Inpatient Internal Medicine Guidelines

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May 5, 2023

Expectations

Be conscientious. Ask if you don't know something. *Contact me* at any time.[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, then please call.

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.

Let me know if a patient makes you feel unsafe or uncomfortable. This can take many forms.[3] We are here to learn, but not at any cost.

[1] Don't use personal devices to text medical information. Don't use personal devices to send photos of ECGs or rashes, even if no identifiers, per Dr. Catic, ACOS Education, March 2023.

[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."

[3] Such as casually bigoted, intentionally insulting, or objectifying comments. Further reading: Jain SH. The racist patient. *Ann Intern Med.* 2013 Apr 16;158(8):632. PMID: 23588752.

Recommendations

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. On existing patients, often there is one diagnosis that explains why they are 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.[4]

Written documentation: Work hard on including an accurate chief complaint on initial H&P notes. Good questions to ask of patients: "What do you do for work?" "Who lives with you at home?" If the patient is a transfer, know where he/she transferred from. Progress notes can be concise: no need to mention labs in detail, unless it helps you. For a very short admission, it is fine to have a very short discharge summary. I prefer to give feedback on written documentation using a paper copy.

[4] 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 in January…, also with COPD, CAD, chronic kidney disease…."

Teaching/EBM: Be ready for rounds right on time. Team members may give a short (∼ 10 minute) topic presentation. I aim to do these first thing if possible. The topic will probably relate to a question that came 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. If possible, make a very short (0.5–1 page, or <300 words) printout for us to read. 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.[5] We may also have very short questions that people look up and present the next day (no printout).

[5] Specialized things I can present include: diabetes management for inpatient medicine, diagnostic error, using medical record data in your research, medication adherence, prediction models, topics in machine learning, and interpretation of statistics.

Daily routine: Since the pandemic, I usually "table round" in the morning. Then I'll "walk round" with/without house staff on patients who are new, sick, or who have status changes, questions, or 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. We can change any aspect of rounds (*e.g.*, the amount of bedside rounds) based on learning or work needs.

There are no "standard AM labs." Please look for reasons to *stop* telemetry and daily CBC or BMP rather than reasons to continue. This is especially true for patients who are "placement."

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. Attending roles have been mainly VA inpatient and non-VA urgent care.

About 75% of my time is research, specifically *clinical research informatics*, which means "using clinical and data warehouse expertise to make data repositories useful for others' studies." I completed a master's degree in biomedical informatics at Harvard Medical School and worked at VA Boston from 2014–2018. In Houston, I work at the IQuESt health services research center, developing electronic methods to detect and reduce diagnostic error; and at the clinical/translational institute, promoting use of BCM clinical data for research.