Inpatient Internal Medicine Guidelines

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Expectations

Be conscientious. Ask if you don't know something. *Call me* at any time or page me.[1] I *like* being called about lots of things. Feel free to call me for any patient status changes, even if minor. Never worry, 'Is this a big enough status change to call him?' If you are ever wondering *whether* you should call/page, then please call/page. Don't criticize or be negative about others[2] while "on stage" in public, but it is OK to vent when we're "backstage" in the work room or somewhere at least as private.

The ideal resident is thinking ahead and has a plan. As resident, you should run the team. Keep us efficient. Be highly available to your interns (touch base a few times daily; more if needed). Review their orders. Give feedback. Balance the workload.

The ideal intern is organized and diligent. Help your students. You are the default writer of orders and communicator (with your patients, with consultants) but the resident will balance this work as needed.

The ideal medical student is inquisitive. Give the presentation every day on your own patients. Learn the basics and tell us what you learned.

[1] E-mail Andrew.Zimolzak@va.gov for non-urgent things. No patient identifiers by text message.

[2] Meaning practically anyone: consultants, technicians, nurses, this hospital, "outside hospital," etc. Actual things I have heard in hallways at other hospitals: "I don't want this patient and am attempting to block." And: "We can't get an ABG back quickly because this is a ghetto hospital."

Recommendations

Everything from here down is "recommended" or "nice to have" but not "required."

Oral presentations: On new patients, focus on the chief complaint. It's OK to use a short "with a history of…" phrase in your one-liner, but keep chief complaint *near* the beginning of this sentence. On existing patients, often there is one diagnosis that explains why he/she is still in the hospital. This one diagnosis should be the bulk of your one-liner. No need to repeat anything on existing patient oral presentations.[3]

Written documentation: Put the chief complaint in exact quotes on initial H&P write-ups. Good questions to ask of patients: "Who's your primary doctor?" "What do you do for work?" "Who lives with you at home?" I encourage calling or otherwise notifying the PCP of their patients' admission. If the patient is a transfer, know where he/she transferred from. Progress notes can be very short. There is no need to mention labs in detail, unless it helps you review them

[3] That means Assessment should simply be "Problem 1, Hypercalcemia due to…" rather than repeating "85 year old with a history of stage IV non small cell lung cancer status post chemotherapy with cisplatin and etoposide, initiated on…, also with COPD, CAD, chronic kidney disease…."

or something similar. There are no "standard AM labs;" not every patient needs every lab every morning. This is especially true for patients who are "placement." For a very short admission, it is completely fine to have a very short discharge summary. I tend to give more feedback on oral presentations, but I'm happy to critique written documentation if you hand me a printout (best for PHI reasons).

Initial 10 minute topic: Be ready for rounds right on time. Team members may give a short topic presentation, as in 10 minutes. I aim to do these first thing if possible. The topic will probably come from a question that comes up on rounds. I will keep a watch for topics that fit this bill, but chime in if you want to present about a specific topic. Make a very short (0.5–1 page, or <300 words) printout for us to read if at all possible. Spend 30–60 minutes preparing this. We will try to make it a very directed question so it is answerable with this amount of effort.[4] We may also have very short questions that people look up and present the next day (no printout).

[4] Specialized things I can present include use of VA data for research, diagnostic error, medication adherence, interpretation of papers especially prediction models or machine learning, biostatistics and epidemiology, diabetes management for inpatient medicine, and CPRS tips and tricks.

Rounds: In the pandemic era, we usually "table round" after morning report. Then we'll see any patients who are sick, who have something I need to see them for, or who have bedside teaching points. I don't need to see patients the morning before discharge. Let me know if workload prevents you from attending conferences. I usually "card flip" quickly with the resident only, in the afternoon. Afternoons sometimes involve topic presentations, radiology image review, observed student H&Ps, or feedback. On call days, we can staff patients the same day, or discuss by phone, or wait until morning rounds, based on the resident's judgment.

About me

I grew up in Michigan. My undergraduate degree is in biochemistry from Michigan State. Medical school was at Washington University in St. Louis. Intern year was at University of Missouri-Columbia, and residency was at Saint Louis University, with an extra year for chief residency. I've worked in VAs since medical school.

I completed a master's degree in biomedical informatics at Harvard Medical School. I worked at VA Boston from 2014 to 2018, doing *clinical research informatics,* which means "using clinical and data warehouse expertise to make VA data usable for research." I moved to Houston in 2018. My projects here include a trial within the VA of an intervention to improve follow-up on clinical test results.