

The NG tube was positive, his hemoglobin is down two grams, and his stool is guaiac positive.

Can you help me understand so I can explain it to my resident and my team?

When the other person provides an explanation, ask yourself if her response or actions are reasonable. Would you think or act the same way if you were in her shoes? If so, move past your difference of opinion (positions: EGD or not) and seek a common solution or understanding.

Whenever you have a difference of opinion, first seek to understand and then to be understood. Unless people believe you understand them, they will be too defensive, upset, or annoyed to hear your concerns or what you have to say.

Principle 2: Go for win/win by appealing to the other person's interests.

In general, the people you work with have the same goal as you: provide outstanding care for your patients. However, you likely have a greater sense of urgency in the matter as the ultimate responsibility falls to you and your team.

Your patient just developed a fever and needs two sets of blood cultures. The phlebotomist is drawing morning labs. He will not draw the cultures because they are not on his list with pre-made labels, and says it has to be entered into the computer. That will take too long, as he's almost done with this floor.

If you can move your discussion away from positions (e.g., blood cultures now or later) toward interests, you can be creative. The common interest of outstanding patient care is the noblest one, but if necessary, you sometimes have to appeal to other interests as well. Your chief interest is prompt evaluation and treatment of your patient. The phlebotomist's interests may be prompt evaluation and treatment of your patient, but also not having to make another trip to the floor, not having to do another blood draw, and not having to wait for labels or to transport the blood cultures.

I see you are very busy, but I would really like to get Mr. Singh's blood cultures down to the lab now so we can treat his infection with antibiotics as soon as possible. If you would be able to draw the blood cultures now, before you leave the floor, I'll work with the unit clerk to print labels and put the labeled bottles on your cart. If you are gone, I'll take them down to the lab myself. Then we won't need an additional STAT draw back on this floor in an hour.

After you can see the issue from his point of view (Principle 1)—either by asking him directly or using your own understanding of workplace realities—try to come up with solutions that allow both parties to gain. The key is not telling him why you are interested in having something happen, but rather help him recognize why it is in his interest that something happens.

Principle 3: Show respect for another person's opinions and avoid criticism or condemnation.

Exhibit great caution when challenging the opinions or statements of others. More often than not this challenge can place you on the road to an argument, and once you have challenged a person in even the slightest of ways, recovering can be very difficult.

You may be thinking: *Why doesn't the respiratory therapist want to place my patient with ARDS on a low-tidal volume mode, which I know to be beneficial from rounds and the literature?*

A better approach might be: *I thought this was the best strategy, but I know you've taken care of many more patients than I have. I understand that patients like this tend to do better on low tidal volume settings. Is there something about this patient's situation that should lead us not to do this?*

If you suspect that a consultant or nurse is wrong or has misjudged a situation, double check your impressions with your references or your resident. If you are correct and have to assert your position to care for your patient, do so with tact and without argument. In the example, starting with an acknowledgment of the other party's expertise and opinion (even if incorrect) instead of a direct challenge can soften the tone and move the issue toward resolution.

Principle 4: Separate the people from the problem.

Every interaction involves two kinds of interests—the problem and the relationship. When relationship issues become entangled with the problem, it can impair your ability to tackle the problem effectively. Learn to separate the relationship from the problem and deal directly with the people first.

Why is the patient's son so mad at me? I know he's upset because the patient developed recurrent C. difficile while being treated for urosepsis, but is that my fault? This is a known consequence of receiving broad spectrum antibiotics.

You may initially feel compelled to respond to this family member with the medical facts, but it is a common tactical error. Do not meet his anger with increased justification of the medical facts—mixing the people with the problem. Allow him to voice his concerns and acknowledge his emotions first, and then respond.

I can see how frustrating this must be. I know you've brought your father to the hospital four times in the last three months, and each time the doctors prescribe an antibiotic, but it doesn't seem to keep him well.

By letting the son express his emotions and acknowledging his experiences and impressions, he is validated and can shift his attention to the medical facts. You can then move from the relationship problem to the medical problem. If you do not first acknowledge his anger and confusion over the situation, you will not get his assistance in caring for this patient.

Conclusion

These approaches to dealing with people are derived from experience, research, and common sense that extend far beyond the world of medicine. Try watching the residents and faculty who are known for their great people skills and you will notice these behaviors. Like any clinical skill, they can be observed, practiced, and refined. Although incorporating these approaches into your daily interactions requires substantial effort at first, as they become second nature, you will see that they require far less energy than conflict. The less energy you spend on conflict, the more you have to spend on your patients and your own learning.

CHAPTER 6: DELIVERING BAD NEWS

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As a subintern in internal medicine, you will care for patients who receive bad news about their health. You may have to deliver such news (with a physician present). Like a complex procedure, you have one chance to do it well, so approach this task systematically with ample preparation and supervision.

Getting Started (Preparation)

- Understand the patient's disease, prognosis, and treatment options.
- Find an appropriate setting where everyone can be comfortable and seated (including you). Ask someone to cover your pager to prevent interruptions.
- Ask the patient who should be present at the meeting. *Would you prefer if I discussed your medical condition with you alone or would you prefer to have family members or a friend present?* If the patient does not have decision-making capacity, then conduct the discussion with the legal decision maker.
- Consider whether other health professionals (consultants, nurses, social workers, chaplains) involved in the patient's care would be helpful at the meeting and obtain the patient's or family's permission for these people to be present.
- Inquire about and respect cultural preferences that could impact how the interaction will proceed.

Find Out How Much the Patient Knows

- Ask the patient or family what they know or understand. *What have you already been told about your illness? What is your understanding of your condition?*
- Before giving bad news, present a brief overview of the patient's course so that everyone has the same information.

Find Out How Much the Patient Wants to Know

- Determine what the patient and family want to know. *Some patients want me to cover every medical detail, but other patients want only the big picture— what would you prefer?*

Sharing the Information

- Warn the patient that bad news is coming. *Unfortunately, I am afraid that I have some bad news. I wish things were different, but the results are not good. The biopsy showed...*
- Proceed to give information at the patient's pace and repeat key information as necessary.
- Allow for silence and emotional reactions.

- Have the patient tell you his or her understanding of what you have said. *I want to make sure you understand what we have talked about. Can you tell me your understanding of what we have discussed?*
- Avoid overwhelming the patient with details. Expect that the patient will remember very little information beyond the bad news itself. Anticipate subsequent visits where more detailed information can be discussed.

Responding to the Patient's Feelings

- Listen carefully; identify and acknowledge the patient's and family's emotional reactions.
- Make sure your body language conveys compassion and openness to questions (*leaning forward, having tissue available, using discretion about touching the patient to give comfort—some welcome this and others shrink from it*).
- Assess for thoughts of self-harm. *Could you tell me a little bit about how you are feeling?*

Planning and Follow-Through

- Summarize your meeting and make specific follow-up plans. *I will return in the morning. It is normal to think of questions as soon as I leave the room. Just write them down as they come to mind so we can talk about them in the morning.* Make sure this plan meets the patient's needs.

Follow-Up Visits

- Ask the patient if he understands what has been discussed about his condition, and repeat or correct information as necessary.
- Inquire about the patient's emotional and spiritual needs and what support systems he or she has in place.
- Use interdisciplinary services to enhance patient care.
- Conclude each visit with a summary and follow-up plan of care.

Conveying bad news is a process, not an event. It is expected that this experience may deeply affect you. Remember also to address your own personal feelings and needs following the delivery of bad news. Make sure you have an outlet to process these emotions whether it is speaking with a friend, journaling, or even allowing yourself some quiet time alone. Arranging a debriefing session with your resident or attending for feedback is also an opportunity to discuss your reaction to the experience.

CHAPTER 7: DISCUSSING ADVERSE EVENTS WITH PATIENTS

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The Institute of Medicine defines an “adverse event” as an injury caused by medical management rather than the patient’s underlying disease. Adverse events are common, estimated to affect 10% of all patients. Degrees of severity include serious (causing death, permanent injury or transient but potentially life-threatening harm), minor (causing harm that is neither permanent nor life-threatening), and near misses (could have caused harm but did not, either by chance or timely intervention). Adverse events may result from an individual’s lack of knowledge, ability, or clinical judgment, or may be due to system flaws; often adverse events are multi-factorial.

As a subintern, you may witness adverse events or near misses that go unnoticed by other members of the team. It is a professional duty to discuss these events with the supervising house staff, chief residents, attending physicians, or the subinternship director. Identification of system flaws can enhance patient safety and improve patient care. Familiarize yourself with your institution’s reporting system for adverse events. Many hospitals now have anonymous online reporting systems for errors and near misses.

Since subinterns follow fewer patients than residents and attending physicians, you are in a unique position of being able to spend more time with your patients and field questions they may not be willing to ask others. You are bound by the same professional and ethical obligations as physicians to provide honest information to patients and their families when an adverse event occurs. However, as a subintern, your role in discussing adverse events with patients is not well defined.

If you think you witness an adverse event in a patient’s care, avoid independently revealing this information to the patient. Rather, assume the role of intermediary and relate the patient’s concerns (or your own) about possible adverse events to the attending and ask to be present for the discussion between the attending and patient. This discussion may include a detailed explanation of events, the need for an investigation to more accurately define the causes of the event, and sharing the results of an investigation. In cases where an adverse event occurred, the attending should issue an apology to acknowledge and accept responsibility for the event. The attending may need the assistance of patient safety or risk management officials as these disclosure discussions may be emotionally charged or have legal consequences.

Sadly, some physicians are still very threatened by acknowledging and reporting adverse events to the point they may mislead or even lie to the patient and expect you to go along. This situation is never acceptable. Lying to or deceiving a patient is always wrong. If it happens, report it to your subinternship director or hospital’s risk management officer.

CHAPTER 8: DECISIONAL CAPACITY AND INFORMED CONSENT

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As a subintern, you will play an important role in helping patients understand their conditions and care options available to them. Sometimes, this role will involve obtaining informed consent. Informed consent is the process by which a patient understands her condition and available treatments and participates in choices about her health care. The physician has an obligation to make recommendations for care in accordance with good medical practice and to present medical information accurately to the patient in language that she can understand. For the patient's consent to be valid, the patient must have the capacity to make medical decisions and the consent must be voluntary.

The legal standard of informed consent varies from state to state and it is your responsibility to learn requirements specific to your state. However, all informed consent should include a discussion of the:

- Patient's diagnosis.
- Nature and purpose of the proposed procedure or intervention.
- Risks and benefits of the proposed procedure or treatment.
- Available and reasonable alternative procedures or treatments, including doing nothing.
- Risks and benefits of the alternative procedures or treatments.
- Assessment of patient understanding.
- Acceptance or a declining of the intervention by the patient.

Discussing these elements with the patient provides the physician useful information to help assess a patient's decisional capacity and to ensure informed consent occurs.

Decisional capacity and informed consent are contextual and decision-specific. Therefore, a patient may have the capacity to refuse a routine blood draw but not necessarily a life-saving surgery. Decisional capacity is also different from competence, which is a legal definition. Establishing decisional or decision-making capacity should include assessment of:

- Understanding (the ability to comprehend what you explain).
- Appreciation (the ability to appreciate the significance of the indication, risks, and benefits to themselves).
- Reasoning.
- Expression of choice.

Additionally, the patient's decision should be consistent with what the physician knows of the patient and her value system. For example, a patient may refuse a therapy for which she can list the risks, benefits, and alternatives, but if reason for the refusal is irrational or inconsistent with stated values, the patient's decisional capacity should be doubted. In the event a patient cannot demonstrate decisional capacity, you and your supervising physicians should seek out a surrogate decision maker.

The following is a specific example of how to approach the process of informed consent in a step-by-step fashion.

Explain the patient's diagnosis using simple language. *We are worried that the swelling in your belly is extra fluid, called ascites. This fluid can collect for many different reasons, including liver or heart problems. To give you the best diagnosis and treatment, I am recommending a procedure called a paracentesis.*

Explain the proposed procedure. *A paracentesis is the medical term we use for removing some fluid from your belly. We have to sample this fluid and send it to the lab so we can try to determine the cause and best treatment to prevent it from coming back or getting infected. First, we clean your skin off with special soap to decrease the risk of infection. Although we do use a needle to draw out the fluid, we numb the area of skin first so it won't hurt any more than a shot. After we remove the fluid, we take the needle out and put a band-aid over the area. We should be able to have results on the fluid in the same day as the procedure or the next day so that we can hopefully tell you more about why your belly is full of fluid.*

Explain the risks and benefits of the procedure. *This is a very safe procedure, and our team routinely performs this procedure on patients who have this problem. We will use physical exam techniques or possibly ultrasound to find the safest place to draw out the fluid. Although we are skilled in this procedure and we use proper technique, rarely problems can happen as a result of this procedure. One potential problem is bleeding, either in the skin or deeper in the belly. There is also the small risk of an infection from the needle as it pierces the skin, or the potential for damage to the bowel or other abdominal organs from the needle, which can be a serious problem. Finally, some patients have continued leakage of fluid from their abdomen following the procedure. We use our best techniques to lower the risks of these complications, but nothing can make this procedure entirely free of these risks. However, the overall risks are small compared to the potential benefit of the information we can obtain from this procedure.*

Explain reasonable alternatives to the procedure, including risks and benefits. *It is possible to make an educated guess about the cause of this fluid on your belly and treat it accordingly—but this would not be the best medical care. The most important reason to draw the fluid out is that a serious condition could be missed if this test is not performed, and you could get sicker. No other test can offer the same information that we can receive from this procedure.*

Assess the patient's understanding. *I need to make sure I explained this clearly. Would you please tell me your understanding of this procedure?* Note the open-ended question. Simply asking the patient if she understands does not give you adequate information to determine true understanding.

Reiterate the patient's consent to the intervention. *It seems that you understand the risks and benefits of having the paracentesis and that you want to proceed with the procedure. Do you have any other questions? I will document in your medical record our discussion and your agreement to proceed with the paracentesis.*

Physicians may proceed with treatment in emergency situations (without obtaining informed consent) if all three of the following criteria are met:

- The situation is a life threatening emergency and time is of the essence.
- The patient does not have decisional capacity and no legal surrogate decision maker is available.
- A reasonable person would consent to the emergency treatment.

Remember that a patient with decisional capacity may decline any and all treatments and the patient can withdraw consent at any time.

CHAPTER 9: OBTAINING ADVANCED DIRECTIVES AND DOCUMENTING DNR

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Patients in the hospital often have complex, multi-system, and life-threatening conditions. As a subintern, one of your responsibilities is to understand your patients' values and preferences as they relate to health care decisions. To care for and advocate for your patients, it is essential that you clarify what outcomes they anticipate and what they hope for from their care. Advanced directives are a patient's way to specify the type of care he would like (or not like) to receive should he lose the ability to make medical decisions for himself. Advanced directives, including code status, should be established early in a patient's hospitalization. Additionally, it is just as important to know who the patient would want as his health care proxy (or surrogate), if he has not appointed one already.

In the best of circumstances, every patient should have an opportunity to discuss and document their care wishes when they have the capacity to do so and in a situation where they are not facing critical illness. In such circumstances, you need only to confirm or clarify the wishes in the context of the hospitalization. Unfortunately, this scenario is rarely the case and these discussions frequently fall to the inpatient medical team who likely do not know the patient on a personal level. It is good to have a clear strategy for how you will engage in these discussions when you assume the care of the patient. As a subintern, you may participate in such discussions, but it is essential that you do so with the direct supervision of your resident or attending.

Policies about advanced directives differ from state to state and may vary among the institutions with which your medical school is affiliated. Try to clarify local policies before discussing advanced directives with patients.

A do not resuscitate (DNR) order is an order placed in the patient's medical record that indicates that the patient should not receive cardiopulmonary resuscitation. Patients should understand that this order applies only in the event of a cardiac arrest and does not influence decisions about other life-sustaining or symptom-directed therapies.

Other decisions to not initiate or withdraw life-sustaining therapy should be made on an item-by-item basis. Examples of life-sustaining therapies include mechanical ventilation, artificial nutrition and hydration, hemodialysis, and administration of intravenous fluids or antibiotics. Such decisions should be approached as any health care decision that requires informed consent. (See Chapter 8 on decisional capacity and informed consent.) Often, these decisions are made when the patient's overall prognosis is poor and the burdens or risks of the intervention are high.

Every patient should have the chance to designate a health care proxy, someone to make health care decisions for them in the event that the patient becomes incapacitated. The health care proxy must be able and willing to make decisions that reflect the patient's wishes. The physician

should not be the health care proxy. A health care proxy form can be filled out in the hospital and does not require a lawyer. If a patient lacks capacity to make a decision about a health care proxy and has not already appointed one, the patient's next-of-kin should function as the patient's health care agent and there is a legal hierarchy to determine which next of kin serves this role (spouse, child, parent, then sibling is a typical order).

Establish the Setting

Ideally, you will have this conversation in a quiet, private, and comfortable location. Find out from your patient if any family members or other important individuals should be present. Set up a time that is convenient for all participants. All of the participants in the conversation, including you, should be seated. Make sure you establish eye contact with the participants during your conversations.

Mrs. Jones, we have some important things we need to discuss with you to make sure we honor your wishes and give you the type of medical care you desire. Is there anyone else you would like present for this discussion?

Assess the Patient's Understanding of the Medical Facts

Mrs. Jones, what is your understanding of why you are in the hospital? What have the doctors told you about your health condition?

Omitting this step is one of the most frequent causes for a discussion of DNR to go awry.

Correct Any Misunderstandings about the Medical Facts

Assess the Patient's Values, Hopes and Expectations

Mrs. Jones, given what we know about your medical condition, what are your expectations for recovery?

If you expect the patient to make a full recovery, this step is straightforward. However, if it is unlikely that the patient will return to her baseline, it can be helpful to frame this discussion in terms of realistic best case and worst case scenarios. Each person has their own value system which is informed by their culture, religion, life experiences, and family. It is essential to ask what makes life meaningful for the patient and if he can imagine a circumstance when life may not be worth living to him.

I agree that your kidneys have gotten worse from this infection to the point that you will need dialysis at least for the short term and that this is putting a strain on your heart. It is our hope that in the best case scenario the infection will clear up quickly with antibiotics and your kidneys will return back to their previous level of function which wasn't normal but didn't require dialysis. However, I do want to be honest with you that it is possible that the infection has already done too much damage to the kidneys and you will need dialysis permanently. And in the worst case scenario, with your weak heart this could all be too much of a stress for your heart and it could just tire out. Right now your heart is doing well and I don't think we will be facing the worst case scenario, and we are doing everything we can right now to aim for the best case scenario. What are your thoughts about these possibilities?

Discussing a DNR Order Specifically

Now that you have established joint understanding of the patient's present and future, you should discuss resuscitation. Pause often to assess reactions, allow questions, and clarify areas of confusion. Establish the context in which treatment or resuscitation could be considered. You may want to offer your opinion that a DNR order may be indicated.

I agree that it makes sense to treat this infection with antibiotics and use dialysis at least temporarily to help get you through this illness. What I need to clarify with you are your wishes should your condition deteriorate. What I mean is: should the infection cause too much stress on your heart and cause it to stop beating, you would die. The only option we have at that point is cardiopulmonary resuscitation, or CPR, which is pushing on the heart to keep it beating, shocking the heart if necessary, and trying strong drugs to make the heart beat again. Most patients with your health conditions will also need to be placed on a breathing machine in this situation. We can attempt all of these life support measures if that is your wish. The other option is to continue all of the treatments we are currently doing (antibiotics and dialysis) but if they were not working and your heart did stop we would not move to these life support measures and we would instead allow you to die naturally.

Note how this example clarifies that CPR is a treatment that attempts to reverse death, while also making it clear that a decision about DNR status is not necessarily related to decisions about the intensity of the effort to cure or treat the underlying conditions.

Another approach to this discussion is to offer your recommendation first. You can offer your suggestion, just as you would for other medical therapies and decisions. After all, CPR is a medical therapy with indications and contraindications. You should also emphasize that DNR status does not mean that the medical team will not treat the patient any longer.

Respond to Emotions

Patients, families, and surrogates often develop a significant emotional response to a discussion of resuscitation even when it is unlikely to be needed. Be sympathetic to their grief, have tissue ready, be patient, and allow them to cope.

Establish a Plan

Mrs. Jones I just want to make sure that I understand your wishes and am honoring them. What I heard is that you want us to continue to aggressively treat your infection with antibiotics and your kidney failure with the dialysis. However, if you were to die, you do not want us to begin CPR or life support. I will make a note of your wishes in the chart so everyone caring for you will honor them. However, if you should change your mind, I can always change this order. You can let anyone on the team know if you have any questions or want to rethink this plan.

Documenting DNR status

Only a physician can write a DNR order; at many institutions, only the attending physician can write this order and they always must co-sign it. However, as the subintern, you may have a patient initiate this conversation with you or even provide you with their advanced directive. After you have established a DNR status with your patient, you must discuss this status with your resident and attending. Documentation of DNR orders in the medical chart includes:

- Date and time.
- Mention of prior advance directives.
- Reason for the DNR order.
- Notification of the patient's attending and other health care providers.
- Names of the patient or surrogate decision makers involved in the decision.
- Any modifications to the DNR order, as allowed per your institution.

DNR decisions for hospitalized patients should also be discussed verbally to all of the appropriate health care providers for that particular patient, and should be included in a patient's sign-out.

SECTION 4: TRANSITIONS OF CARE

As a subintern, you will help coordinate discharge planning, sign out patients to the on call teams, write off service notes on the last day of your rotation, and write cross coverage notes on patients you took care of while on call. It is vital to recognize the importance of these key communication issues surrounding patient care so that you can develop skills and strategies to ensure continuity of patient care and effective hand-offs. In fact, communication failures are the most common root cause of sentinel events (unexpected occurrences involving death, serious physical or psychological injury, or the risk of these) reported to the Joint Commission (JC). Consequently, JC now requires that all health care organizations “implement a standardized approach to ‘hand off’ communications, including an opportunity to ask and respond to questions.”

A wealth of research on safety from many high-risk industries (e.g., aviation) can be applied to patient care. Key strategies to improve successful transfers of information include:

- Standardization (e.g., use of templates and avoiding idiosyncratic abbreviations).
- Routine updates of information to maintain accuracy.
- Limited interruptions (e.g., use quiet area/setting).
- Face-to-face updates that allow questioning.
- Structured communications (e.g., read-back of key data and tasks) to ensure accuracy.

This section offers guidelines, templates, and tips that will help you provide the most effective and seamless transitions of patient care.

CHAPTER 10: CROSS-COVERAGE

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HOW TO WRITE AND COMMUNICATE A SIGN-OUT

Medical sign-out is the process by which the physician going off duty transfers patient information and patient care responsibilities to the physician coming on duty. It is also called a “hand off” or “change over” and is a critical point in communication. Two mnemonics serve as “best practice” formats used to standardize sign outs.

S-B-A-R: Situation, Background, Assessment, Recommendation (Verbal Format)

- **Situation:** *Mr. Smith is a 45 year-old man admitted yesterday (give actual date) with a massive upper GI bleed with accompanying hypovolemic shock.*
- **Background:** *He was aggressively volume resuscitated, and emergent EGD revealed a large duodenal ulcer that eroded into an artery which was actively bleeding. The active bleeding was successfully controlled endoscopically with epinephrine injection and thermal coagulation.*
- **Assessment:** *He is hemodynamically stable now with serial hemoglobins holding stable (around 9.5g/dL) over the last 3 measurements. His condition remains tenuous such that if he re-bleeds again or if his hemoglobin starts to drop...*
- **Recommendation:** *...Call GI back to re-scope him immediately rather than wait until morning. Here is the GI fellow/attending that you call (give name and pager number); and he/she already knows about this patient. This is the key information you need to know now. I can tell you about his other stable medical problems later.*

ANTICIPATE (Written Format)

- **A** Administrative information
 - Patient's identification: name, age, ethnicity, sex, medical record number.
 - Patient's location: ward/unit and room number.
 - Patient's team information: primary inpatient team name/color (include individual team members' names and pager numbers).
 - Date of admission.
 - Patient's family contact information.
- **N** New clinical information
 - Admitting diagnosis (give any relevant supporting data) with management plans and response to treatment.
 - List other active medical problems with management plans.
 - Include results of recent procedures and tests; any other significant events.
 - Current baseline status: cardiovascular/hemodynamics, respiratory, and neurological/mental status. Important to include abnormal but stable baseline (e.g., residual dense hemiparesis from a remote stroke).
 - Medication list and allergies (include patient's reaction).
- **T** Tasks
 - Give very specific "to do" instructions—e.g., check pending test results and what, if any, specific action needs to be taken in case of test abnormalities.
 - Prepare for certain tasks ahead of time (e.g., informed consent for procedures or for transfusion of blood products, an active type and cross, secure intravenous access).
- **I** Illness assessment
 - Is the patient sick / unstable?
- **C** Contingency planning/Code status
 - Anticipate any problems that may arise and what to do about them, using specific "if-then" statements.
 - List what management steps have or have not worked in the past.

Most hospitals are transitioning to electronic sign-out templates that should include all of the above information. You should use these if they are available. It is not appropriate to sign out to follow up the results of studies completed during your shift. You should try your best to follow through the studies to avoid burdening the physician coming on duty.

Sample Written Sign-Out

1/4/2008

Bond, J MR# 007

Rm5555

M team, Dr. Q (pager 999-0000)

Contact: Ms. Moneypenny (555-4981)

Full Code

45 yo wm admitted 1/2 after being found unresponsive after an unwitnessed assault

- Head CT negative
- Hypoxic in ER - CXR showed pneumothorax; CT surgery placed chest tube- sats improved.
- Woke up 1/3 and c/o left leg pain- plain film w/ nondisplaced fracture- ortho casted
- Currently alert and stable, chest tube removed at 4PM today and vitals stable with O2 sats 100% on 2L NC

Other issues:

1. Renal failure likely dehydration--initially concerned about rhabdo (CPK 700- now decreasing and also r/o MI w/ troponins); creatinine decreasing with hydration- 2.8 (1/2) to 1.9 (1/4).
2. Mild hyponatremia- corrected with fluids.
3. Heavy ETOH history- watching for withdrawal but not giving prophylactic ativan as no history of DTs

Meds: morphine PCA (he's getting a basal rate but hasn't used the demand)

dulcolax 100mg BID

acetaminophen 650 mg q6hours prn breakthrough pain

lorazepam 0.5-2mg prn signs of ETOH withdrawal

heparin 5000units SQ TID

All: NKDA but NO NSAIDS!! (renal dysfunction)

To Do:

- Check f/u CXR at midnight to look for any recurrence of the pneumothorax (CT surg wanted it repeated in 8 hours after they removed the chest tube)
 - If fever, panculture
 - If CP, check ECG and CXR (r/o pneumothorax)
 - If hypoxic consider recurrent pneumothorax and recheck CXR, if negative then consider PE and get CT PE protocol

THE CROSS-COVERAGE NOTE

When you are covering for a colleague, it is critical to communicate medical information effectively, including any change in patient's clinical status, therapeutic and diagnostic interventions, and your assessment. Cross-coverage notes are an efficient way to ensure all caregivers are aware of significant medical events.

The critical elements to include in every cross coverage note:

- Write clearly and succinctly.
- Document the time and date when you saw the patient.
- Identify the time and the main reason you were called to assess the patient.
- Derive the history of the event from the nurse and the patient.
- Describe briefly the pertinent physical exam findings at the time of your evaluation.
- Discuss briefly your assessment and plan, including medications given and tests ordered.
- Document your interpretation of any ECGs and radiological studies performed.
- Document tasks pending completion or follow up ("To Do" list).
- Document discussions you had with the patient, family, or consultants.
- Document change in code status if applicable (This should be communicated verbally as well).
- Sign legibly and leave your contact information for questions.

Example of a good cross coverage note:

1/5/08. 11:15 PM. Called by RN at 11:00 PM to see patient for increasing shortness of breath. Patient has known CHF according to chart w/ EF 35% from ECHO this admission. Symptoms started ~10:00PM. Patient denies chest pain, palpitations, or cough. Pulse 110, RR 28, BP 140/80; pulse ox 92% on 6L, patient using accessory muscles, lungs w/ bibasilar crackles. ECG shows sinus tach with no ST-T wave changes and unchanged compared to prior ECG from 1/4/08. CXR showed new interstitial infiltrates consistent with pulmonary edema. Presume CHF from volume overload due to IVF. Cardiac enzymes ordered. IV fluids discontinued and 40mg of IV furosemide given. Cardiology fellow on call (give the name) informed and agreed with plans.

12:15 AM: Patient breathing much better. Lungs now clear. First set of cardiac enzymes negative. Patient responded well to IV furosemide and feels much better.

Signed by _____ (pager _____)

Signing Back In

It is not enough to leave a written note when a key event occurs in patient care. The loop must be closed with a face-to-face update. The cross-coverage note format works well as a verbal communication template that includes:

- Time you were called to see the patient.
- Reason you were called to see the patient.
- Your clinical assessment of the patient (SOAP format).
- Actions taken and your rationale for these actions.
- Pending test results or tasks to be followed up by primary team.

CHAPTER 11: TRANSFER AND OFF-SERVICE NOTES

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Transfer Notes

Transfer notes from an intensive care setting to an acute care setting or from one inpatient service to another (for example, a general internal medicine ward to an oncology ward) address patients who are still acutely ill. The hospital course must be emphasized with relevant details, including:

- Diagnostic and therapeutic interventions.
- Rationale for interventions and their outcomes.
- Status of all ongoing investigations and treatments.
- Baseline mental and physical status of the patient.

Transfer notes from an acute care setting to a subacute or chronic care setting follow the format of discharge notes with fewer details of the hospital course and more emphasis on ongoing treatments, pending studies, and the baseline clinical status of the patient. All transfer notes should include:

- Medications (including their rationale).
- Allergies.
- Code status.
- Any difficult or unique family, cultural, or psychosocial issues.

The patient safety literature recommends that to further decrease the risk of miscommunication, ambiguities, or unanswered questions, transferring and accepting teams should discuss the patient verbally (ideally face-to-face) in addition to the written documentation.

The Off-Service Note

The off-service note is an essential element of documentation that helps ensure effective transition of patient care between services. An effective off-service note should decrease the potential for patient harm by succinctly summarizing the relevant and critical information regarding the patient's clinical course to the incoming service. There are many different styles for the off service note and you should be open to suggestions for improvement. Computer

assisted technology may be used for information transfer. It is very important that you understand the electronic medical record system available at your institution, including the templates that have been developed by your department for sign outs. However, a few critical elements need to be included in every off-service note.

- Document the day and chief reason for admission.
- Describe the hospital course sequentially, highlighting clinical diagnoses and new problems developed since admission, and treatments, both successful and unsuccessful.
- Describe briefly the patient's condition on the day of transfer, including cognitive status, cardiopulmonary status, mobility, and nutrition.
- Document the diagnostic tests done with relevant findings.
- Document all consultations and key recommendations.
- List patient's current medications.
- Summarize the active issues related to patient care and your plans and rationale for each issue.
- Document the tasks to be completed and followed up by the oncoming service, including laboratory data, consultation recommendations, and family meetings that need to be arranged.
- State relevant discussions you had with the patient, family or consultants. Highlight relevant psychosocial information (e.g., complex family dynamics, family beliefs).
- Document the code status.
- List all the medications patient is on at the time of the transfer.
- Sign legibly and leave your contact information.

CHAPTER 12: DISCHARGE PLANNING, COUNSELING, AND SUMMARY

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As a subintern, you will discharge patients from the acute care hospital setting to their homes or other facilities, such as rehabilitation centers or nursing homes. Each patient's discharge should follow specific steps to ensure patient safety and quality of patient care. Recognizing the importance of discharge planning in patient care, in 2005, the Society of Hospital Medicine endorsed a checklist (see **Figure 1**) that includes the required and optional elements of the discharge.

**Figure 1- Ideal discharge of the elderly patient: a hospitalist checklist
(x = required element, o = optional element)**

Data Elements	Processes		
	Discharge Summary	Patient Instructions	Communication to follow-up clinician on day of discharge
Presenting problem that precipitated hospitalization	x	x	x
Key findings and test results	x		x
Final Primary and Secondary Diagnoses	x	x	x
Brief Hospital Course	x		x
Condition at discharge, including functional status and cognitive status if relevant ^{25, 26}	x—functional status o -- cognitive status		
Discharge destination (and rationale if not obvious)	x		x
Discharge Medications: Written schedule	x	x	x
Include purpose and cautions (if appropriate) for each ²⁴	o	x	o
Comparison with pre-admission medications (new, changes in dose/freq, unchanged, “meds should no longer take” ²³)	x	x	x
Follow-up appointments with name of provider, date, address, phone number, visit purpose, suggested management plan ³¹	x	x	x
All pending labs or tests, responsible person to whom results will be sent ⁵	x		x
Recommendations of any sub-specialty consultants	x		o
Documentation of patient education and understanding	x		
Any anticipated problems and suggested interventions	x	x	x
24/7 call-back number	x	x	
Identify referring and receiving providers	x	x	
Resuscitation Status And any other pertinent end-of-life issues ²⁰	o		

PLANNING

This section deals with the key steps in the discharge planning process prior to and on the day of discharge.

Prior to Day of Discharge

- Discharge planning begins at the time of hospital admission as you set therapeutic endpoints for the inpatient portion of care. If you do not anticipate that your patient will be at baseline, start anticipating what she will need (e.g., an elderly woman with severe pneumonia may require temporary home oxygen).
- Involve the social workers or case managers early on and communicate effectively with all members of the health care team to let them know what is expected of them and needed for the patient and so they can help you find the resources your patient needs.
- Once you anticipate the patient's needs (e.g., home intravenous antibiotics, heparin, home oxygen, etc.), initiate the process to make sure the patient has the resources to receive them.
- Nurses are an integral part of the discharge process in making sure the patient has all of the supplies that she may need at discharge and reconciling the patient's medications at the time of discharge.
- Review the patient's medications two to three days prior to anticipated discharge and make sure that routes of administration are appropriate for discharge.
- Assess the patient's activity level and advance it during the hospital stay. Consult physical therapy early if you have concerns about mobility or safety. Never discharge a patient home without assessing her ability to walk or otherwise move about her environment.
- Assess daily which catheters or lines can be removed, whether oxygen can be weaned, and which medications can be stopped or converted to oral administration.
- Ensure that the patient or caregiver competently demonstrates self care (ADLs), administration of medications (e.g., insulin injections), and other special care needs (e.g., G-tube feedings).
- Provide appropriate discharge counseling to the patient (see following section on discharge counseling).

On Day of Discharge

- Perform medication reconciliation. Most hospitals use a medication reconciliation form that is a safety goal of the Joint Commission (JC). Have your pharmacist print this form out for you as soon as you know the patient is being discharged, review the list, and decide which medications to continue, change, or stop. Be specific! The nurses will use this form as part of the patient's instructions at the time of discharge.

- Write discharge instructions, including the critical elements.
 1. Referring and receiving providers
 2. Follow-up plans:
 - a. Diagnostic Tests already scheduled or needed (list each one specifically – e.g., BMP, CBC, renal ultrasound etc.).
 - b. Primary care provider appointments: Include date, name, address/location, phone number, purpose.
 - c. Home health care needs.
 3. Diet
 - a. Changes, restrictions of diet.
 4. Activity instructions and restrictions
 5. Medications
 - a. Review of outpatient/admission medications.
 - b. Dose, route of administration, refills.
 - c. New medications that were added.
 - d. Medications that patients should no longer take.
 - e. Medications that were kept but doses were changed.
 - f. Patient education materials.
 - g. Follow up plans for specific medications (i.e., INR testing for someone being discharged on warfarin).
 6. Advance directives
 7. Patient instructions
 - a. Attention to health literacy.
 - b. Anticipated problems and suggested interventions.
 - c. If there are any other supplies the patient needs (i.e., oxygen, dressing changes, etc.), these also must be written in the discharge orders.
 8. Post discharge questions:
 - a. Who should the patient/family contact in case of questions or emergency after discharge?

- Communicate with the primary care provider responsible for follow-up either via a phone call to the physician, an email, or a fax. Phone calls are preferred as they give the primary care provider a chance to ask questions and clarify elements of the admission.

- Dictate or write your discharge summary in a timely fashion (see Chapter 14 for elements of a discharge summary). In an ideal world, every patient should be seen within two weeks of discharge by his or her primary care provider.

DISCHARGE COUNSELING: THE CRITICAL ELEMENTS

One of the many roles you will have as a physician is that of a patient educator. Whether it is counseling a patient on how to use his insulin, how and when to take medications, or how to stop smoking, you will be considered the expert. Experience in providing counseling is critical to developing expertise in this area.

Your role as a health care provider is to make sure everything is in place for discharge, including making sure the patient is aware of what is expected of him and what will occur at the time of discharge. Remember these critical elements when counseling your patient before discharge:

- Communicate with the patient in a private environment, ideally free of distractions.
- Spend time with patient prior to discharge to discuss the disease process, medication changes, and important follow-ups. Utilize trained interpreters when language barriers exist.
- Include family members, when relevant, to identify their concerns and ensure that they understand the key points regarding the patient's illness.
- Use simple terms when discussing disease process with the patient so that he can understand. Encourage the patient to repeat back what he understood to help you assess his comprehension.
- Document patient education and understanding of the education.
- Be available to answer any questions the patient may have and educate the patient on discharge instructions. Remember that nurses, social workers or case managers, pharmacists, and ancillary staff are there to support and assist you in this matter.
- Provide important follow-up information to the patient and provide a 24/7 call back number to contact for questions or concerns that may arise following discharge.
- Provide patient education materials whenever appropriate on the patient's disease process, smoking cessation, diet, exercise, etc.

Education is the key to compliance. Even the most motivated, intelligent, and well-intended patient will not be able to comply if he does not understand your instructions. You are not only the healer but also the teacher for patients.

PREPARING A DISCHARGE SUMMARY

An effective discharge summary provides the critical information to other caregivers necessary to facilitate continuity of care and is often the only reliable information other health care professionals receive about the patient's hospitalization. Therefore, it should be thoughtfully written. The highest quality discharge summaries are usually done within 24 hours, are generally less than two pages, and contain pertinent data that concentrates upon discharge information

necessary to provide a smooth transition of care. Hospitals may provide a standardized discharge summary template. If not, you should follow a consistent format when writing or dictating your discharge summaries. The key elements of the discharge summary are:

- **Date of Admission.**
- **Date of Discharge.**
- **Admitting Diagnosis:** This item is the condition that you feel is responsible for the patient's admission. It is your working diagnosis, not the chief complaint.
- **Primary Discharge Diagnosis:** List a specific diagnosis and not a sign or symptom.
- **Secondary Diagnoses:** Include all active medical problems regardless of whether they were diagnosed this admission. (Active medical problems include any condition for which the patient may be receiving treatment.)
- **Procedures:** List all procedures with the date of occurrence and key findings.
- **Consultants:** List all consultants and key findings/recommendations.
- **History of Presenting Illness:** (optional except when discharge diagnosis is uncertain). Typically, this brief snapshot of how the patient presented to the hospital is followed by the phrase "see dictated full H&P for details." It is basically the same thing you would write as your one to two sentence summary statement under the assessment before you detail your thought processes, differentials, and plan. You may want to include pertinent and abnormal physical findings.
- **Hospital Course:** This section is not a day-to-day account of the hospital course. It needs to balance appropriate details with conciseness. For example, instead of "*he appeared to have pneumonia at the time of admission so we empirically covered him for community-acquired pneumonia with ceftriaxone and azithromycin until day 2 when his sputum culture grew Strep Pneumoniae that was pan- sensitive so we stopped the ceftriaxone and completed a five-day course of azithromycin. However, on day 4 he developed diarrhea so we added metronidazole to cover for c. diff, which did come back positive on day 6 so he needs three more days of that...*"

This information can be summarized more concisely: "*Completed 5-day course of azithromycin for pan- sensitive Strep Pneumoniae pneumonia complicated by C. diff colitis. Currently on day 7/10 of metronidazole and now C. diff negative on 9/21.*"

Include any major interventions, key findings and test results, and complications. Self-limited electrolyte abnormalities, minor medication adjustments, and routine fluid administration are too detailed. For hospitalizations less than three days, two or three sentences will likely suffice.

- **Condition at discharge:** Try to provide a brief functional and cognitive assessment (e.g., “ambulatory with walker,” “stable but confused and requires assistance with ADLs”).
- **Disposition:** This item notes where the patient is going upon discharge (e.g., “home with home health,” “daughter’s home,” “Frazier Rehab Center,” or “Northfield Nursing Home”).
- **Discharge Medications:** List all medications including doses, route, frequency, and duration if applicable. On this list of discharge medications, explicitly identify:
 - Any changes from the patient’s admission medications and the rationale for change.
 - Any medications that the patient should no longer take.
 - Any new medications started during the hospitalization.
- **Discharge Instructions:** Include diet, activity level, wound care, and other pertinent issues. (This is different from the discharge instructions you give to patients, which include signs and symptoms to report or seek care and uses basic language. These instructions are for other health care providers.)
- **Pending Studies/Issues:** List all important tests/labs that are outstanding and to whom the results will be sent. List outstanding medical or social issues at discharge. List the abnormal laboratory data that require follow-up.
- **Follow-up:** If possible, schedule appointment(s) for patient and include name of doctor and specialty, date of appointment, phone number, address, and visit purpose. If the patient will schedule the appointment, be sure to include the timeframe by which the patient should schedule the appointment (e.g., “Patient to arrange follow-up appointment within two weeks”).
- **Prognosis/ Resuscitation Status:** When prognosis is grave, note whether the issue was discussed with patient and family.

If the discharge summary is completed online, you should determine whether it is hospital policy to give a copy to the patient.

SECTION 5: PRACTICAL NUTS AND BOLTS

Effective time management skills are essential to working efficiently in the hospital and maintaining a fulfilling personal life outside of medicine. To be a competent subintern you will also need to be highly organized. There are a variety of other skills that may not have come up in the first three years of medical school, but will be necessary to be a successful physician. You will need to document your patient encounters accurately both in writing and using a new skill of dictation. This section contains several necessary practicalities that may not have been addressed elsewhere.

CHAPTER 13: ESSENTIAL TIME MANAGEMENT AND ORGANIZATIONAL SKILLS

Cynthia H. Ledford, MD

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Interns contribute more to patient care, are less stressed, and learn more when they are organized and efficient in their work. Hospital-based medicine occurs in a very fast paced and hectic environment in which patients face life-threatening illness. You can train yourself to be organized and make the most of your time.

Develop a System for Keeping Patient Data Organized

- Key information for each patient should be summarized concisely and at your fingertips whenever needed (e.g., primary physician, family contacts, home and current medications, past medical history, etc.).
- Tasks for all patients should be organized to allow efficient completion and avoid omissions.
- Know when the day's labs, EKGs, or consults become available so you do not have to repeatedly look for results.
- Group tasks by physical or electronic location (e.g., plan to proof and sign all dictations, check for all microbiology results, to review all radiographs, or see all patient visits on a certain floor together).

Identify Priorities for Patient Care and for Learning

- Take the time to identify and prioritize the most important problems, decision points, and pending results for each patient. Use your prioritized list to organize your data-gathering and notes.
- Try to anticipate the next step (e.g., what is needed for diagnosis or for discharge, what complication might the patient develop).
- For every patient, every day, pick one question that you will answer to add to your knowledge and the care of that patient.

Develop Your Routines

- Practice makes perfect. Develop regular patterns for performing an H&P, writing a note, and presenting to a consultant to improve your efficiency and help you avoid omissions.

Make Time to Learn from Every Aspect of Your Patient's Care.

- Go to procedures with patients.
- Watch PT, OT, speech, and other ancillary evaluations.
- Learn about beds, lines, equipment, masks and oxygen delivery systems.
- Learn to perform procedures that might not be considered the usual task of the physician: placing leads for an EKG, drawing an ABG, placing a peripheral IV, or administering a respiratory treatment.

Take Time for Review at the Beginning and End of Each Day

- Look at your calendar to get an overview of events with their times and locations.
- Quickly review your patient task list to make certain it is complete and nothing was missed.

Set Time Limits for Each Task to Force You to Develop Efficiency

- Try to see and gather morning data on each patient in less than 15 minutes.
- Work to develop the ability to triage patients quickly. For example, when covering patients on call, try to determine how ill a patient is in less than 10 minutes.
- Complete a comprehensive patient evaluation in less than 40 minutes.
- Write orders in 10 minutes.
- Summarize all the key information and your assessment of a patient in one sentence (the perfect 60 second presentation).

Spend Extra Time When It Really Counts

- Organize an interdisciplinary meeting between consultants and the health care team to collaboratively make the best decisions for particularly complex patients.
- Conduct a family conference to coordinate care and answer questions from multiple caregivers, patient permitting.
- Spend time with patients: communicate, explain, and allay fears; learn their life stories; and meet the people who matter most to them.

Take a Minute to Reflect Every Day

- Recall one experience that day that best inspired you to become the type of physician that you want to be.
- Think of one moment when you were at your best.

The following table is used in the business world to help with time management (and in finding work/life balance to be discussed in the next chapter). The key issue is that we can easily end up spending too much time on the “urgent & unimportant” issues (e.g., most email and text messages), when we need to make more time for the “not urgent & important” issues (e.g., family, spending time at the bedside with patients, and scholarship). You may find it helpful to use this model below to list your life and work responsibilities, priorities, and goals by placing them in the appropriate box, then reflect on how you are actually dividing your time to accomplish them.

Urgent & Important	Not Urgent & Important
Urgent & Unimportant	Not Urgent & Not Important

CHAPTER 14: TIPS FOR WORK/LIFE BALANCE

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There is no single formula for obtaining a balanced life. You need to be able to communicate, plan, organize, delegate, and set limits effectively to achieve a satisfying, fulfilling, well balanced personal and professional life.

- Figure out what really matters to you in life. Set priorities and drop unnecessary activities. Set boundaries between work and home. When you leave work, do not continue to think about work. Turn off your work pager or cell phone. Do not recheck your work email.
- Protect your private time, even if it is for a walk, bike ride, or pizza night. Coordinate times with your friends and your spouse or significant other.
- Set goals for both your work and your personal life. Match the number of personal goals to work goals.
- Schedule time for regular exercise. Take care of your physical health. Implement a daily practice of meditation.
- Get organized and delegate. Build a support network. Do not be afraid to ask for help and allow yourself to be helped. If you have children, always have a back-up plan and an emergency plan in place. Do not feel guilty about hiring help (if that is an option).
- Be flexible. Do not ask or expect too much of yourself. Forgive yourself when things do not get done and congratulate yourself for doing as well as you did.
- Create some time for yourself on a regular basis - even one hour a week to read your favorite magazine or attend a yoga class. Find at least one hobby or activity that is not related to the field of medicine.
- Plan ahead- do not let the days slip by.
- Talk to others who have "been there." More experienced colleagues may have a lot to share about life balance.
- Spend time with friends who are not physicians. It is amazing how that helps to put things in perspective.
- Allow your spouse or significant other time to adjust to a call schedule and long days. Remember that cognitive understanding is not the same as living it.
- Be creative and allow yourself a few silly luxuries.

- Do not make promises you can't keep. There will be family events or holidays that you will not be able to attend.
- Learn to say no to requests that are not on your priority list.
- Ask for help or advice when you need it.

CHAPTER 15: A DOZEN PEARLS TO KEEP YOUR PATIENTS SAFE (AKA: ASSUME NOTHING!!)

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The first principle of being an excellent physician is to assume nothing as the buck really does stop with you. Ironically as the acting intern, you are the person everyone (the team, nurses, patients, consultants) assumes is on top of all the details even though you have little authority to make things happen. Details in patient care can easily get overlooked or improperly prioritized but can significantly improve patient safety if attended to on a daily basis.

- Perform a line inventory. Ask yourself every day what tubes and lines your patients are connected to and whether they still need them.
- Look at your patients' skin (all of it).
- Reconcile the MAR (Medication Administration Record) with your plan every day and discontinue medications that are not needed.
- Narrow antibiotic coverage whenever possible within 72 hours to prevent antibiotic-related complications.
- Do not leave the room of a patient who needs an emergent intervention (e.g., acute chest pain without an ECG; fever and neutropenia or sepsis without seeing antibiotics hanging)
- Sliding scale insulin (SSI) is temporary. Every day you should make adjustments in basal insulin dosing unless there is a clear reason not to.
- Fluids are medications—do not lose track of them. Consider including a stop time on vulnerable patients (e.g., NS @ 125mL/hr x 24 hr).
- Never guess a free water deficit or sodium deficit, calculate it and correct it according to guidelines.
- Address patients' pain as aggressively as you would if you were in pain.
- If it will not change your treatment, do not order it.
- Talk to your colleagues! Do not use the chart to substitute for simple face-to-face or face-to-phone conversations that can prevent or perpetuate serious misunderstandings. Nurses are your best ally.
- Print your name and contact information legibly. Though often it may not seem like it, you really will want nurses and colleagues to be able to talk with you about your patients. Do not make it hard for them.

CHAPTER 16: WHAT TO DO WHEN A PATIENT DIES*

Michelle Sweet, MD

Rush Medical College of Rush University

***As a subintern you will not be pronouncing deaths nor filling out death certificates. This section is meant to prepare you for internship.**

Who to Contact When Death Occurs

- The patient's family or other surrogate. (This is an appropriate time to discuss an autopsy with the patient's family).
- Notify your resident and attending of the death.
- Check with your institution policies to determine which cases need to be referred to a local medical examiner.

Pronouncing and Documenting Patient Death

- Examine the patient (auscultate for heart sounds, observe for respirations, and check pupillary and corneal responses).
- Record the results of the exam.
- Record the exact time and date of your pronouncement.
- Record whom was notified.
- Record whether autopsy was requested and the decision of the family or surrogate (or if case referred to medical examiner).

Filling Out the Death Certificate

The death certificate is a very important legal document which must be filled out by a physician. Exact requirements vary from state to state; check with your local state laws and your institution. The death certificate lists personal information about the patient as well as the circumstances and cause of death. It is a permanent record of the fact of death, cause of death, and is frequently used in state and national mortality statistics.

When you become a physician, you will be responsible for completing the medical part of the death certificate. Your main responsibility will be pronouncing death and determining the cause of death. You will need to use a current form designated by your state. You will need to legibly complete each item on the certificate without using abbreviations. The cause of death section represents your best medical opinion and consists of two different parts.

First, in Part I, you will need to report the sequence of events leading to death, proceeding backwards from the final disease or condition that led to the death. This final condition is the "immediate cause" of death. This immediate cause that led to your patient's death needs to be specific and not leave any doubt as to why it developed. For example, "respiratory failure" is not

specific because many conditions can lead to respiratory failure, but “multi-lobar pneumonia” is specific. Every other condition in the sequence of death in Part I should directly cause the “immediate cause.” Use your best medical opinion to determine the “immediate cause” of death and you can also use the qualifier “probable” if no definite diagnosis has been made.

In Part II, you will list other chronic diseases or other substance abuse, injury, or surgery that may have adversely affected your former patient and contributed to their death. These conditions in Part II may be unrelated to each other or causally related to each other.

The cause of death can include information provided by an autopsy. It is crucial that the underlying cause of death be as specific and precise as possible for statistical and research purposes.

You also will want to include on the certificate whether an autopsy was performed and whether the findings were used to complete the cause of death. Please specify who the pronouncing physician is if different from the certifying physician.

CHAPTER 17: TIPS FOR DICTATING*

Michelle Sweet, MD

Rush Medical College of Rush University

***Many institutions do not allow students to dictate, but these tips may help prepare you for internship.**

- Complete your dictation as soon as possible after the operation, hospital course, office visit, etc. when details are fresh in your memory.
- Get an instruction card for your hospital's system that gives you the codes to enter for the specific type of dictation and other tips unique to your system.
- Find a quiet location.
- Organize your thoughts and jot down some notes to help you.
- Avoid dictating from cell phone (bad reception), eating, chewing gum, and loud background noise.
- Speak at a constant tempo that is not too rapid with clear enunciation and phrasing.
- Speak at a normal speaking volume and avoid mumbling, particularly when you are tired.
- Do not be afraid to pause if you need a break or to collect your thoughts.
- Spell out any words, names, or terms that may be unclear for your transcriptionist.
- Avoid unconventional abbreviations.
- Specify punctuation when it may be unclear (e.g., state "comma") and particularly specify new paragraphs starts by stating "new paragraph."
- Identify yourself clearly and the date.
- State the type of document and whether it is stat.
- State and spell the patient's name followed by the medical record number.
- Indicate to whom it should be sent (providers, consultants, referring physicians).
- When you are done dictating say "thank you" to your transcriber or provide some other indication that the dictation is completed.

What if I Make a Mistake?

Most dictations have errors and require editing. The more you follow the tips, the less time you will have to spend editing dictations. However, for live transcription (as opposed to voice recognition software), you may be able to fix errors or omissions as you dictate by alerting the transcriber and providing clear instructions.

“Note to transcriber, please go back to the hospital course and add to the last paragraph: Mr. Milton was weaned off his oxygen and is currently satting 94% on room air. Now go back to the discharge instructions.”

“note to transcriber please change right ankle to left ankle”

Example

This is John Eager (E-A-G-E-R), medicine student dictating a discharge summary for (give attending's name) on May 9, 2008 for patient James (J-A-M-E-S) Milton (M-I-L-T-O-N) medical record number 876543. Please cc a copy of this to Dr. Mary Pleasant (P-L-E-A-S-A-N-T) at Peaceful Groves Rehabilitation Center 123 Sunnybrook Lane Aging, FL 32765. Paragraph admission date, colon, May 4, 2008 new paragraph, discharge date, colon, May 9, 2008 new paragraph...*

CHAPTER 18: DOCUMENTING PROCEDURES

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Every procedure that is performed, or attempted, should have several crucial elements documented in the chart as outlined below.

Date and time

Procedure

Example: *Paracentesis*

Indications

Example: *Diagnosis and relief of abdominal distension*

Operators

Informed consent (usually a standard statement)

Example: *Risks and benefits of the procedure explained and informed consent obtained and signed on chart _____*

Brief description of procedure (including type of anesthesia and sterile prep)

Example: *Abdomen prepped and draped in usual sterile fashion. 1% lidocaine injected in LLQ and 1.5 L serous fluid drained using zigzag technique, pressure dressing applied.*

Complications

Results (specimens obtained, follow-up studies or plans)

Example: *Fluid sent for cell count w/ diff, culture, albumin*

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