

A low-angle, upward-looking photograph of several modern skyscrapers. The buildings feature a mix of dark, textured facades and large glass windows. The sky is a clear, bright blue. The perspective creates a sense of height and architectural grandeur.

**Department of Medicine  
House Staff Manual  
2009-2010**

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## **WHO'S WHO**

The Chairman of the Department of Medicine, under the auspices of the Mount Sinai School of Medicine, is responsible for organizing, implementing and evaluating the medical residency training program in accordance with the requirements set forth by the Accreditation Council for Graduate Medical Education. The Chairman delegates ongoing operational responsibilities for the residency training program to the Vice Chairman. The Chairman and Vice Chairman provide direction to the Chief Medical Residents, who provide supervision to the residents. The supervision of medical care on the medical service, for patients who do not have a private attending physician, is delegated from the Chairman to the teaching and Internal Medicine Associates (IMA) attendings. These supervisory attendings make daily rounds, are available 24 hours each day, and are within a relatively short traveling time from the hospital. The supervising attendings delegate responsibility to the senior medical residents, who are available in hospital 24 hours a day to supervise the interns and subinterns who provide primary care for patients.

### **CHAIRMAN**

Dr. Paul E. Klotman is the Murray M. Rosenberg Professor of Medicine and the Chairman of the Department of Medicine. He is available for career guidance and any issues that cannot be resolved at a lower level. His office is Annenberg 23-92 and his extension is x44200. Dr. Klotman's assistant is Charmaine Francis.

### **VICE-CHAIRMAN**

Dr. Mark Babyatsky is Vice Chairman of Education and Program Director for the Internal Medicine Residency. Dr. Babyatsky has overall responsibility for the medical housestaff program and is available for any issues or problems. His office is Guggenheim 9W-178 and his extension is x48707. His administrative assistant is Sappherin Miranda.

### **CHIEF RESIDENTS:**

Louai Razzouk, Lauren Stern, Daniel O'Connor and Kristofer Smith are the Medicine Chief Residents. They have offices on GP 11E -378B, 7C at the Bronx VA and D6-16 at Elmhurst. At least one of the four chief residents will be available 24 hours a day for assistance with any medical or personal problems that may occur. Sinai beeper #9999 will bounce to the chief resident on call at all times; the Sinai page operator can also provide the pager number of the chief resident on call. The chief residents are responsible for the education of house staff, including conferences, specialty rounds and resident report. They schedule grand rounds and QUARC conferences. They are also responsible for all issues pertaining to scheduling, conflicts between medical house staff and other services, and quality of life of the house staff.

Many of the administrative and supervisory tasks of the residency program are delegated to the medical chief residents. There are two chief residents in attendance at The Mount Sinai Hospital, one at the Elmhurst Medical Center and one at the Bronx Veterans Administration. These two affiliated hospitals also have their own chief residents. The chief residents are the first line of communication, contact and

supervision for housestaff, focusing on problems, quality of care issues, teaching and general day-to-day supervision and management.

**Program Administrator:**

Liz Perez is responsible for many aspects of the house staff program. She is your first contact for problems that involve payroll, house staff verification letters, beeper problems (including replacement batteries), scheduling electives, submitting receipts, etc. Her office is located in Guggenheim 9W-178, extension 48140.

## CONTACT LIST

Mount Sinai phone extensions are five or six digits beginning with '3', '4', '5', '7' or '8'. 5 digit extensions beginning with the numbers '4', '5' or '8' can be accessed externally with a '241', '824' or '659' exchange (respectively) followed by the last 4 digits of the number. For example, if the phone number listed is '43210', '54321' or '87654' then these numbers can be dialed using '241-3210', '824-4321' or '659-7654' respectively. From certain locations within the medical center it is necessary to add an '8' before the '4' for some extensions. When this is needed you will be prompted by the operator to add the '8'. To reach a short-range pager, dial x41300 and then the four digit pager number.

	Phone
Main Office Number for Department of Medicine Annenberg 23-95	45484
Paul E. Klotman, MD Professor and Chairman Annenberg 23-92	44200
Charmaine Francis Administrative Assistant to Dr. Klotman	44200
Mark Babyatsky, MD Associate Professor and Vice Chairman Guggenheim Pavilion 9W-178	48707
Lillian Galindo Administrative Assistant to Dr. Babyatsky Coordinator, Student Affairs	48139
Liz Perez Administrator, Internal Medicine Guggenheim Pavilion 9W-178	48140
Neile Reyes Coordinator, Internship Recruitment	46609
Lillian Galindo Coordinator, Program and House Staff	48170
<u>Mount Sinai Chief Residents</u>	pager 9999
Louai Razzouk	
Lauren Stern	
Daniel O'Connor	
Kristofer Smith	

Office Locations and Telephone Numbers

Mount Sinai – Guggenheim Pavilion 11E-378B -- 43817 or 43820

Bronx VA – 7C -- 718 584-9000 x5919

Elmhurst – D6-16 -- 718 334 5235

Mount Sinai Teaching/Consult Resident	pager: 2125
Mount Sinai Medical Admitting Resident	pager: 7785 phone: 46142
Pager Operator	41800
Team 7000 (cardiac arrest team)	47000
Crisis Team	4STAT
Patient Representatives	47724
Pager forwarding	41200

**Departments of Medicine at Affiliated Hospitals**

Bronx VA Medical Center  
130 W. Kingsbridge Road  
Bronx, N.Y. 10468  
(718) 584-9000 x6753  
Clive Rosendorff, M.D., Chairman of Medicine

Elmhurst Hospital Center  
79-01 Broadway  
Elmhurst, NY 11373  
(718) 334-3446  
Joseph Masci, M.D., Chairman of Medicine

Elmhurst Chief Resident Onyema Ogbuagu	718 334 5236
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Elmhurst Teaching Resident	718-334-6605 Pager: 11004
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## **INPATIENT CARE LOCATIONS**

### **THE MOUNT SINAI HOSPITAL**

#### **Care Centers**

At The Mount Sinai Hospital, patient care is organized around specific diagnoses. Each Care Center caters to its patients special needs with its own nursing staff, social workers and ancillary services. Medical house staff will have the opportunity to rotate through many of the care centers during their tenure at Mount Sinai.

#### **10 West**

Focus is on the care of general medical patients, with emphasis on patients with rheumatologic and hematologic illnesses.

#### **6 West (Geriatrics Care Center)**

This unit concentrates on the special needs of the acutely ill elderly population. There is a strong emphasis on the interdisciplinary team approach (physician, nursing, psychiatry, and social services). Several times a week there are meetings with the interdisciplinary team.

#### **GICC (GI Care Center)**

The GICC is organized to provide care to patients with a variety of luminal and hard digestive organ disorders. Care is primarily delivered on the following units: 8 Center, 9 Center, 9 East and 10 East. Whenever possible, patients known to the liver transplant service will be preferentially placed on 9 Center. Patients without “private” GI attendings will be assigned an attending by the GI admitting office.

#### **9 West**

9 West is part of the General Medical Care Center and provides cares for those with a variety of general medical illnesses. Medical house staff from all three ward services may have a panel of patients on 9 West.

#### **Cardiac Care Center (Telemetry and Cardiac Care Unit)**

The Cardiac Care Center focuses on the care of patients with cardiovascular disease. Patients requiring telemetry monitoring may be admitted to 7 West, 7 Center and 7 East. Cardiovascular patients who are critically ill and require intensive monitoring are cared for in the CCU.

#### **11E**

The main emphasis of this care center is the treatment of patients with known HIV disease. In addition, some beds are allocated to general medicine and Palliative Care cases.

### **10 Center and 11 Center - Oncology Care Center**

The emphasis of this care center is the treatment of patients with neoplastic disease. Care includes diagnosis, surgical and medical management, chemotherapy, treatment of oncologic emergencies, and palliative care. All patients on the Teaching Service are cared for by full-time faculty with the assistance of the Oncology Fellow.

#### **ISOLATION BEDS POLICY**

Patients admitted to the medical service may require respiratory isolation. There are a limited number of isolation beds on the medical floors. All patients requiring respiratory isolation will be taken care of by their admitting medicine team regardless of which floor their bed is on.

#### **Services**

The individual care centers have been combined to form three major “services”, each named after former renowned physicians, leaders, and medical pioneers of MSH. Each service is comprised of 4 teams, each of which consists of one senior resident, two interns and medical students.

**Wasserman Service** is comprised of the Oncology Care Center as well as the 11E AIDS cluster and palliative care patients

**Berson Service** is comprised of General Medicine and Geriatric Care Center

**Popper Service** is comprised of the GI Care Center, Cardiac Care Center and Advanced Pulmonary Service

#### **Special Units**

**Medical Intensive Care Unit.** 14 beds located on GP-5W, for patients requiring a high level of nursing care or invasive monitoring techniques. Care of patients transferred to this unit is assumed by six PGY-2 MICU residents, pulmonary fellows, rotating attendings and the director of the MICU. The rotation is 4 weeks occurring twice over the PGY-2 year. The residents will be paired, and call will be every third night.

**Cardiac Care Unit.** 14 beds located on GP-5E, for patients requiring careful cardiac monitoring and/or invasive monitoring techniques. Care of patients admitted to this unit is assumed by three interns, three PGY-3 residents, cardiology fellows, rotating attendings and the director of the CCU. Each intern is paired with one resident, and call will be every third night.

**Medical Step Down Unit.** 4 bed unit located on GP-9W, for patients requiring closer monitoring than is available on floor but who do not require intensive care. Admissions and discharges to this unit are overseen by the MAR and patients will be followed by their primary medical team while in this unit.

**Respiratory Step Down Unit.** This unit is for patients requiring long-term mechanical ventilation. Coverage during the day is by a pulmonary fellow and a nurse practitioner and at night and weekends by the HMP service.

**BRONX VA MEDICAL CENTER**

The Bronx VA Medical Center is located in the Kingsbridge section of the Bronx. There is frequent bus service from Mount Sinai on weekdays. Schedules are available from the Medicine Chief Residents' Office. After hours and on weekends, El Barrio car service is available by calling 212-722-5555.

**ELMHURST HOSPITAL CENTER**

Elmhurst Hospital Center is a city hospital located in Elmhurst, Queens. There is frequent bus service from Mount Sinai to Elmhurst on weekdays. Schedules are available from Medicine Chief Residents' Offices. After hours and on weekends, El Barrio car service is available by calling 212-722-5555.

## **WHO'S WHO ON THE WARDS**

**Third Year Medical Students.** The junior medical students should see patients independently, and then, review their findings and their patient care plan with the house staff. The intern and resident are responsible for teaching the junior students. They will be expected to stay until 10 pm on the long call day.

**Fourth Year Medical Students (subinterns).** There are usually one or two. They are expected to function as interns, taking long call every fourth night, and carrying half as many patients as the intern. They are expected to carry out all duties of a medical intern except for the fact that their orders and notes must be countersigned by the supervising resident. They are supervised by the ward resident.

**Senior Residents.** Senior residents will be assigned to supervising ward teams. Senior residents are responsible for coordinating work rounds, the daily schedule of the team, the teaching of the interns and 3rd and 4th year medical students, and the overall quality of care of each and every patient. During long call weekend days the resident is also responsible for daily care for another resident's service. The weekend resident should feel comfortable making changes in the plan when the original admitting resident is not present. However, nobody should ever hesitate to call a fellow resident or colleague at home on a weekend or weeknight, at any time, if a patient care issue arises that requires the opinion of the primary resident.

**Teaching Attendings.** There is one teaching attending per team. These attendings are responsible for house staff education, the conduct and content of rounds and house staff evaluation and feedback. In certain circumstances, they may also serve as the attending of record for patients admitted to the teaching service who are from the primary care clinic or who do not have a physician. Patients who are followed in the Mount Sinai clinic system or who present to the emergency room and do not have a private physician with privileges at Mount Sinai will be assigned to the appropriate teaching attending.

**Private Attendings.** These physicians are the physicians of record for private patients. Although the house staff play major roles in determining the work up and treatment of their patients, the input of the private attendings must be incorporated and they must be informed of any unexpected changes in their patient's condition. The private attending should be contacted when the patient is being admitted for information about the patient's prior medical history and evaluations. The private medical attendings are not permitted to write orders on their patients on the teaching service. All orders must be written by the house staff. Any time a private patient dies the primary resident caring for the patient or the resident on call must inform the private attending or his/her coverage.

**Medicine Consult Residents (MCR) (aka Teaching Resident or TR).** There will be two medicine consult residents (MCRs) working Sunday – Friday in alternating shifts, 8:30am – 6:30pm and 6:30pm – 8:30am. On Saturdays the position is filled by PGY-3's or PGY-2's (later in the year) who are on outpatient block. The MCR is responsible for all cardio-pulmonary arrests and **must be ACLS recertified prior to the PGY-3 year.** The MCR will also be responsible for admissions arriving after the team has capped and before the night float resident has arrived at 7pm; admitting transfers from HMP or non-medicine services after 7pm; admitting ICU transfers to the floor after 7 pm, and for admissions arriving after midnight or team caps on Friday and Saturday nights. The MCR may also be asked to assist with ER admissions if night float is overwhelmed. There is no cap for the teaching resident. During the day the MCR provides consult assistance to non-medicine services requiring assistance with management and during the night does so on an emergency basis. The MCR makes daily rounds with a hospitalist on consulted patients. Finally, the MCR also serves as a resource for the MAR, and for interns and residents on the wards who need help with procedures or management or who are overwhelmed with work. The MCR pager is 2125. Please see detailed MCR manual for further details.

**Medical Admitting Resident (MAR).** The MAR triages every medicine patient admitted through the emergency room as well as direct admissions and inter-hospital transfers. The MAR is responsible for assigning patients to appropriate wards in a timely fashion and distributing patients as evenly as possible across services. The MAR also controls the step-down unit on GP 9W. The MAR pager is 7758. For further information see the MAR manual.

## **DUTIES AND RESPONSIBILITIES**

### **PGY-1 (Intern)**

1. During the first year of training the PGY-1 is responsible for initial evaluation of a patient upon admission to the in-patient medical unit. This consists of a complete medical history, physical examination and an assessment and plan to be completely recorded in the patient's chart and discussed with a supervising resident. PGY-1's are required to review all of their findings with a more senior resident or attending before writing orders and beginning the diagnostic and therapeutic plan. PGY-1's are responsible for presenting new admissions to the supervising attending, who will review the admission history and physical exam, as well as their diagnostic and treatment plan. Prior to the beginning of internship each PGY-1 is given a list of selected invasive procedures that must be supervised and documented in a procedure log by a credentialed resident, or attending physician. Housestaff must be credentialed before they perform these procedures unattended. The interns are privileged to perform histories and physicals, routine ward work and write orders, including but not limited to orders for the use of restraints. As procedures are completed please submit the white sheets from the procedure log book to Lizette Perez. Do not wait until the end of the year to do so.
2. The PGY-1 must examine his/her patients daily, write daily progress notes, write orders, and request and follow up on laboratory data. All of the above duties must be carried out under the direct supervision of the ward resident and attending. All findings should be corroborated with supervising residents.
3. At Mount Sinai, interns will rotate through the medical services and the CCU. The ward time will be divided between the three medical services. There will be a rotation in the Emergency Room consisting of the main ER and urgent care. Not all interns will rotate through all services. Call is every fourth night on the ward services and every third in the CCU. All services have four teams consisting of two interns (A & B) and one resident each. Intern call is overnight, and residents do not take overnight call (except on Friday and Saturday nights). Interns A and B will alternate taking overnight call every eighth night. When Intern A is on overnight call, Intern B admits until 7 pm; she/he will go home with the senior resident upon completion of their admissions. The following morning, intern B is responsible for writing the notes and providing care for the entire team's patients (including those of intern A).

Interns also rotate on the general medicine ward at Elmhurst Hospital where the call is overnight every 4<sup>th</sup> day. At the Bronx VA, interns rotate on the medical wards and/or the CCU. The call schedule is overnight every 4<sup>th</sup> or every 3<sup>rd</sup> day respectively. At Elmhurst or the Bronx VA they may serve as day floats; there is no night float at those institutions.

4. It is the responsibility of all PGY-1s to communicate with their fellow PGY-1s about their patients during ward switches. It is the primary responsibility of the intern picking up the service to communicate effectively with the intern leaving the service about their patients before the block begins. Therefore, if you are picking up a new service, it is

your responsibility to call the off-service intern.

5. Each PGY-1 is expected to write thorough off-service notes on their patients. These notes should include pertinent medical histories, hospital course, medications, physical exam, and assessment and plan such that patient care continues in a responsible and professional manner. An on-service note is not necessary.
6. All orders and notes are to be LEGIBLY SIGNED and STAMPED with the intern's name, dictation code, and beeper number. Finally, interns are responsible for dictating the discharge summaries of patients that they discharge who are "service" cases. At Mount Sinai, only phone dictation will be accepted.

## **PGY-2**

1. During the Second Year (PGY-2), medical residents are responsible for supervision of medical interns, as well as for independent evaluations, and presentations of all new admissions at daily morning report to senior members of the medical staff. The PGY-2 conducts daily work rounds with the team. Work rounds should focus on the daily plan, the discharge plan and acute patient care issues. PGY-2s must see and evaluate each patient daily with the team, review the chart daily and are responsible for the care of their patients. They are responsible for teaching the interns and students and coordinating activities of the medical team with the Attending Staff. Residents must communicate with attendings about changes in a patient's clinical status, patient deaths or management issues.
2. At Mount Sinai, PGY-2's rotate through the Medical Intensive Care Unit (MICU) for two-four week blocks. During this period of training, a PGY-2 is the primary care provider for all patients in the MICU. Two PGY-2's function as a team and take overnight call every third night. During this time, PGY-2's also function as consultants for critically ill patients in the Emergency Room and on the Medical Floors. As a consultant, a PGY-2 is responsible for evaluating patients in a timely manor and transmitting their clinical impression to either a Critical Care Fellow or Attending. They must also document their clinical impression and plan in the medical record and contact the primary team in a timely fashion. At the Bronx VA, second year residents may work on the medical wards and/or in the MICU. Ward call is every fourth and MICU call is every third night. While on the Medical Floors at Sinai, PGY-2's are on call every fourth night and stay overnight only when their call falls on a Friday or Saturday.
3. In the second year the focus of the admission note should be on assessment and plan, and all notes should be signed LEGIBLY with the resident's dictation code and pager number.
4. During the PGY-2 year, residents are responsible to organize a clinical elective during their 2wks of 'Consult Elective'. During this time a PGY-2 abides by the rotation specific schedules and clinic responsibilities.
5. At Mount Sinai, PGY-2's begin to rotate through the Night Float schedule. Clinical

responsibility during this rotation involves assessing newly admitted patients, either via the Emergency Room, transfers out of the Medical Intensive Care, Cardiac Care Unit or other services to the Medical Service. An admission note should be placed in the chart after the patient has been assessed, and the Attending of record and consulting services be notified as deemed appropriately.

### **PGY-3**

1. Third year medical residents are responsible for coordinating the activities of the junior house staff and medical students on the inpatient service. PGY-3's should take an especially active role in the clinical and educational activities on the unit. As in the second year, PGY-3's act as team leaders and conduct work rounds.
2. At Mount Sinai, PGY-3's rotate through the general medical wards, where the call is q4 (overnight on the weekend nights only), and the CCU, where the call is q3. PGY-3's also rotate on the medical floors at the Bronx VA Medical Center and at Elmhurst Medical Center. PGY-3's will also function as nightfloats during the year.
3. PGY-3's spend a month as medical consult resident (MCR) at Mount Sinai or Elmhurst Hospital Center, or as the "Book Resident" at the Bronx VA Medical Center. As medical consult, residents provide other inpatient services with input on medical management issues. Under the supervision of senior medical staff, the consult resident rounds daily and provides follow-up for the patients on the consult service. During the month, pre-operative assessment of surgical patients, as well as management of medical problems in the non-medical patient is emphasized. The consult resident responds to all Team 7000 (cardio-pulmonary arrests). **Therefore, all third year residents must be ACLS recertified prior to the PGY3 year.**
4. Third years will also function as MARs (medical admitting residents). This is an ER-based rotation during which the resident triages and assigns a team to every patient admitted to the medical service (see detailed MAR manual).
5. As a third year resident, the focus of the admission note should be on assessment and plan.

### **ORDER WRITING**

All PGY 1's should have their orders reviewed by more senior residents until they are comfortable with the process of writing orders. This is especially true in the early months of internship.

All orders written by medical students must be countersigned by a house officer.

All orders on the medical teaching services are to be written by the house staff caring for the patient or covering for that team. Attending, fellows, and physicians from other services are not to write orders. Exceptions to this rule are:

- orders that need to be written in life threatening emergencies when the house staff

- are not readily available
- orders directly related to procedures performed by another physician.

### **ELECTIVES**

Each resident will have several months of elective time during residency. Residents must register their choice of elective prior to the start of the rotation with Lizette Perez. Residents also rotate on sick call during elective blocks, during which they may be called in to any site to take the place of an absent resident. During electives all residents are expected to be at work all day, every work day, and be available by beeper at all times. Residents may not take electives away from The Mount Sinai Medical Center except with prior approval from the chief residents and Dr. Babyatsky, and this will be restricted to one away elective during the entire 3 years of their Residency. This elective must offer an experience not available at Mount Sinai and be pre-approved by the Mount Sinai Hospital or else malpractice insurance and pay will not continue during the month. Away electives are not available during blocks 6 or 13.

### **RESEARCH**

All residents are required by the RRC of Internal Medicine and the ABIM to perform scholarly activities prior to graduation. Research mentors must be selected, projects described in detail, and all research time approved by the department. Before graduation every resident must have participated in at least one annual research day symposium by giving a talk or presenting a poster.

### **FEEDBACK**

As part of the department's commitment to quality improvement, the department encourages you to identify problems that are affecting patient care or your educational experience. Creative ideas for solutions to the problems are especially welcome. Please provide the information to the chief residents, Dr. Babyatsky or Dr. Klotman. Although it may not be possible to solve all problems immediately, the department will make every effort to improve the situation.

### **DRESS**

As a professional, it is expected that you act and dress in a certain manner. Although this would appear to be obvious, often times the rigors and grind of residency erode away at our sense of propriety. It is required that house staff are properly dressed at all times. Scrubs are permitted on call in the ICU or after 5 pm on long call days on the wards. Use of the provided personalized white coat is strongly encouraged, with other Mt Sinai issued white coats to be used as needed. When scrubs are worn, only those with the Mt Sinai insignia, as provided by the Department of Medicine, are to be used.

## SCHEDULES AND CONFERENCES

The American Board of Internal Medicine requires that all house staff attend a minimum of 60% of all required teaching exercises and that attendance be kept on record by the Department and in each individual resident's file. The required teaching conferences are Medical Grand Rounds, noon conferences, and resident report at Mount Sinai Hospital, Bronx Veterans Administration and Elmhurst Medical Center.

### **THE MOUNT SINAI HOSPITAL**

**Work rounds** begin between 6:45 and 7 am with the teams seeing each patient, reviewing the medical record, discussing clinical care plan and writing orders. All interns are expected to have prepared for work rounds by pre-rounding on their patients prior to their resident's arrival.

**Morning report** for the ward residents will take place Monday, Wednesday, Thursdays and Fridays from 8:30 am until 9:30 am. All ward residents must attend morning report and be punctual. Post call residents are responsible for presenting short and long call admissions and related literature. Interns are expected to do ward work during this time.

**Attending rounds** occur each workday at 9:45 am and last approximately 75 minutes. All house staff should be prepared to present cases. The choice of cases is negotiated between the ward resident and attendings. On Tuesdays, prior to grand rounds, attendings will make work rounds with the teams from approximately 7:30 a.m. to 8:30 a.m. and then all team members are to attend grand rounds, including the post-call team.

**Grand rounds** take place in the Hatch Auditorium on Tuesdays at 8:30 am. ATTENDANCE FOR DEPARTMENT OF MEDICINE GRAND ROUNDS IS MANDATORY FOR ALL HOUSE STAFF. There are no attending rounds scheduled for Tuesdays. Instead, team will make work rounds with the attendings on the ward as above. A member of the medicine housestaff is expected to present a short clinical vignette before each talk.

Once a month in place of grand rounds, a QUARC grand rounds will take place. The QUARC examines a case with a quality of care issue and utilizes the opportunity to educate the medical staff. A member of the medicine housestaff or a chief resident will present the case. An expert attending will provide commentary on the case and the issues raised.

**Noon conference** is held Monday, Wednesday and Friday in Guggenheim 2C. Location and topics are posted in the team rooms. Attendance is mandatory and lunch is always provided.

**Resident report** is held Tuesday in 9W 180 at 1:00 pm. Residents are required to attend. Interns and medical students may attend as their schedule permits. Each service will be assigned a specific day to present. There should be a minimum of one case ready to be presented in detail with all appropriate studies available, i.e. EKG's, X-RAYS,

photographs.

**Intern report** takes place on Tuesdays at noon. Each intern will be assigned a specific day to present. The presentation should include EKG's, X-Rays, photographs, articles and an in depth discussion. The resident will hold the intern's pager during this hour.

**ECG/Radiology rounds** take place on alternating Thursdays at 1 pm. All housestaff are expected to attend. ECG fundamentals will be reviewed with Cardiology fellows, and radiology reading will be reviewed with staff radiologists.

**Special rounds** for each team are held with senior members of the teaching faculty. The schedule will be posted in the team rooms. Attendance is mandatory, as is preparation of cases for discussion. It is the PGY3's responsibility as a ward leader to make sure everyone attends the special rounds and that a case and presenter have been selected.

**Sign-out rounds** occur when most of the interns have completed their work and are preparing to leave. This takes place earlier and earlier throughout the year. In July, 6:00 p.m. is typical. It is not expected that house staff sign-out during an unstable situation. The team should stay to resolve any acute care issues before signing out to the on-call resident team. Sign-outs should be focused, thorough and complete. Excellent medical care must continue even if the patient's primary team is not in the hospital, especially over the weekend. The work-up of a patient as well as discharges should continue over the weekend.

**Clinic-pathologic conference** is held on a monthly basis which involves the house staff of the departments of Medicine and Pathology. This "clinical unknown" format allows the admission and hospital course of an interesting case to be described by one of the Medicine residents. Expert commentary is provided by an attending not familiar with the final diagnosis with the goal of expanding on the thought process involved in the case. The post-mortem examination is then presented by a resident or attending from the Pathology Department. This conference is well attended by housestaff and faculty from both departments.

## NIGHTS AT THE MOUNT SINAI HOSPITAL

**On-call overnight Intern.** During the week (Sun-Thurs), there is no overnight call for the senior resident. Interns alternate overnight call every eighth night. The on-call intern is responsible for covering each service after the oncall team goes home. The night float senior resident will serve as back-up for any problems or questions that may arise and will do the admissions. The intern is responsible for carrying on care, seamlessly, as if he or she were the primary intern.

**Night float residents (NF).** There will be two night float residents on Sunday-Thrusday nights. The night float resident is responsible for supervising the on-call interns in addition to doing any admissions that come in from 7p until 5am. The night float resident is expected to provide appropriate teaching to the on call intern. The MAR has the ultimate say in distributing admissions as he/she sees fit in order to keep the stream of

admissions as smooth as possible. This includes having the MCR do admissions overnight when the MAR sees fit.

### **BRONX VA MEDICAL CENTER**

There is one general medicine ward with two teams, each consisting of two interns and one resident. Overnight call is every fourth night. Day float interns manage the post call team with assistance from the no admit resident as needed. There is also one cardiac rotation which follows both patients in the cardiac intensive care unit and those on the telemetry floor. This team consists of three interns who take call every third night, and two PGY-3's who take call every fourth night. On overnight calls those residents also double as the "book" resident, who is responsible for triaging all new admissions and running codes. Morning report at the VA takes place only on Thursday mornings at 8:30am. Noon conference takes place daily, usually with food provided as well. There is no intern report or resident report, but there are radiology rounds every day at 10:30am. Please refer to the VA House staff Manual for specifics.

### **ELMHURST HOSPITAL CENTER**

The medical service at Elmhurst consists of three wards, each of which has four teams of one intern and one resident each. . Overnight call is every 4<sup>th</sup> night. Day float interns manage the post call team with assistance from the no admit resident as needed. Morning report starts at 7:45 a.m. Mon – Fri. Prompt attendance is mandatory for ward residents and optional for interns. Noon conference is held daily with lunch provided.

## **INPATIENT PRACTICALITIES**

### **THE MOUNT SINAI HOSPITAL**

#### **Admitting**

All service teams are each staffed by four teams, with each team consisting of two interns (Intern A and B) and one resident. Call is every fourth night. Prior to each long call will be a short call. On long call, teams will admit a maximum of eight admissions, including holdovers, four to each intern. On short call, teams will admit up to 2 pm with a maximum of four admissions. Any additional patients will go to the long call team. On any day, if admissions exceed the maximum admission number for the team before 7 pm, additional admissions will be worked up by the medical consult resident or night floats as holdovers for the following morning. When short call or non-admitting days fall on Saturday or Sunday the team will be off. No resident may refuse any admission from the MAR (medical admitting resident) for any reason other than medical necessity. Any disputes are to be referred to the chief resident on call if necessary.

“Bouncebacks”: A patient that has recently been discharged from the hospital and then is readmitted can be “bounced back” to the original admitting team under certain circumstances in order to insure continuity of care. The same is true of a patient who had been transferred to an ICU from a teaching team, and is now stable for transfer out of the ICU. The patient can be “bounced back” to the original team only if 1) the original resident and/or intern are still on service, 2) the patient is being admitted with the same diagnosis, and 3) the patient was discharged or transferred to an ICU less than 14 days ago. Patients that were on a teaching team for less than 24 hours before being transferred to an ICU should NOT be bounced back upon transfer out of the ICU. Please be considerate of other residents: the bounce back system is designed to improve continuity of care, not as a way for residents to “diurese” their team; if the original admitting team is already very large and yours isn’t, keep the patient on your service.

#### **Consultations**

These are available from subspecialty areas of medicine as well as other services. Before calling a consult on a private patient, you must confer with the patient’s attending as to the choice of consultant. IMA physicians generally request consultations from the full-time faculty. No consults should be called without discussion with your senior resident. After paging and speaking to the consultant, fill out a consultation sheet and place it in the patient’s chart. The more specific the question that you pose to the consultant the more likely you are to get the information you wish. The consultant is required to leave a report in the chart within 24 hours of your request.

#### **Studies**

Labs, radiology studies and special studies including echocardiograms, PFTs, etc. can be ordered through TDS. Bloods will be drawn the next morning by the nursing staff. The unit clerks will make up the tubes for you. The nurses on the floors are currently trained to put in IV’s. You will only be called if the nurses are unable to put in the

IV. They must notify their nursing supervisor prior to calling you (the supervisor is not required to attempt the IV; s/he must merely be informed).

Results: Results are available on TDS, SCC (laboratory only) and EDR (most comprehensive). You will receive a password and training for each of these systems. It is critical to always log off after using any hospital computer terminal. NEVER give your password to anyone else, as YOU will be held responsible for all orders placed using your password

### **Notes**

All patients require an admission note within 6 hours of admission. All patients on the teaching service require daily notes. Any significant change in patient status, change in therapeutic plan or abnormal laboratory tests must be noted in the daily progress note. Progress notes should be concise and clear. They should reflect any significant changes in the patient's physical exam or laboratory studies, as well as a synthesis of what you believe is happening to the patient. If the patient's condition has been discussed with the attending physician, you should note that as well. It is important that every entry you make in a chart contains the date, time, your signature, and your dictation number (legible), and pager number, and is stamped with your name and dictation number.

### **Dictations**

All patients require dictation summaries as soon as possible. Interns dictate all service cases and residents dictate all discharges covered by the subintern. Dictations must be done by phone in the hospital by calling x46653. These dictated discharges then become available on the hospital computer system. Once transcribed, they can be electronically signed or hand-signed in the chart completion room on GP 211.

### **Discharges**

When a patient is ready to leave, several steps are necessary to ensure a safe and rapid discharge from the hospital:

1. As soon as the discharge is imminent (ideally 24 hours before), the house staff will activate the order in TDS to Initiate Discharge Plan. This alerts the nursing staff that discharge is imminent and allows them to begin their paperwork. This order is not binding and can always be changed if the patient's condition changes.
2. Write the final discharge order as soon as you are sure the patient is going home.
3. A discharge note must be written before discharge. This is the single most important note in the chart and must include: 1) all diagnoses, 2) all procedures, 3) all meds, 4) plans for follow-up care, 5) all instructions given to patients.
4. Every patient requires a follow-up appointment. If it is to be at one of the clinics at Sinai, tell the desk clerk, who can make the appointment. If with a private doctor, write the time, place and name of physician on the discharge instruction sheet given to the patient on discharge.
5. Write any required prescriptions.

6. Patients can appeal discharges if they don't feel ready to leave. If this happens, don't get upset. Merely call the discharge planning coordinator and the patient representative. In general the discharge planning coordinator is very helpful in arranging discharges.

### **Pagers**

Every intern will receive an alpha-numeric long-range beeper on July 1 that s/he will keep throughout their residency. This beeper must be carried at all times, whether on the wards, at affiliates, or on elective. At Mount Sinai each intern and resident will also receive a short-range beeper on arrival to a ward in addition to your long-range pager. These short-range pagers can be reached by dialing 41300 and then the pager number. Liz Perez is your first contact for beeper trouble. If she is not available, go to the communications department on the MC level. Replacement beepers are available if they break; please be sure to bring all the pieces. Replacement batteries can be obtained from the medicine office GP 9W-181.

There are times that house staff will be paged about a patient that is not their responsibility. The proper response is to make that person aware of the error and then help them find out who is responsible and how to contact him or her. If you are unsure of a patient's primary team providers, you can direct your questions to the Medical Admitting Resident (MAR), beeper 7785.

When any resident or intern leaves the hospital, he/she should be sure to forward his/her pager to the proper covering pager (usually the on-call intern). In order to do this, dial 4-1200, and follow the directions as prompted.

## **ELMHURST HOSPITAL CENTER**

### **Admitting**

The short call team admits a maximum of three holdovers or three admissions by 12 noon. The long call team admits a maximum of 8 patients (5 for the intern and the additional 3 patients for the resident) or until 3am, whichever comes first. Post-call intern service will be covered by the day float intern. The float is supervised by the no admit resident.

### **Consultations**

Medical Consultation for Elmhurst Hospital consists of two PGY 3s who will cover medical consultation services in twelve hour shifts. Responsibilities include:

1. performing consults on all surgical services and rehabilitation medicine and backup consult service for psychiatry units/neurology service in the absence of their own consult internists.
2. evaluating and admitting all holdover patients (i.e. any medical admissions listed after 03:00 or admissions to the medical teams after they have exceeded their admission cap). The consult resident will then endorse the cases to the appropriate team in the morning. During times of excessive numbers of admissions when the teams cap early, if the consult resident is

overwhelmed, s/he will page the Elmhurst Chief Resident to decide if a relief TR will need to be called in.

3. responding to all consults called for the renal service from 5:00 p.m. until 7:00 a.m. of the next day. Renal patients shall be admitted to the B5 team and floor only.
4. covering renal service consults on weekends and nights and discussing all cases directly with the renal attending on call.
5. evaluating all admissions called in by all clinics into the medical service.
6. assisting and supervising PGY 2s and PGY 3s on call, including the PGY 2 in the CCU.
7. handling any problems on psychiatry if the PGY 1 psychiatry intern requests assistance.
8. acting as Senior House Officer for Team 700 anywhere in the hospital except in the Emergency Room or on pediatrics. The medical consult resident will respond to all cardiac arrests within the hospital. She or he is the responsible physician on the medicine service and should assist other physicians in the conduct of cardiac arrest treatment on other services. If the patient survives the cardiac arrest, the medical consult resident should facilitate transfer of the patient to the appropriate critical care area of the hospital.
9. assisting in procedures
10. maintaining close contact with medical on-call (Bell) attending so any potential problems (e.g. DNR's, bed, pre-operative consults, interdepartmental/supervisional conflicts) can be readily addressed.

## **AMBULATORY CARE: INTERNAL MEDICINE ASSOCIATES**

Internal Medicine Associates (IMA) is the name of the resident ambulatory care practice. Preliminary residents do not have IMA responsibilities except during one month as walk-in physician. For categorical residents, IMA is a three year continuity of care clinic in which the resident will follow his or her own patients, accept new patients into his or her practice, and manage a patient panel.

IMA is divided into four firms, each with approximately four practices. The resident will be assigned to one of these practices for the entire three years. Within this practice each resident will be assigned to one primary attending.

### **LAYOUT OF INTERNAL MEDICINE ASSOCIATES**

#### **Front Desk**

Patients check in and receive follow-up appointments at the front desk. Patients also register there for nursing and social work visits.

#### **Mailboxes**

You will have your own mailbox at IMA. The majority of paperwork you receive will be nurses' orders from visiting nurse services which should be signed and returned to the sender in a timely manor.

#### **Abnormal lab or x-ray results**

All abnormal results are sent electronically by the EPIC (out patient Electronic Medical Record) to the ordering provider (resident), the primary provider, and the supervising attending. It is the responsibility of the 'ordering' provider to act upon an abnormal test result with clinically appropriate and document the action taken as a 'Result Note' or 'Misc Encounter'.

#### **Scheduling Problems**

If there is any problem with patient scheduling for a particular day, see your preceptor, not the front desk staff. The late policy is discussed in detail elsewhere.

### **STAFF AND ANCILLARY SERVICES**

#### **Medical Assistants**

The medical assistants will handle all forms for home health aides, etc. They process patients, which includes stamping prescriptions, sending patients to the lab, and drawing blood work. Other responsibilities of the medical assistants include assisting with Pap tests, doing EKGs, chaperoning breast exams and translating Spanish.

#### **Nurses**

There are RNs in each practice. The RN assists with diabetic education and instruction on home glucose monitoring. The RN can make referrals to Visiting Nurse Service, can review medications with patients, and do other teaching as needed. The RN in collaboration with the resident will follow patients on coumadin with laboratory protimes. Fingerstick protimes are no longer available in the IMA clinic. The RNs are also responsible for recalling patients when requested to do so.

### **Social Workers**

A social worker is on call every session and will be available for emergency situations. Some of the major responsibilities of the social worker include:

1. High risk screening of elderly patients, new IMA referrals, and/or hospital discharges.
2. Evaluation of patients presenting in acute psychosocial distress (anxiety, depression, suicidal ideation, etc.) or who require psychiatric care. In order to refer a patient to psychiatry the resident must first schedule the patient for a social work intake meeting and from this session the social worker will refer the patient to psychiatry.
3. Assessment and triage of patients with resource problems (financial, Medicaid problems), or who present difficulties in self management, (transportation, referral for home care, alternative living arrangements, etc.)
4. Management, together with the MD preceptor, of the disruptive problematic patients (following Disruptive Patient Protocol).
5. Initial contact with patients who will require more extensive social work evaluation and treatment for problems such as maladaptive response to illness; non-compliance with medical recommendations; somatic complaints without physical basis; family relationship problems, including domestic violence and elder abuse; suspected alcoholism/drug abuse; bereavement, etc.

## **MANAGING YOUR PATIENTS**

### **Appointments**

IMA appointments are managed by Ava Mancero. However, it is the provider's responsibility to discuss appointment changes with the Firm Attending prior to rescheduling patients.

### **Patient Encounter Notes**

Encounter Notes in EPIC (electronic medical record) do not need to be completed at the time of the encounter, but residents are encouraged to do so. Encounter Notes **must be** completed within **24hrs** of evaluating a patient.

### **Telephone Coverage**

Residents while on ambulatory block time rotate being on call evenings and weekends. When patients call the office an answering service will contact the resident who is on call. The telephone coverage policy will be discussed when the resident is on ambulatory block time. During working hours messages will be handled by the resident on ambulatory block who is in the same practice as the patient's primary physician. All phone encounters which required a change in medical plan are to be documented in EPIC under 'Telephone Encounter'.

### **IMA Patients in the Hospital**

When a resident's patient from IMA has been admitted to Mount Sinai the ward resident will contact the resident about the admission. As a primary care provider for a patient admitted to Mount Sinai, you will be notified of their admission through EPIC.

### **Business Cards**

The resident will be given business cards with his or her name and number on them. Residents should distribute these cards to their patients at IMA. The resident should also give them to patients whom they refer from the Emergency Department and medical wards to follow up at IMA.

### **IMA LATE PATIENT POLICY**

A patient is considered late if s/he arrives 30 minutes after the scheduled appointment, or 20 minutes after the scheduled appointment if it is the last appointment of the session.

#### How to Handle Lateness

1. Reschedule the patient into an underbooked slot with that doctor during that session or one later in the day. Front desk must immediately put this into computer to avoid possibility of overbooking.
2. If there is no availability later in that session or day, the resident must be questioned as to whether he or she can squeeze the patient in for an abbreviated visit.
3. If the resident cannot do this, the front desk is to try to put that patient into an underbooked slot with someone else in that firm for the same session or day and enter it into the computer.
4. If there are no underbooked slots available, the front desk staff will present the problem to the preceptor. The preceptor will determine whether the patient needs to be seen or can be rescheduled and will arrange to have this accomplished.
5. **ALL PATIENTS THAT WANT OR NEED TO BE SEEN, MUST BE SEEN!**
6. Many patients who are late are arriving so because of circumstances out of their control and in fact, have made an extraordinary effort to come for their scheduled appointment. Professionalism and caring dictate that most patients should be seen by their physician despite their tardiness.

### **CANCELLATION OF CLINICS**

1. Residents have primary responsibility for their IMA patients and are expected to attend all scheduled clinic sessions.
2. It is the responsibility of the resident to find coverage for a scheduled clinic session if s/he is unable to attend (i.e. for interviews).
3. No resident may cancel his or her clinic. If a scheduling problem arises and the clinic session in question is more than 3 months in the future, the resident may contact the chief resident and discuss options concerning coverage.
4. If the scheduling conflict is within 3 months of the clinic date, it is the duty of the resident to arrange coverage.
5. Residents who call in sick will have their clinic covered according to the sick call policy.

**This is your practice and these are your patients for the duration of your tenure at Mount Sinai Medical Center. Take care of them!**

## **CREDENTIALING AND PRIVILEGES**

It is a requirement of the New York State Department of Health and the American Board of Internal Medicine, that medical students and residents be credentialed by the Department as to their judgment, understanding, and proficiency in doing procedures and then, granted privileges by the teaching hospital to perform those procedures either independently or with indirect supervision.

It should be noted that the Department Chairman, the Program Director and their delegates perform a credentialing process that is the verification of the successful performance of a required number of a given procedure and the demonstration of competence in that procedure. They then recommend to the hospital the granting of privileges. These privileges are required for a house officer in order to perform those procedures without direct supervision.

A physician trainee may perform procedures prior to privileging only under the direct supervision of an appropriately credentialed person or in a life-threatening emergency when no person with privileges is available.

### **DELINEATION OF PRIVILEGES/CERTIFICATION FOR PROCEDURES**

Delineation of Privileges/Certification for Procedures for House Staff in Internal Medicine

A protocol has been established such that all house officers will perform procedures under direct supervision until appropriately credentialed and privileged. This protocol does not obviate the need for informed consent by the patient and approval by the patient's attending physician (except in emergency situations). All serious procedures and their outcome and those that require consent should be documented in the patient's chart as well as in the resident's log book. Successful and unsuccessful attempts at a procedure need to be recorded.

Privileges may be granted to perform procedures independently. This means the house officer, once appropriately credentialed and privileged, may in fact proceed to perform procedures on patients when indicated and after consultation with the attending physician and after appropriate consent is obtained from the patient. Privileges to perform procedures on patients under indirect supervision means the house officer may perform the procedures after discussion with the attending physician and after appropriate consent has been obtained, only if a physician with independent privileges for that procedure is on site and available to that house officer and concurs with the performance of the procedure. Direct supervision means that a physician appropriately privileged in the procedure is present in the room as the procedure is performed.

#### **PGY-1**

All PGY-1s are assumed to be competent, on the basis of successful graduation from medical school, in basic bedside skills of history taking and physical examination as well as standard venipuncture and peripheral venous catheter placement. A Clinical Evaluation Exercise (CEX), as required by ABIM, will be performed on all PGY-1s

to document these skills. If any incoming PGY-1 is unsure of these procedures, they should simply ask their resident for guidance.

The following procedures are to be successfully performed as soon as possible by each intern under direct supervision of any PGY-2 or more senior resident who is appropriately privileged in these procedures. Proficiency must be demonstrated in each skill and the appropriate number of procedures done successfully. In addition, the intern needs to demonstrate an understanding of the procedure itself, the indications, contra-indications, precautions, and complications before being allowed to perform the procedure without supervision. This proficiency will then be acknowledged by the Department.

### **PGY-2**

PGY-2s must complete all mandatory intern procedures in order to be able to be privileged by the hospital and thus able to supervise interns in the performance of those procedures. Any PGY-2 who has not completed the intern procedures must do so promptly.

The following procedures then should be successfully completed as a PGY-2 under direct supervision prior to receiving credentialing and privileging if they have not been completed in the PGY-1 year.

Once credentialed, the PGY-2 will receive privileges to perform these independently and supervise others who are learning the procedures.

In addition, PGY-2s are encouraged to document any other procedures, similar to the list under the PGY-1 category, that they perform during the course of training. These must all be done under direct supervision.

### **SUPERVISION**

Any PGY-2, PGY-3, Fellow or Attending who is appropriately credentialed and has independent privileges for the procedure that is being performed may supervise a resident. They must sign the procedure log for documentation and evaluation of the resident's understanding of the procedure.

### **EMERGENCY SITUATIONS**

Any physician may perform a life saving procedure in the absence of more senior house staff or physicians if they feel competent to perform the procedure at that time, and there is no other alternative.

### **RECORD KEEPING**

The Department of Medicine House Staff Coordinator will periodically review the procedure log of the residents, certifying and forwarding copies of these logs to the Office of House Staff Affairs. The Office of House Staff Affairs, as an agent of the hospital, will ultimately privilege residents to perform these procedures without direct supervision.

## **SUMMARY OF PRIVILEGES AFTER CREDENTIALLING**

### Independent Privileges granted to PGY-1 following graduation from medical school

History

Physical

Venipuncture

Peripheral venous catheter

### Independent Privileged as PGY-1

Foley Catheter Placement

NG Tube Placement - Conventional Tube

Blood Transfusion including transfusion protocol

Use of indwelling Catheter for Chemotherapy infusion protocol

Arterial puncture

### Privileged for indirect supervision as PGY-1 and independent as PGY-2

Abdominal paracentesis

Central venous line placement

Lumbar puncture

Thoracentesis

Arterial line placement

### Privileged only for performing under indirect supervision

Arthrocentesis

Bone marrow aspiration

Pleural biopsy

Swan Ganz catheter insertion

Flexible sigmoidoscopy

Cardiac Stress Testing

## **CONFLICT WITH PATIENTS**

It is natural to occasionally find yourself in conflict with wishes of a patient or family. Do not let these situations escalate into shouting matches or the loss of cool. Simply walk away and collect yourself before approaching the individuals, or call for help. Your senior resident, the nursing supervisor, the patient representative, and your chief residents may be able to help. Drs. Babyatsky and Klotman are also available if problems arise that require their help. If you witness or are subject to threatening or violent behavior on the part of a patient or a visitor you should immediately call a crisis team (4-STAT). An administrator, a psychiatrist and many security officers will converge at very high speed. Reserve this for truly grave and dangerous situations.

One way that Mount Sinai responds to both its hospitalized and ambulatory care patients is through its patient representatives. The Department provides a means through which special requests can be registered and solved. It provides feedback to administrators concerning hospital policies and procedures.

The representatives provide a liaison between the patients and the institution and act as central source of information to the patients and staff. The patients can dial one number on the phone for a "hot line." You can call them for any patient problems that you can't resolve (x 47724).

## **ADVISING AND EVALUATION**

### **ADVISING**

Each member of the house staff is assigned a faculty advisor, who is expected to provide support and to offer feedback based upon monthly evaluations. This person is also a resource for career planning. Residents are required to meet with their advisors at least twice a year, but are encouraged to meet with them more often. The advisors will make the first contact with you to introduce themselves.

### **EVALUATION**

1. At the completion of each clinical rotation, all housestaff evaluate their medical students, interns, residents and attendings. Likewise, housestaff are evaluated by their medical students, interns, residents and attendings. For the system to function properly, evaluation forms must be submitted in a timely fashion.
2. The American Board of Internal Medicine (ABIM) requires that residents have a clinical evaluation exercise (CEX), and each intern will be asked to perform a history and physical in front of an attending physician at some time during internship. In addition, a multiple-choice, in-service exam will be administered during PGY 2 and PGY 3 years as required by the ABIM.
3. Evaluations become part of the permanent record and are reviewed at regular intervals by the individual's faculty advisor. At least twice a year, all evaluations are presented to the Program Director at the Housestaff Evaluation Committee. This process helps the Department identify outstanding performances as well as problems. When problems arise, the advisory system serves to identify them and then provide the guidance and support necessary to correct them. If you have questions about your evaluations at any time, you can review them with your advisor or Dr. Babyatsky.

## **ABSENCES AND LEAVE**

Any changes in rotation or on-call schedules among residents must be cleared with the chief medical residents. You must submit your request via e-mail to the chiefs, and all parties involved must also e-mail the chiefs the agreed-upon plan. There are, of course, unforeseen and unfortunate events in any resident's life and should this occur, you should contact your chief resident as soon as possible for assistance in coverage arrangements.

### **Sick Call**

There is a sick call schedule for each block made up of people on elective. The purpose of sick call is to provide coverage for interns and residents who are unable to work due to medical illness, death of an immediate family member, or scheduling conflicts as determined by the chief residents. Whenever possible, people will be pulled to cover a sick call for someone in their class. Occasionally, however, it may be necessary to draw upon sick call from another class.

For any given day there will be two people from each level on call if the schedule permits. The person who is designated "Sick Call 1" will be the first person called to cover a sick call. This person must be within 30 minutes of the hospital and be able to be reached by pager. The person who is designated "extended sick call" will be the person called to cover a second sick call. The extended sick call person must be within 60 minutes of the hospital. The extended sick call person may also be called upon to provide coverage for a house officer who will be absent for an extended period of time. Sick call begins at 5a on the day of sick call and lasts 24 hours; extended sick call lasts until there is a new person scheduled for extended sick call or the absent person returns. Sick call residents must be available by pager on the day prior and day of sick call duties.

All changes to the sick call schedule must be cleared by the chief residents. Both parties must submit an e-mail request of the switch to the chief residents. Prior to submitting the switch request, both parties must make sure that there are no conflicts with the clinic schedule (i.e. you cannot take sick call if you have clinic the same day or the day after).

When can I call in sick?

- If you are physically unable to perform your duties as housestaff.
- If there is a death in your immediate family.
- Sick call is not to be used as a "personal day."
- An attending physician's note may be required.

Payback

- When you call in sick, payback will be expected. You should arrange this with the person you are covering within several days.
- There are certain situations, including illness requiring hospitalization, which do not require payback. This is at the discretion of the chief residents.

**INTERVIEWS**

When scheduling interviews for fellowship, jobs, etc. residents must make their own arrangements for covering their clinical responsibilities and inform the chief residents of their plans.

We strongly suggest that if you know that you will be applying for a fellowship, that you select a schedule that will allow you to interview during an elective block.

**ORIENTATION/STARTING FELLOWSHIPS/MOVING DURING BLOCK 13**

Residency ends June 30. You are responsible for all clinical duties up to and including the last day.

If you are starting a fellowship, moving, or need to attend an orientation during block 13, you must make your own coverage arrangements in advance. Sick call will not be called to cover you.

**JURY DUTY**

Physicians are no longer exempt from performing jury duty. If you are called for jury duty, you must reschedule it for your next available vacation or elective. No one may schedule jury duty during elective blocks 6 or 13, which are very limited with sick call.

**MATERNITY LEAVE/PATERNITY LEAVE**

The American Board of Internal Medicine is strict in its requirement that no more than three months be taken as vacation, sick time, and maternity leave during residency. Residents taking more than this may need to extend their residency to complete the required training to be eligible to take the Internal Medicine Specialty Certifying examination. Please contact the chief residents as soon as possible, who will work with you to rearrange elective and vacation time to allow for as much time off of the wards as possible following a birth. You will not be expected to take sick call during elective time immediately following a birth but will be required to perform independent study.

## **MOONLIGHTING**

The Department of Medicine understands that residents have multiple financial obligations. Therefore, residents are permitted to moonlight on HMP (Hospital Medical Practice), a non-teaching medical service at Mount Sinai Hospital. In order to remain compliant with the State regulations regarding working hours, residents who moonlight must adhere to the following rules:

1. Moonlighters must be at least PGY level 2.
2. Residents who want to moonlight must have a valid NYS license.
3. Residents who want to moonlight cannot exceed the 80 hours per week or 24 consecutive hours as stated in the 405 Rule of the Bell Commission. These hours limits are for combined moonlighting and usual clinical duties. Residents are not permitted to moonlight during ward and ICU months.
4. Moonlighting is subordinate to all regular academic duties such as clinics, reports and conferences.

## **SIGN-UP**

1. Once a resident signs up for a particular shift, that resident may not remove him/herself from the list unless he/she finds coverage.
2. Boarder sign-up is open to Department of Medicine fellows as permitted by their individual divisions. Sign-up is the 3<sup>rd</sup> Wednesday of each month
3. Non-compliance with these rules will result in suspension of moonlighting privileges as per the discretion of the chiefs.

Whether additional service is to be performed on or off Mount Sinai's premises, it is the obligation of the house staff member to obtain written permission from the Medicine Program Director for this purpose.

## **LOAN DEFERMENTS**

In order to facilitate house staff loan deferments, Liz Perez is authorized to provide a letter of verification of house officer's status at Mount Sinai to loan program. Loan forms need verification by Department of Medicine and hospital seal.

# Appendix

## **RESIDENTS' PROCEDURAL RIGHTS IN THE DEPARTMENT OF MEDICINE**

The purpose of this policy is to set forth the procedures in the Department of Medicine available to residents in case of an adverse action taken by the Department. The Department is committed to making certain that the procedures are fair and that they provide each resident a full opportunity to be heard. There are two types of adverse actions that the Department may take regarding a resident:

1. disciplinary action and 2. adverse evaluations. Each has its own procedure.

### **ADVERSE EVALUATIONS.**

Twice a year the Housestaff Advisory Committee convenes to discuss the progress of all residents. The Committee makes recommendations based on written evaluations to the Program Director and Chairman.

In the event the Program Director decides that he intends to give a resident an adverse annual evaluation, the resident will be notified in writing. For the purpose of this policy, an "adverse annual evaluation" is one that will result in any of the following:

Academic probation or a "marginal" evaluation for the academic year

Non-renewal of a resident's contract for a succeeding year

An "unsatisfactory" evaluation for the year and/or no credit for the year

An unsatisfactory Chairman's letter of reference.

If the resident chooses to request a reconsideration of the proposed adverse evaluation, he must do so within 10 days of receiving such notice. An appeal process will follow.

The resident shall have access to all of the written evaluations and any other materials used by the Program Director in proposing the adverse evaluation. However, with respect to the written evaluations of the resident, the resident shall not be allowed to contact any evaluators to discuss their evaluations nor attempt to have the evaluations changed. Any attempts to do so outside of a committee hearing will result in the immediate termination of discussions of reconsideration of the adverse evaluation and make the resident subject to disciplinary action.

The evaluation and appeal will be passed on to the Chairman. After reviewing the material, he will make a final determination. The Chairman may meet with the resident. The Chairman's determination shall be final and will be reported in writing to the resident.

## **DISCIPLINARY ACTION**

Institution-wide procedures for disciplinary action are set forth in the House Staff Personnel Guidelines of the Mount Sinai Hospital. ( A copy of the relevant provisions from the Guidelines is appended hereto.) In summary, the Chief of Service or the Hospital Director may take disciplinary action against a House Staff Officer for four enumerated reasons. Any resident who is disciplined must receive notice of the reasons for the disciplinary action, an opportunity to be heard before an impartial tribunal consisting of house staff and attending physicians from outside the Department, an opportunity to question witnesses against him/her and a right to an appeal. See page 22, House Staff Manual, 1995.

In the Department of Medicine, prior to taking disciplinary action, the Department Chairman may ask the Department's House Staff Advisory Committee to review or investigate the matter and make recommendations to him or her. During the investigative phase, if undertaken by the House Staff Advisory Committee, and before determining whether the imposition of the disciplinary action is appropriate, the Department Chairman may reassign the resident or require that he/she take a leave of absence. Such reassignment or leave must be of a duration sufficiently limited so as not to affect the resident's eligibility for credit for the year. The imposition of the leave or reassignment is at the discretion of the Department Chairman. In the event the Chairman decides that a leave is required, the affected resident may require that a summary suspension be imposed to make a full due process hearing immediately available to him/her. If the resident elects to require a summary suspension, the Chairman may impose the suspension or take other appropriate action, but the leave will end. Should the Chairman decide such suspension is appropriate, it will be considered a disciplinary action, and carry with it all of the reporting responsibilities to governmental agencies.

## **END OF LIFE ISSUES, DNR, DEATH, AND DEATH CERTIFICATES**

### **DEATHS**

When a patient dies, you must do the following:

1. Call the patient's attending physician.
2. Call the family, if this is not done by the patient's attending (the nursing supervisor can help if you are unable to reach the family).
3. Inform the medical examiner if need be (see below).
4. Attempt to obtain permission for an autopsy from the family.
5. You, or the private physician, are required by New York State law to attempt to obtain organ donations from the family.
6. Fill out the "physicians death note worksheet" to assist the desk clerk in filling out the death certificate. This takes priority over all ward duties. Interns may use their resident's or chief resident's license number to complete the form. You need not ever have seen the patient alive to do this. The Appendix carefully explains how to fill out a death certificate. Try to do it carefully; you will be amazed at how particular the people who read them are. Be aware that any doctor can sign a death certificate whether or not he/she took care of the patient. The certificate must be signed in **BLACK** ink. If a death certificate is not signed the hospital will not release the body to the bereaved family and this can be a very traumatic experience for the deceased's family.

### **DNR ORDERS**

The State of New York has mandated a system of determining a patient's resuscitation status. The legal department has prepared flow charts to help you create appropriate documentation of the patient's code status. These flow charts are available on every ward. They are available for five different settings, depending on the capacity of the patient and the presence or absence of family. All DNR sheets must be signed by an attending physician within 24 hours of a DNR order being placed in the chart.

Health care proxies and living will material are also available for distribution to patients. Residents are encouraged to gain familiarity with these materials and to use them in their interactions with patients.

### **CAUSES FOR MEDICAL EXAMINER NOTIFICATION**

The following deaths must be reported to the medical examiner. The medical examiner will either accept the case or reject the case. Either way, he/she will give you a case number, which you must list on the death certificate.

Call the M.E. for:

1. Homicide, or suspicion thereof
2. Suicide, or suspicion thereof
3. Accidental traumatic injury
4. Abortion
5. Death during or immediately after invasive radiological procedure

6. Poisoning or suspected bacterial poisoning
7. Chronic alcoholism with manifestations of traumatic injury
8. Unusual or peculiar circumstances
9. Unattended by M.D. and insufficient knowledge of circumstances
10. After coma or convulsive seizure
11. Drug addiction
12. Prisoners
13. After therapeutic, surgical or anesthetic procedures (O.R, P.A.C.U.)
14. Hip fractures in the elderly
15. Unusual reaction to medication
16. Injury after hospital admission
17. Accidental burns
18. Expiration during transportation between services
19. Death by cardiac arrest within 24 hours of admission with no previous history
20. Incorrect medication

Note: If a patient expires within 24 hours of admission, it is not automatically a case for the medical examiner (see #19).

#### **HOW TO CORRECTLY FILE A DEATH CERTIFICATE**

See [www.sinaimed.org](http://www.sinaimed.org) for complete instructions on how to fill out electronic New York State Electronic Death Certificate.

#### **INSTITUTIONAL POLICY REGARDING BRAIN DEATH**

See institutional manual [http://www.mssm.edu/gme/mount\\_sinai/manual](http://www.mssm.edu/gme/mount_sinai/manual)