Wright Center for Graduate Medical Education

Primary Care Internal Medicine

Competency Based Curriculum
2011

Linda Thomas, M.D.
Program Director
Wright Center for Graduate Medical Education
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Letter from the President, CEO and DIO

July 1, 2011

To: WCGME Residents and Faculty

Re: Curriculum

I am happy to present you with this WCGME Competency Based Curriculum. It represents much hard work and considerable thought on the parts of Dr. Linda Thomas and Dr. Arjinder Sethi. They deserve our thanks.

A curriculum is nothing more than a conscious declaration of learning expectations. What and how we learn to attain and maintain the competencies delineated by the Accreditation Council for Graduate Medical Education (ACGME) and the Residency Review Committee (RRC) for Internal Medicine in order to attain proficiency as practicing physicians needs to be explicit. We need this resource before beginning each period in our training so that we enter it with awareness of what we need to accomplish. It will also serve us well to reexamine it at the conclusion of each rotation in order to evaluate the increment and remaining gaps that we have relating to the competencies.

This curriculum is a work in progress. This is a dynamic plan and score board by which we judge our progress toward expertise as internists. Your feedback is vital to its relevance. Please use it and provide Drs. Thomas and Sethi with your input.

Robert E. Wright, M.D., F.A.C.P.
President, CEO and DIO
Wright Center for Graduate Medical Education
July 1, 2011

To all WCGME trainees:

In 1999 under the leadership of Dr. David Leach, the Accreditation Council for Graduate Medical Education (ACGME) approved six areas of resident competencies to ensure residency training alignment with the continuously changing needs of the healthcare system, including 1) Patient Care, (2) Medical Knowledge, (3) Practice-Based Learning and Improvement, (4) Interpersonal and Communication Skills, (5) Professionalism, and (6) Systems-Based Practice. Residency training programs are expected to teach and evaluate professional development of their trainees based on these six competencies, using clearly specified teaching and evaluation approaches communicated through a competency based curriculum.

WCGME endorses these six ACGME competency domains and strives to optimize our residents’ learning environment by promoting a learner and patient centered environment that values competency based education. Our competency based curriculum is intended to provide overall rotation based guiding principals focused on mastery of the core competencies, skills and attributes for becoming competent internal medicine doctors ready for independent practice or subspecialty training. Successful redesign of our curriculum was completed in 2006 with the intent of incorporating principles of adult learning and competency based educational experiences and evaluation. Designing and implementing a new competency based curriculum is a continuous educational quality improvement process mandating regular updates and upgrades. Our curriculum redesign process was and remains participatory, engaging all residents and faculty in the shared processes of teaching and learning to enhance our learning environment.

WCGME hopes you will find true value in our competency based curriculum and be actively engaged, participatory learners and teachers in our educational environment. We really value every opportunity for resident feedback and input into our curriculum, as we believe that resident buy in to the curriculum is the greatest catalyst for its’ successful implementation and continued improvement.

Linda Thomas, M.D.
Program Director
Wright Center for Graduate Medical Education
Introduction to the Competency Based Curriculum

July 1, 2011

Residency curriculum is a document that provides the residents with an overview of what is to be achieved during the residency training, how it could be achieved, and how they would be evaluated to make sure that they achieved what was expected of them.

The Accreditation Council for Graduate Medical Education (ACGME) is the authority that accredits the residency programs while the American Board of Internal Medicine (ABIM) certifies the residents. Both the ACGME and the ABIM want a residency program to confirm if, after three years of training, a resident is competent to practice medicine. Specifically, the ACGME requires that programs have measurements of certain outcomes to document that their residents are competent before they recommend that their residents be permitted to take the ABIM Certifying Examination in Internal Medicine.

Since 2003, ACGME expects the residency programs to certify if their graduating residents are competent with respect to the six core competencies of:
- Patient Care
- Medical Knowledge
- Practice-Based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems-Based Practice

So now the new Competency Based Curriculum has to describe the six core competencies to be acquired, the experiences necessary to achieve them and an assessment process (with feedback). This has made it necessary for all the residency programs in the United States to rewrite their curricula based on the six core competencies described above.

After numerous meetings with the faculty members and the residents and umpteenth revisions of the initial draft, this curriculum has taken shape. However, it is still a work in progress for which I welcome you all to provide your input.

Finally, I would like to thank Dr. Jay Vanston for his help with the Palliative Care Curriculum, Dr. Shubra Shetty for her help with the Infectious Diseases Curriculum and Dr. Ghada Mitri with her ideas on the Ambulatory Care Curriculum. From start to finish, Dr. Linda Thomas was a source of constant input and guidance for this massive project and this curriculum could not have taken the present shape without her support. Dr. Robert E. Wright was the guiding force throughout the project (like he is for so many other projects) and provided important inputs at all stages of the curriculum development.

Pavan Irukulla, MD
Associate Program Director
Wright Center for Graduate Medical Education
WCGME Faculty

Robert E. Wright, M.D., F.A.C.P.  President, CEO and DIO
Linda Thomas, M.D.  Program Director, Director Ambulatory Care, Director Mid-Valley Practice
David Lohin, D.O.  Program Director, Osteopathic Residency Program
Pavan Irukulla, M.D.  Associate Program Director, Clinical Coordinator at Community Medical Center
Devathi Sreedhar, M.D.  Key Clinical Faculty, Clinical Coordinator
Shubhra Shetty, M.D.  Key Clinical Faculty, Infectious Diseases Education Coordinator
Gregg Novak, D.O.  Key Clinical Faculty, Director Scranton Temple Health Center
Jayakrishna Chinatanaboina, M.D.  Key Clinical Faculty, Clinical Coordinator
Deeza Gopavaram, M.D.  Key Clinical Faculty, Clinical Coordinator
Michael Kondash, D.O.  DME Osteopathic Training
Richard L. Weinberger, D.O.  Osteopathic Medical Education Coordinator
Edward Dzielak, D.O.  Geriatrics and Critical Care Education Coordinator
Stephen Pancoast, M.D.  Scranton Temple Health Center Preceptor
Charles S. Deck, M.D.  Inpatient and Scranton Temple Health Center Preceptor
Martin Hyzinski, M.D.  Inpatient and Scranton Temple Health Center Preceptor
Rajiv Bansal, MD  Key Clinical Faculty, Clinical Coordinator

INTERNAL MEDICINE

Dr. Robert E. Wright  Dr. Linda Thomas  Dr. Rajiv Bansal
Dr. Vincent J. Vanston  Dr. Shubra Shetty  Dr. John Guzek
Dr. Haitham Abughnia  Dr. Shireen Lobo  Dr. Shawn McCall
Dr. John McGeehan  Dr. Richard Weinberger  Dr. James Sheerer
Dr. Randall Brundage  Dr. Charles S. Deck  Dr. Edward Dzielak
Dr. Rajan Mulloth

ALLERGY & IMMUNOLOGY

Dr. Joel Laury  Dr. Rosanne Cech

ANESTHESIOLOGY

Dr. Joseph Ruzbarsky  Dr. Sanford Holland  Dr. Michael Kline
Dr. Senen Alday  Dr. James Arscott  Dr. Eric Barren
Dr. Subhash Arora  Dr. Patrick Grady  Dr. Barbara Penetar
Dr. Albert Belardi  Dr. Wael Hassanein  Dr. Cubyson Oxley
Dr. Rahmat Shah
CARDIOLOGY

Dr. Christopher Dressel  
Dr. Samir Pancholy  
Dr. Sampath Kumar  
Dr. Thomas Dzwonczyk  
Dr. John Lundin (Electro-Physiologist)  
Dr. Vitale Geyfman  
Dr. Linda Barrassse  
Dr. Leonard Denis  
Dr. David Lohin  
Dr. Thomas Roe  
Dr. Stylianos Galanakis  
Dr. Raymond S. Resnick  
Dr. Stephen Voyce  
Dr. Chau-Fe Huang  
Dr. Sun-Tak Han  
Dr. Madhava Rao  
Dr. Dave Fitzpatrick  
Dr. Barry Weinberger

DERMATOLOGY

Dr. Michael O’Donnell  
Dr. Mark Marsili  
Dr. Douglas Sheldon  
Dr. Jo Ann Zenker  
Dr. Greg Severs

EMERGENCY MEDICINE

Dr. Mary Sewatski  
Dr. Tanja Adonizio  
Dr. Richard Rudloff  
Dr. Gerard Nealon  
Dr. Adrian Dormans  
Dr. Paul Dubiel  
Dr. James Jones  
Dr. Joseph Russo  
Dr. John Viteritti  
Dr. Anthony Sauter  
Dr. Gerard Maritato  
Dr. Ammie Maravelli  
Dr. Dennis Kapp  
Dr. Richard OBrien

ENDOCRINOLOGY

Dr. Gregory Borowski  
Dr. Matthew Levy

FAMILY PRACTICE

Dr. Thomas Majernick  
Dr. Lisa Robertson  
Dr. Michael L. Kondash  
Dr. Armando Sallavanti  
Dr. Jehad Charabati

GASTROENTEROLOGY

Dr. Christopher Barbarevech  
Dr. Bharatkumar Patel  
Dr. Alexander Lalos  
Dr. Ronald Cianni  
Dr. David Rutta  
Dr. Edward Sherwin

GERIATRICS

Dr. Edward Dzielak

HEMATOLOGY & ONCOLOGY

Dr. Christian Adonizio  
Dr. Richard G. Emanuelson  
Dr. William Heim  
Dr. Gloria Morris  
Dr. Martin Hyzinski  
Dr. Salvatore Scialla  
Dr. Edward Jordan  
Dr. Abdalla Sholi  
Dr. Lisa Thomas  
Dr. Carl Barsigian


**INFECTIOUS DISEASES**

Dr. Rodger Fagerburg  
Dr. Stephen Pancoast  
Dr. Shubra Shetty

**NEPHROLOGY**

Dr. Jeremiah W. Eagen  
Dr. Roger Getts  
Dr. Henry Yeager  
Dr. John E. Prior

**NEUROLOGY**

Dr. Michael Baccoli  
Dr. Juan Barrera-Martinez  
Dr. Seth Jones  
Dr. Kevin Madden  
Dr. Michael D. Kim

**OBSTETRICS & GYNECOLOGY**

Dr. Lee Davis and associates  
Dr. Gehred Wetzel  
Dr. J. M. Tedesco  
Dr. Erroll Goldstein

**OPHTHALMOLOGY**

Dr. William J. Jordan  
Dr. William Jordan, Jr  
Dr. Arthur J. Jordan, Jr  
Dr. Christopher S. Jordan  
Dr. Jerome Jordan  
Dr. Thomas Boland

**ORTHOPEDICS**

Dr. John Doherty, Jr  
Dr. Theodore J. Tomaszewski  
Dr. Kevin R. Colleran

**OTORHINOLARYNGOLOGY**

Dr. Mark A. Frattali  
Dr. Keith M. Pritchyk  
Dr. Anthony Brutico  
Dr. Louis DeGennaro

**PALLIATIVE CARE**

Dr. Vincent J. Vanston

**PEDIATRICS**

Dr. Linda Thomas  
Dr. Martha Sauter  
Dr. Michelle Sudo  
Dr. Stanley Blondek  
Dr. F. D. Dawgert & Associates  
Dr. Jeffrey Zero  
Dr. Kathleen Walsh  
Dr. Jill McCoy
PSYCHIATRY

Dr. Ashok Kumar Patel  Dr. Matthew Burger  Dr. Daniilo DeSoto
Dr. Nelson K. Asante   Dr. Peter Moskel   Dr. Mohamad Rahman

PULMONARY MEDICINE

Dr. Ajay Shetty  Dr. S. Ramakrishna  Dr. Kenneth Jacobs
Dr. Gregory Cali   Dr. Sander Levinson   Dr. Terrence Lenahan

RADIOLOGY

Dr. Suman Patel  Dr. Joe Lahoda   Dr. Timothy Farley
Dr. Charles Barax

RHEUMATOLOGY

Dr. Eugene Grady  Dr. Marianne Santioni  Dr. Mark Cruciani
Dr. Julio Ramos

SURGERY

Dr. Joseph P. Bannon  Dr. Kristine Kelley  Dr. John A. Kutz
Dr. David Onofrey   Dr. James Roche   Dr. Michael Sunday
Dr. David Onofrey   Dr. Joseph DelSerra   Dr. Timothy J. Farrell

UROLOGY

Dr. Jerald Gilbert  Dr. Ronald Barrett  Dr. Donald Preate, Jr
Dr. James Stefanelli   Dr. Ira Kohn   Dr. Jeffrey Weiss

CLINICAL RESEARCH & INFORMATICS

Dr. John Guzek  Gustav J. Stangline  Mark Smerdon
Richard May
CORE COMPETENCY CURRICULA
I. Educational Purpose and Goals

Patient care is the keystone of all the skills possessed by a good internist. Such skills include demonstration of compassion while collecting highly personal data, assimilation of information that may need to be collected from multiple providers, performance of complete physical exams, managing complex problems while facilitating patient care, performing procedures in a competent fashion, effectively educating patients and their families, and advocating for patients within our complex healthcare system. Our goal is to train physicians who are competent in these pursuits.

II. Principal Teaching Methods

a. Supervised Direct Patient Care: Residents participate in rotations involving supervised direct patient care in both hospital-based and ambulatory settings. WCGME faculty supervises the residents one-on-one during these rotations. Where appropriate, senior residents assist, guide and supervise the interns and medical students. Rotations involving supervised direct patient care include those in:
   i. Allergy & Immunology
   ii. Ambulatory Care (both in an intense block format [Mid Valley Practice – MVP] and as a continuity clinic [Scranton Temple Health Center – STHC])
   iii. Anesthesiology
   iv. Cardiology
   v. Consult Medicine
   vi. Dermatology
   vii. Emergency Medicine
   viii. Endocrinology
   ix. Family Practice (for DO interns only)
   x. Gastroenterology
   xi. General Inpatient Medicine ("service block")
   xii. Geriatrics
   xiii. Hematology & Oncology
   xiv. Infectious Diseases
   xv. Intensive Care Unit
   xvi. Medical Ophthalmology
   xvii. Nephrology
   xviii. Neurology
   xix. Night Float
   xx. Non-Operative Orthopedics
   xxi. Otorhinolaryngology
   xxii. Palliative Care
   xxiii. Psychiatry
   xxiv. Pulmonary Medicine
   xxv. Rheumatology
   xxvi. Urology

b. Group Discussions, Didactic Sessions: For details kindly refer to the individual rotation curricula.

c. Simulated Patients: Every two years the residents participate (and are certified) in the BLS and ACLS simulated patient education program.


III. Educational Content

a. **Learning Venues:** Main venues include Mercy Hospital, Moses Taylor Hospital, Scranton-Temple Health Center (STHC), and Mid Valley Practice (MVP). In addition, residents rotate through a number of ambulatory community facilities (mostly sub-specialty clinics) affiliated with the Wright Center for Graduate Medical Education (WCGME).

b. **Disease Mix:** The mix of diseases is quite broad and includes common as well as rare physical and psychiatric conditions generally encountered in adolescent through geriatric age groups.

c. **Patient Characteristics:** Patients seen by the residents range from above 16 yrs age to the geriatric age group. They could be from the surrounding counties or from out of the area and they belong to different racial and socioeconomic backgrounds. Some are uninsured while others do not have (at least locally) a family doctor with admitting privileges to either hospital so they are admitted to the “teaching service”.

IV. Principal Ancillary Educational Materials

A wide range of resources are available to the residents. At the beginning of each rotation, residents are given general learning goals and objectives for that rotation. To these each resident adds his/her own personalized goals and objectives so as to tailor the rotation to their individualized needs. Residents additionally have access to library facilities at both the hospitals, and have internet access to numerous web based databases, search engines, and texts. Text and articles that provide opportunity for critical review may be assigned on the individual rotations. PDAs are given to all the interns at the beginning of their residency and they are encouraged to keep them updated with the latest PDA based programs including Uptodate.

V. Methods of Evaluation

a. **Resident Performance:** Resident performance is evaluated in a multitude of ways including:

i. For each clinical rotation, supervising faculty completes a web based (www.myevaluations.com) electronic resident evaluation that includes assessment of the core competency performance in patient care.

ii. Mini-CEXs are performed on the residents by the supervising faculty, both in inpatient and outpatient settings.

iii. Nursing evaluations are received from both the hospitals and the ICU of Moses Taylor Hospital.

iv. Patient evaluations are obtained from both inpatient and outpatient settings.

v. Residents do self-evaluations during various times of the year including their semi-annual meeting with the Program Director or his assignee.

vi. Residents maintain a portfolio in an electronic format in the Program Administrators computer. They present their updated resident portfolio every six months at their semi-annual meeting with the Program Director or his assignee. This portfolio includes entries in all the six core competencies including patient care.

The first four evaluations are shared with the residents by making them available online for review by the residents at their convenience. A summary of these evaluations (including the self-evaluation and the resident portfolio) is incorporated into the semi-annual performance review.
done by the Program Director or his assignee. In other words, formative evaluation semi-annually includes summative and self-evaluations.

b. **Faculty Performance:** Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. **Program Performance:** At the end of each six-month period, residents complete a formal review of the residency program.

**VI. Specific Competency Objectives with Progressive Learning Goals and Graded Responsibilities**

a. **Relationship Building Skills:** Residents must demonstrate the importance of effective communication when caring for patients as they collect highly personal information.

   i. PGY-1 and PGY-2 residents should consistently demonstrate integrity, respect, compassion and empathy for patients and their families. They should establish trust and recognize that the primary concern is the welfare of the patient. Residents at this level of training should respect personal preferences and understand patient rights. They should engage in shared decision making with their patients.

   ii. PGY-3 residents should demonstrate the above and aid junior residents in effective communication with their patients.

b. **History Taking Skills:** Residents must demonstrate an understanding of the importance of history in deriving a differential diagnosis.

   i. PGY-1 residents should consistently gather essential and accurate information. Their database should be organized in a manner consistent with accepted medical convention and charted in a timely and efficient manner. The information should be comprehensive and include data gathered by/from other providers and laboratory investigations.

   ii. PGY-2 and PGY-3 residents should be precise, logical and efficient in their data collection in addition to the above.

c. **Physical Examination Skills:** Residents should demonstrate the importance of performing an appropriate and relevant physical examination.

   i. PGY-1 residents should perform a comprehensive physical examination with a consistent sequence. Residents at this level should be able to identify normal from abnormal and should be able to describe the physiological and anatomical basis of the findings.

   ii. PGY-2 residents, in addition to the above, should correctly detect subtle findings and understand their significance. They should be able to teach physical examination skills to their juniors, including medical students.

   iii. PGY-3 residents additionally should strive to perform a focused physical exam at the level similar to a sub-specialist, and understand the sensitivity and specificity of the maneuvers.

d. **Clinical Judgment, Medical Decision Making and Management Plans:** Residents should progressively become more adept at assimilating information that they have gathered from the history and physical exam.

   i. PGY-1 residents should be able to identify all of their patients’ problems and should be able to develop a prioritized differential diagnosis. They should establish an orderly succession of testing based on their history and physical findings, thereby demonstrating appropriate
use of diagnostic and therapeutic procedures. In general, they should be able to identify sick versus non-sick patients based upon their assessment by the mid academic year. By this time, they should also begin to develop therapeutic plans that are evidence or guideline based.

ii. PGY-2 residents should regularly integrate medical facts and clinical data while weighing alternatives, keeping in mind patient preference. They should regularly incorporate considerations of cost and risks vs. benefits when considering diagnostic tests and therapies. They should consistently monitor and follow-up patients appropriately.

iii. PGY-3 residents should demonstrate the above and, in addition, should demonstrate appropriate reasoning in ambiguous situations, while continuing to seek clarity. Residents at this level of training should not overly rely on tests and procedures. They should assist junior residents and medical students to become efficient managers through appropriate use of clinical judgment and effective decision making. PGY-3 residents should consistently establish monitoring procedures, demonstrating the ability to change therapeutic programs for ineffective or adverse side effects.

e. Oral Case Presentation Skills: Residents at all levels of training should be adept in oral presentation skills. This should be demonstrated by delivering a case presentation that is organized consistent with medical convention. They should include all the important aspects of the history, physical exam and laboratory investigations. The assessment should be well documented including in-depth differential diagnosis and carefully executed diagnostic and therapeutic plan. Extraneous information should be deleted and residents should appropriately and accurately field audience questions. Pertinent materials such as X-rays and EKGs should be included and correctly interpreted.

f. Counseling Skills: Residents should recognize the importance of clear and accurate instructions for patients and their families.

i. PGY-1 residents should give patients accurate instructions regarding usage of their medications and follow up of care. They should document their counseling conversations.

ii. PGY-2 residents should effectively counsel and educate patients about pertinent health issues, tests and treatments. They should recommend appropriate screening exams by gender and age.

iii. PGY-3 residents, in addition to the above, should consistently and thoroughly educate patients and their families, using patient education as a form of intervention and partnering.

g. Use of Technology: Residents should understand the increasing role that technological advancements bring to the bedside.

i. PGY-1 residents should demonstrate use of computer-assisted databases for diagnosis and decision-making. They should utilize the electronic medical record system appropriately. They should regularly utilize drug information and drug-drug interaction programs.

ii. PGY-2 and 3 residents, in addition to the above, should utilize electronic databases for patient educational materials.

h. Procedures: Residents should competently perform medical procedures essential for the practice of general internal medicine.

i. PGY-1 residents should demonstrate knowledge of procedural indications, contraindications, necessary equipment requirement, process for handling specimens and patient after-care. They should participate in informed consent and assist the patient with decision making through their knowledge. Residents should attend to the comfort of the patient. PGY-1
residents should be supervised for all procedures until certified competent for a certain procedure by the program. Procedures should be thoroughly documented.

ii. PGY-2 and 3 residents should also be supervised until certified for a procedure. They should demonstrate extensive knowledge and be facile in the performance of procedures while minimizing risk and discomfort to patients. They should assist their junior peers in skill acquisition.

i. **Preventive Care**: Residents should understand the importance of disease prevention and health maintenance.

j. **Electronic Medical Records**: All residents should demonstrate the ability to utilize electronic medical records appropriately.

i. PGY-1 residents should utilize electronic medical records to ensure that their patients receive the recommended screening tests and other preventive practices. Residents should utilize electronic medical records in an effort to decrease the incidence of complications in patients with chronic disease states.

ii. PGY-2 and PGY-3 residents, in addition to the above, should demonstrate appropriate age-based screening and preventive care. These residents should remain vigilant for the changes in recommendations from federal and professional societies and apply recommendations to their patient populations.

iii. PGY-3 Residents should demonstrate an understanding of public health and its broad implications to the population being served.

k. **Patient-Centered Care**: Residents at all levels of training should demonstrate sensitivity and responsiveness to patients’ age, culture, gender and disabilities. Residents should work effectively with allied health care professionals and physician consultants to provide effective patient-centered care.

To summarize, the progressive learning goals and graded responsibilities for the core competency of Patient Care are as follows:

**PGY-1**

1. Perform a thorough history and physical examination
2. Synthesize data into a problem list and differential diagnosis
3. Recognize psychosocial issues that may effect patient compliance and outcomes
4. Formulate a diagnostic and therapeutic plan with some supervision
5. Optimize patient care plans by routine use of Uptodate website
6. Demonstrate humanistic and professional behavior in patient, peer and staff interactions
7. Accept personal responsibility to follow-up on patient care plans and test results
8. Respond in person to nursing calls on patient issues and document problems, assessment and plans of care
9. Apply preventive care in an outpatient setting and recognize overdue preventative care needs in inpatients and the need for follow-up
10. Perform the majority of procedures available during the course of the year

**PGY-2**

1. Coordinate patient care among all members of the health care team
2. Establish and identify oneself as a responsible and responsive team leader
3. Review the intern’s history, physical examination and assessment and plan
4. Formulate therapeutic and diagnostic plan independently
5. Use information technology to support patient care decisions
6. Counsel and educate patients and families
7. Engage the patient in management plans and address noncompliance
8. Develop skills for end of life and palliative care discussions and planning
9. Promote seamless patient care by optimizing discharge planning and follow-up
10. Perform and supervise (for procedures certified in) procedures as and when available

**PGY-3**

1. Efficiently evaluate and manage patients in the inpatient and outpatient setting at the level of a general internist
2. Function independently as a competent internal medicine consultant
3. Coordinate patient care among all members of the healthcare team and demonstrate leadership skills to promote multidisciplinary management for optimal patient outcomes
4. Demonstrate effective ability to lead end of life and palliative care discussions planning
5. Achieve full competence in all procedures
I. Educational Purpose and Goals

Physicians must demonstrate knowledge about both established and evolving biomedical, clinical, and cognate sciences and must be able to apply this knowledge to patient care. WCGME residents, therefore, must not only develop a breadth and depth of medical knowledge, but they must also develop analytic skills to continuously refine and apply their knowledge in varied clinical settings. They must also demonstrate a commitment to lifelong learning and professional growth.

II. Principal Teaching Methods

a. Supervised Direct Patient Care: Residents encounter diverse inpatient and outpatient populations. When providing care to these patients under the supervision of an attending physician, residents must incorporate knowledge of both biochemical and social-behavioral sciences. Experiences contributing to this knowledge base include lectures, workshops, grand rounds, online resources, and clinical experiences including inpatient teaching with management and teaching rounds and outpatient clinical experiences in the STHC continuity clinic, MVP block rotation clinic and the sub-specialty clinics.

i. Inpatient medicine clinical experiences include those in general inpatient medicine including consult medicine, intensive care unit, night float medicine, neurology, geriatrics, hematology & oncology, emergency medicine, pulmonary medicine, gastroenterology, nephrology, cardiology, rheumatology, infectious diseases and palliative care.

ii. Outpatient medicine learning experiences include the weekly continuity clinic at the STHC and the MVP ambulatory medicine block rotation. Residents are exposed to HIV medicine through the HIV clinic being run at the STHC. This is a Ryan White funded clinic providing total care to patients afflicted with HIV illness. In addition, residents rotate through the ambulatory practices of sub-specialists in the fields of psychiatry, dermatology, allergy & immunology, otorhinolaryngology, rheumatology, urology, endocrinology, ophthalmology, orthopedics, pulmonary medicine, gastroenterology, neurology, hematology & oncology, nephrology, cardiology, infectious diseases and geriatrics.

b. Group Discussions:

i. Morning Report: All residents (except those in the ICU who only attend the ICU morning report held on Thursdays) including the night float team attend the morning report. Morning report is a faculty led small group discussion addressing history collecting, physical examination, laboratory interpretation, differential diagnosis development, and care plan development pertaining to cases admitted to the teaching service. Morning reports are held every Tuesday in Mercy Hospital and every Friday in Moses Taylor Hospital.

ii. Ambulatory Care Conference: Every Monday morning residents present and discuss an ambulatory care topic under the supervision of Dr. Linda Thomas.

iii. ICU Morning Report: Every Thursday morning ICU residents present an interesting ICU case followed by a faculty led discussion on appropriate history taking, physical examination, laboratory interpretation, differential diagnosis development, and management pertaining to that case. Topics and articles of importance on critical care issues may also be discussed during these ICU morning reports.
iv. Teaching Attending Rounds: The attending in charge of the inpatient general internal medicine service (teaching attending) conducts teaching round sessions for a minimum of 4.5 hours per week. These teaching rounds extend the management rounds by a minimum of 4.5 hours per week to ensure adequate teaching and bedside physical diagnosis review. Discussions are held on varied topics including basic sciences, pathogenesis of disease, epidemiology, pathology, physical examination skills, data analysis, evidence based medicine principles, and differential diagnosis development. Teaching rounds include bedside teaching, and provide a format to assess and improve medical knowledge as well as knowledge of physical examination technique.

v. Journal Club: A required monthly journal club for all residents teaches clinical reading skills and evidence based medicine with resident presentation of articles demonstrating application of evidence based medicine principles to current medical literature. Articles contributing to recent advances in knowledge are stressed.

c. Didactic Sessions:

i. Tuesday Noon Conference: Held every Tuesday (except the fourth Tuesday of every month which is reserved for a Morbidity and Mortality / Quality Improvement Conference) at the STHC, it covers a wide range of topics, many covered by sub-specialist speakers. In addition, workshops are held on the ACGME mandated core competencies. Also covered are topics such as medical genetics, the business of medicine, legal aspects of medicine, risk management, ethics, impaired physician, substance abuse, domestic violence, women health issues, and adolescent medicine. Topics are repeated in a 24 month cycle to ensure adequate opportunity for all residents to attend these conferences.

ii. Grand Rounds: Traditional grand rounds are held the rest four days of the week at either of the two hospitals. A wide range of topics are covered including presentations of X-rays, CT scans, MRIs, PET scans, and pathological slides. Residents present interesting cases at the grand rounds every month.

iii. Morbidity and Mortality Conference: While this conference is primarily focused on practice-based learning and improvement, systems-based practice and patient care, it also covers fundamental medical knowledge including basic and clinical sciences.

iv. Visiting Professor: Prominent physician teachers from out of the area are invited to spend a full or a half day with the residents, interacting with them in varied formats including case discussions, question and answer sessions, presentations etc. This exposes the residents not only to different perspectives on common diseases but also to the opportunities available outside Scranton.

vi. Resident Specific Symposia / Workshops: Throughout the year residents participate in a number of resident specific symposia / workshops. These include workshops on the core competencies, workshops on better documentation and residents as teachers workshop.

d. Simulated Patients: All first year residents (and every two years thereafter) are required to participate in and complete a BLS and an ACLS training course, which, among other things, involves the use of simulated patients.

e. Independent Study:

i. Residents are suggested to buy the MKSAP study guide. This study guide is used for the monthly self-directed study as well as in preparation for the internal medicine boards.

ii. Residents have 24-hour access to written and electronic medical reference materials, including access to web-based search engine capabilities. Residents are expected to do
independent study on patient and clinically generated medical topics throughout their three years of medical training.

iii. Senior residents may request up to 5 days/yr to attend scientific symposia or other CME activities. In addition, senior residents receive a yearly book allowance toward texts and journals and a yearly conference allowance towards attendance at an approved scientific meeting or board review course.

III. Educational Content

a. Learning Venues: The primary learning venues include the following:

i. Mercy Hospital: A community-based hospital under the management of Catholic Health Partners.

ii. Moses Taylor Hospital: Another community based hospital in Scranton.

iii. Scranton-Temple Health Center: An ambulatory care center housing the continuity clinics and the HIV clinic.

iv. Mid Valley Practice: Site for the ambulatory care block rotation. It is located in the town of Jermyn, PA.

b. Patient Characteristics: Medical knowledge is acquired during supervised care of a diverse population of general internal medicine patients. Residents also see medical consults on surgical, obstetrics & gynecology, orthopedics or subspecialty patients. The patient population has extensive socio-economic diversity. When necessary hospital employed interpreters and electronic interpretation services are provided to enhance patient care.

c. Structure of the Curriculum:

i. General Ambulatory Internal Medicine: All residents do a minimum of one ambulatory block rotation per residency year at the MVP. They also participate in an ongoing continuity care clinic at the STHC to achieve a minimum of 108 weekly sessions over the three years of their residency training.

ii. General Inpatient Internal Medicine: Content is rotation specific and is outlined in the individual rotation curricula.

iii. Medical Sub-specialties: Curriculum for the medical sub-specialties is addressed via didactic lectures as well as in the content of each specific rotation. This is outlined in the rotation specific curricula and includes each of the classical sub-specialties of internal medicine.

iv. Interdisciplinary Knowledge: Topics covered include:

1. Adolescent medicine
2. Clinical ethics
3. Medical genetics
4. Quality assessment and quality improvement
5. Risk management
6. Preventive medicine
7. Medical informatics and decision-making skills
8. Law and public policy
9. Pain management
10. End-of-life care
11. Domestic violence
12. Physician impairment
13. Substance use disorders
14. Physician burn out and fatigue

v. Knowledge central to the performance and interpretation of procedures:

1. Technical knowledge for the performance of procedures
   a. Instructed at the beginning of residency and every two years thereafter
      i. Basic and advanced cardiac life support (BLS and ACLS)
      ii. Endotracheal intubation is addressed in ACLS classes, during the ICU rotation, and under supervision of faculty during acute code situations as clinically indicated.
   b. Self study with discussion in indications, contra-indications, and technique for arterial line puncture, central venous line placement, lumbar puncture, thoracentesis, paracentesis, nasogastric intubation, and arthrocentesis. Though ABIM has stopped recommending these procedures as essential requirements for graduation, WCGME believes that knowledge of these procedures is useful.
   c. Instructed in the ambulatory care clinic
      i. PAP and pelvic examination
      ii. Arthrocentesis

2. Interpretation of laboratory and other technical data is covered in various fora including the internship survival series, morning reports, teaching attending rounds, case presentations, noon conferences, sub-specialty rotations etc. Topics covered include:
   i. Peripheral blood smears
   ii. Sputum gram stain
   iii. Microscopic urine examination
   iv. KOH and wet prep of vaginal discharge
   v. Fecal occult blood
   vi. Electrocardiogram interpretation
   vii. X-ray interpretation including CXR, abdominal films etc.
   viii. Spirometry
   ix. ABIs
   x. Fluorescein eye examination

3. Optional procedural knowledge content available to interested residents during the course of subspecialty and MVP rotations includes (Rotations with the available experience are noted):
   i. Cryosurgical removal of skin lesions – dermatology, MVP
   ii. Elective cardioversion – cardiology, emergency medicine, ICU
   iii. Skin biopsy – dermatology, MVP
   iv. Soft tissue and joint injections – ambulatory medicine, rheumatology, non-operative orthopedics
   vi. Treadmill exercise testing – cardiology
   vii. Spirometry – pulmonary medicine
   viii. Sleep study interpretation – pulmonary medicine
   ix. Ambulatory electrocardiogram interpretation – cardiology
   x. Ambulatory blood pressure monitor interpretation – cardiology

IV. Principal Ancillary Educational Materials

   a. Residents are provided funds for the MKSAP books of the American College of Physicians.
b. Readings in primary literature are assigned by attending physicians throughout rotations and via required journal clubs.

c. Libraries with paper, electronic and web-based databases are present at both the participating hospitals. Standard texts and medical journals are available in print and/or electronic formats. All residents have 24-hour accessibility to computers having access to Uptodate website and online search engines.

d. In the residency office, DVDs of board review course are available upon request.

e. Continuity clinics are stocked with numerous resource texts.

V. Methods of Evaluation

a. Resident Performance:

i. Faculty completes web-based electronic resident evaluation (at www.myevaluations.com) provided by the residency office for each rotation. The evaluation is competency based and assesses medical knowledge. The evaluation is shared with the resident and is available for on-line review by the resident at his/her convenience. Evaluations become part of the resident file and are incorporated into the semi-annual performance review for directed resident feedback.

ii. Mini-CEXs are performed on the residents by the supervising faculty, both in inpatient and outpatient settings.

iii. Residents are required to pass BLS and ACLS upon entry into the program. They are also required to keep updated BLS and ACLS certification throughout residency.

iv. Morning reports, ambulatory care conferences, grand round presentations, ICU journal club presentations and other presentations done by the residents are all formally evaluated.

v. Annually, residents must take the ACP in-training examination. Residents are provided with their scores and made aware of content-specific deficits. Residents, who perform poorly, as judged by the Program Director, may be required to participate in specific remediation activities. It is important however to realize that performance on the in-training examination is not used as a criteria for promotion.

vi. Residents do self-evaluations during various times of the year including their semi-annual meeting with the Program Director or his assignee.

vii. Residents maintain a portfolio in an electronic format in the Program Administrators computer. They present their updated resident portfolio every six months at their semi-annual meeting with the Program Director or his assignee. This portfolio includes entries in all the six core competencies including medical knowledge.

b. Faculty and Program Performance:

i. Using the online evaluation system, residents complete rotation evaluations. The residency office reviews these evaluations and attending faculty physicians receive anonymous copies of aggregate completed evaluations at least once per year.

ii. Residency key faculty assess instruction outcomes using results of the annual in-training examination.

iii. ABIM board certification pass rates are reviewed yearly for outcomes assessment.
VI. Specific Competency Objectives with Progressive Learning Goals and Graded Responsibilities

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the application of this knowledge to patient care. Residents are expected to:

a. Know and apply the basic and clinically supportive sciences which are appropriate to their discipline:

i. PGY-1 residents should
   1. Demonstrate knowledge of common procedural indications, contra-indications, equipment, specimen handling and patient after-care.
   2. Demonstrate knowledge of basic and clinical sciences.
   3. Demonstrate satisfactory knowledge of common medical conditions, sufficient to manage urgent complaints with supervision. Residents must exhibit sufficient content knowledge of common conditions to provide care with minimal supervision by completion of the PGY-1 year.
   4. Take and successfully pass the USMLE Step 3 examination.

ii. PGY-2 residents should additionally
   1. Demonstrate a progression in content knowledge and analytical thinking in order to develop well-formulated differential diagnoses for multi-problem patients.
   2. Demonstrate understanding and responsiveness to socio-behavioral issues.
   3. Develop knowledge of statistical principles. Understand and appropriately use sensitivity, specificity, predictive values, likelihood ratio, number needed to treat, and odds ratios. This is reflected in requirements for evidence based presentations and journal club requirements.

iii. PGY-3 residents should additionally
   1. Demonstrate growing knowledge in the area of their chosen career path.
   2. Demonstrate knowledge regarding performance of procedures while minimizing patient risk and discomfort.
   3. Exhibit knowledge of effective teaching and evaluation methods, including RIME, one-minute preceptor, and evaluation techniques (discussed in residents as teachers workshop).

b. Demonstrate an investigatory and analytic approach to clinical situations:

i. PGY-1 residents should
   1. Demonstrate use of hospital library and online search resources.
   2. Exhibit self-motivation and learning.
   3. Demonstrate sufficient analytic skills necessary to develop appropriate assessments and plans for common medical diagnoses and complaints.

ii. PGY-2 residents should additionally
   1. Independently present up-to-date scientific evidence to support hypotheses.
   2. Should successfully complete grand rounds style presentation(s).

iii. PGY-3 residents should additionally
   1. Regularly display self-initiative to stay current with new medical knowledge.
   2. Regularly demonstrate knowledge of the impact of study design on validity or applicability to practice.
   3. Successfully complete a formal didactic CPC in grand rounds style format demonstrating in-depth knowledge of a clinical topic as assigned.
To summarize, the progressive learning goals and graded responsibilities for the core competency of Medical Knowledge are as follows:

**PGY-1**

1. Describe basic pathophysiology for common internal medicine conditions
2. Develop basic knowledge base for common inpatient and outpatient conditions
3. Demonstrate commitment to continued knowledge accrual
4. Utilize Uptodate website routinely on a patient-to-patient basis
5. Develop skills for effective review of the medical literature
6. Follow up on questions regarding optimal, evidence based patient care
7. Develop skills for effective case presentation and discussion of optimizing medical care for common medical diseases

**PGY-2**

1. Demonstrate in-depth pathophysiology for common internal medicine conditions
2. Demonstrate knowledge of medical literature analysis
3. Demonstrate informatics skills to promote evidence based medicine and quality care application
4. Develop filter skills for keeping up with medical discovery and evolution of evidence based medicine guidelines and standards of care
5. Review MKSAP on a regular basis
6. Solidify knowledge base by educating others

**PGY-3**

1. Demonstrate in-depth pathophysiology for common and uncommon internal medicine conditions
2. Apply critical reading skills to current internal medicine literature
3. Commit to intensive sub-specialty medical review while on elective rotations
4. Read and review key journal publications on a regular basis
5. Demonstrate a systematic approach to acquiring and maintaining current medical knowledge
6. Complete and present a comprehensive literature review for a senior project of the resident’s choice
7. Engage in scholarly activity and available research
I. Educational Purpose and Goals

Residents must be able to investigate and evaluate their patient care practice, appraise and assimilate scientific evidence, and then improve their patient care practice. In addition, residents must develop and maintain a willingness to learn from error and to use errors to improve systems and processes of care. This curriculum assists residents in their efforts to locate, critically appraise, and assimilate evidence from scientific studies and apply this evidence to analyze and improve their own practice. The goal is to foster the development of reflective physicians.

II. Principal Teaching Methods

a. Supervised Direct Patient Care: Training in Practice-Based Learning and Improvement (PBLI) is a continuous process that occurs with faculty supervision across the spectrum of inpatient and outpatient rotations. Residents also learn to use consultants as a means of improving patient care and self-knowledge.

b. Didactics: Full details are listed within the general inpatient medicine and the individual rotation curricula. In addition to rotation experiences, residents participate in monthly Morbidity and Mortality (M&M) conferences. These conferences focus on performing a root cause analysis and identifying potential systems errors in the case. The importance of error identification and working to improve the processes of care is stressed to the residents. Residents are further exposed to PBLI during medicine grand rounds. Lastly, journal club emphasizes the role of critical analysis of scientific studies and application of key findings into daily practice. Incorporated into the journal club is a longitudinal curriculum that focuses on study design and statistical analysis to provide residents with the necessary tools to critically appraise the literature.

c. Group Discussions: Residents are an important part of the committees that allow residents to examine the impact of practice improvement efforts and recommend changes to enhance their practice of medicine, both in the inpatient and outpatient settings. Also, residents on night float are expected to generate a clinical question and review pertinent literature pertaining to that question. The resident then presents the evidence-based review in one of the Friday morning report sessions.

d. Teaching: Residents also have the ability to work with and teach medical students on a regular basis. The majority of this teaching experience occurs in the inpatient setting, but residents also have exposure to students on some of the ambulatory blocks as well as some sub-specialty rotations.

e. Resident Scholarly Activity: Residents are encouraged to initiate or participate in any research opportunity that arises, whether in the domain of general medicine or one of its sub-specialties. The goal of resident participation in research at WCGME is to improve resident education, promote quality of patient care, and stimulate residents to become lifelong active learners and scientific participants by enhancing their participation in clinical investigation and scholarly activities.

The WCGME research staff provides residents with individualized project support that includes literature searching, statistical analysis, data presentation, formatting and editing, and preparing protocols for submission to the Institutional Review Board (IRB).
WCGME annually hosts a **Health Science Research Conference** where our residents have the opportunity to present their research projects.

Our **Research Lecture Series** occurs the second Tuesday of the month at the Scranton Temple Health Center. A sample of our research lectures are listed below:

- An Introduction to Clinical Research (Role of the IRB, consent and HIPAA)
- Creating a Study Question (Developing a testable hypothesis)
- Basic Research Study Designs – I (Observational studies)
- Basic Research Study Designs – II (Interventional studies and randomization)
- Measure of Effect (From relative risk to negative predictive value)
- Statistical Issues (p-values and statistical tests)
- Measure of Morbidity and Mortality (Rates and proportions)
- Data Interpretation (Validity, confounding and bias)

WCGME promotes scholarly activity among the residents so that they can develop habits of inquiry, learn to evaluate research findings and obtain new knowledge as part of their investigations.

### III. Educational Content

a. **Learning Venues:** There are four main clinical sites viz. Mercy Hospital, Moses Taylor Hospital, STHC and MVP. All these sites have computers that allow access to patient information as well as point-of-care review of medical literature. This allows residents to perform literature searches as soon as a clinical question is generated, in both the inpatient and outpatient settings.

b. **Disease Mix:** The mix of diseases is quite broad and includes common as well as rare physical and psychiatric conditions generally encountered in adolescent through geriatric patients. This forces residents to investigate practices and scientific evidence for a broad array of clinical problems.

c. **Patient Characteristics:** Patients seen by the residents range from adolescent to the geriatric age group. Patients are of varied racial and socioeconomic backgrounds.

d. **Structure of the Curriculum:** PBLI is a longitudinal process across all training experiences throughout the three years.

### IV. Principal Ancillary Educational Materials

a. Patient data is found within the hospital’s computerized patient database and is accessible from the inpatient and outpatient settings.

b. Extensive online medical resources, including MDConsult, Uptodate, Micromedex, PubMed and others are available on computers kept at all the four sites.
V. Methods of Evaluation

a. Resident Performance: Resident performance is evaluated in a multitude of ways including:

i. For each rotation, supervising faculty completes a web based (at www.myevaluations.com) electronic resident evaluation that includes assessment of the core competency performance in PBLI.

ii. Mini-CEXs are performed on the residents by the supervising faculty, both in inpatient and outpatient settings.

iii. Nursing evaluations are received from both the hospitals and the ICU of Moses Taylor Hospital.

iv. Patient evaluations are obtained from both inpatient and outpatient settings.

v. Residents do self-evaluations during various times of the year including their semi-annual meeting with the Program Director or his assignee.

vi. Residents maintain a portfolio in an electronic format in the Program Administrators computer. They present their updated resident portfolio every six months at their semi-annual meeting with the Program Director or his assignee. This portfolio includes entries in all the six core competencies including PBLI.

The first four evaluations are shared with the residents by making them available online for review by the residents at their convenience. A summary of these evaluations (including the self-evaluation and the resident portfolio) is incorporated into the semi-annual performance review done by the Program Director or his assignee. In other words, formative evaluation semi-annually includes summative and self-evaluations.

b. Faculty Performance: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Specific Competency Objectives with Progressive Learning Goals and Graded Responsibilities

The ability to use clinical practice and direct patient care as a venue for practice improvement and learning is a life long process; however, it is expected that a resident should satisfactorily function as follows:

a. Evidence Based Medicine: Location, appraisal, and assimilation of evidence from scientific studies related to patients’ health problems. Application of knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.

A PGY-1 resident should demonstrate the ability to:

• Be self-motivated to acquire knowledge
• Locate scientific literature to support decision-making

A PGY-2 resident should additionally:
• Be able to appraise and assimilate scientific literature
• Demonstrate understanding and use of an evidence-based approach in providing patient care
• Quickly access appropriate reference material for patients
• Voluntarily (without prompting or assignment) discuss and research relevant literature to support decisions

A PGY-3 resident should additionally:
• Effectively and efficiently use consulting services to improve both patient care and self-knowledge, appropriately integrating evidence-based medicine with expert opinion and professional judgment
• Acquire and use appropriate evidence-based information when acting as a consultant
• Learn and be able to research non-internal medicine patient care issues
• Apply knowledge of study design and statistics to relevant literature
• Respond to critical problems in a manner reflecting more than rote learning and protocol management. The resident should be able to utilize and suggest data-driven modification of protocol

b. Continuous Quality Improvement and Quality Assurance: Analysis of practice experience and performance of PBLI activities using a systematic methodology. Obtaining and using information about their own population of patients and the larger population from which their patients are drawn.

A PGY-1 resident should demonstrate the ability to:
• Understand his or her limitations of knowledge
• Ask for help when needed
• Admit to errors and seek help in remedying them
• Accept feedback and develop self-improvement plans
• Seek formative feedback on performance
• Deliver care that reflects learning from previous experiences
• Assess patient adherence to ambulatory regimens and accordingly modify prescribing practices
• Actively participate in quality improvement practices pertaining to patient care (e.g. M&M conferences)
• Review autopsy findings to understand illness and the care of critically ill patients
• Demonstrate improvement in clinical management by continually improving on their various rotations

A PGY-2 resident should additionally:
• Use self-assessments of knowledge, skills and attitudes to develop plans with insight and initiative for addressing areas for improvement
• Voluntarily plan learning experiences in procedures not yet mastered
• Use unique cases seen in a rotation to self-assess performance patterns

A PGY-3 resident should additionally:
• Analyze personal practice patterns systematically, and seek to improve patient care
• Utilize ambulatory practice data to actively improve practice and patient management
• Compare personal practice patterns to larger populations and seek to improve disparities in own patient care

c. Information Technology: Using information technology to manage information, access online medical information, and support own education.
A PGY-1 resident should demonstrate the ability to:
• Use the hospital database and web-based resources to access medical literature and data to support and enhance patient care

A PGY-2 and PGY-3 resident should additionally:
• Independently use PubMed or OVID and other web-based search engines to search the medical literature to enhance patient care and education

d. Teaching: Facilitation of learning of students, resident colleagues, and other health professionals.

A PGY-1 resident should demonstrate the ability to:
• Facilitate the education of students and other PGY-1 residents

A PGY-2 resident should additionally:
• Facilitate education of PGY-1 residents and other healthcare professionals
• Demonstrate evidence based independent research and preparation when teaching
• Use interactions with nursing staff and other professionals as two-way educational opportunities

A PGY-3 resident should additionally:
• When acting as a consultant, identify the questions and wishes of the physician requesting the consultation, and respond to these issues
• Assist in leading discussions of PBLI issues in various teaching settings

To summarize, the progressive learning goals and graded responsibilities for the core competency of Practice-Based Learning and Improvement are as follows:

**PGY-1**

1. Keep a checklist of patient care needs from rounds and assume responsibility
2. Ask for help when needed
3. Seek and accept feedback
4. Participate in quality improvement activities and root cause analysis
5. Demonstrate continual improvement in clinical management and knowledge
6. Teach students effectively
7. Use Uptodate website regularly
8. Focus on improving medical knowledge deficits as demonstrated on the in-training examination and global rotation evaluations. Assume responsibility to "patch the gaps" in one's knowledge base and skills

**PGY-2**

1. Encourage intern requests for help and respond in a timely and patient centered fashion
2. Teach students, interns and peers effectively
3. Use patient care errors and near misses to teach students, interns and peers
4. Promote continuous quality improvement with root cause analysis
5. Use information technology such as PubMed or Ovid to enhance patient care

**PGY-3**

1. Teach interns, students, and other residents effectively
2. Analyze own practice for needed improvement
3. Complete a QA/QI project under faculty direction
INTERPERSONAL AND COMMUNICATION SKILLS
COMPETENCY CURRICULUM

I. Educational Purpose and Goals

Effective communication and interpersonal skills are cornerstones of physicians’ professional identities. The successful internal medicine physician must be able to establish therapeutic doctor-patient relationships; work within multidisciplinary teams in a variety of settings, both as a member and a leader; and interact with other physicians verbally and in writing in a manner that facilitates coordination of patient care. In addition, residents act as teachers of other residents and students, a role facilitated by the same skill set.

II. Principal Teaching Methods

a. Supervised Direct Patient Care: During clinical activities, residents observe attending physicians, fellow residents, and other personnel modeling effective communication and interpersonal skills, and are observed in return. Such modeling may occur during bedside rounds, clinic visits, family meetings, case conferences, documentation activities, or while performing care-oriented tasks.

b. Teaching Rounds: Residents provide concise oral presentations of patient history and physicals, participate in academic discussions of medical issues, and perform problem-focused history and physicals during teaching rounds. Faculty moderate these discussions and model effective communication skills.

c. Intern Orientation: The required first year orientation emphasizes communication within systems, including hospital and clinic orientations and training in the Electronic Medical Record (EMR).

d. Required Presentations: All residents are expected to complete a scholarly project during their training. In addition to a presentation to the residency, these projects can be presented at a variety of local, regional, national and international conferences, or through journal publication. PGY-1 residents in the later part of their year and PGY-2 & 3 residents can be assigned responsibility for journal clubs, grand rounds, and M & Ms. In addition, residents may present an evidence based search of a clinical question defined during their night float rotations.

e. Residents as Teachers Day: All PGY-1 residents are required to attend a half-day meeting where selected senior residents and faculty discuss the interns upcoming role as teachers. Sessions focusing upon professionalism, communication and skills such as the One Minute Preceptor are held.

III. Educational Content

a. Learning Venues:

i. Location of Patient Care Activities: As previously described, residents rotate through two principle inpatient sites, Mercy Hospital and Moses Taylor Hospital. Roughly one half of their experience is in ambulatory settings, either at the STHC, MVP, or sub-specialists’ offices. Residents participate in a half day per week longitudinal continuity clinic at the STHC.
ii. Conferences: Residents attend a variety of conference series, including morning reports, lectures, grand rounds, morbidity and mortality conferences, journal clubs, and an ambulatory care conference series.

b. Patient Characteristics: The Scranton area boasts of a diverse population with a mix of urban, suburban and rural backgrounds. Residents encounter individuals from a variety of socioeconomic and demographic backgrounds. Residents also interact with a broad area of individuals as their fellow team members and patients, requiring them to utilize excellent interpersonal and communication skills for effective functioning.

c. Mix of Skills:

i. Information exchange: Effective information exchange encompasses both verbal and written interactions, with behavioral, cognitive, and time dimensions. That is, the successful physician can:
   • organize information succinctly and efficiently
   • use appropriate language (medical terminology and common English) to convey that information in either verbal or written formats
   • use appropriate non-verbal cues in face-to-face or other verbal interactions
   • use technology (electronic medical records, dictation systems, pagers, etc.) appropriately for purposes of information exchange
   • have legible handwriting
   • assess and address barriers to information exchange, on either their part or that of their audience
   • and do so in a timely manner.

ii. Doctor-patient relationships: The effective doctor-patient relationship requires the physician to listen, elicit information, educate patients and / or their families, and develop diagnostic and therapeutic plans using informed decision making, all within the context of ethically sound relationships. This requires:
   • the ability to actively listen
   • interpretation and use of nonverbal cues
   • development of explanatory, questioning, and writing skills
   • and the ability to use shared decision making skills.

iii. Working within teams: In fulfillment of their duties, residents must work with personnel at a variety of levels within the system, both as a team member and as a leader. Skills essential to these tasks include:
   • Communication skills as addressed above
   • The ability to coordinate, prioritize, and initiate tasks or activities
   • Professionalism (please see the Professionalism Competency Curriculum).

d. Interactions with Other Team Members: Residents interact with a variety of other physicians at all levels of training in their own and a variety of other specialties. These interactions may be as a junior member of the team (e.g., working under the direction of an emergency medicine attending physician during a required rotation), as a peer (e.g., as a medical consultant on a surgical subspecialty patient), or as a supervisor (e.g., as a senior resident overseeing the work of an intern). In addition to other physicians, they also work closely with case managers, social workers, nursing personnel, respiratory therapists, physical or occupational therapists, speech therapists, and other ancillary staff. They supervise medical and pharmacy students on inpatient rotations.

IV. Principal Ancillary Educational Materials

Residents have access to a full range of materials through the libraries, which includes electronic resources, paper materials, and multimedia productions.
V. Methods of Evaluation

a. **Resident Performance:** Resident performance in this core competency is evaluated in a multitude of ways including:

i. For each clinical rotation, supervising faculty completes a web based (at www.mynevaluations.com) electronic resident evaluation that includes assessment of the core competency performance in Interpersonal and Communication Skills.

ii. Mini-CEXs are performed on the residents by the supervising faculty, both in inpatient and outpatient settings. They allow assessment of medical interviewing skills, humanistic qualities, counseling skills, and organization/efficiency.

iii. Morning reports, grand round presentations, ICU journal club presentations and other presentations done by the residents are all formally evaluated.

iv. Nursing evaluations are received from both the hospitals and the ICU of Moses Taylor Hospital and includes an evaluation of this competency.

v. Patient evaluations are obtained from both inpatient and outpatient settings.

vi. Residents do self-evaluations during various times of the year including their semi-annual meeting with the Program Director or his assignee.

vii. Residents maintain a portfolio in an electronic format in the Program Administrators computer. They present their updated resident portfolio every six months at their semi-annual meeting with the Program Director or his assignee. This portfolio includes entries in all the six core competencies including PBLI.

These evaluations are shared with the residents. A summary of these evaluations (including the self-evaluation and the resident portfolio) is incorporated into the semi-annual performance review done by the Program Director or his assignee. In other words, formative evaluation semi-annually includes summative and self-evaluations.

b. **Faculty Performance:** Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. **Program Performance:** Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Specific Competency Objectives with Progressive Learning Goals and Graded Responsibilities

a. **PGY-1:**

i. Communication: PGY-1 residents should be able to:

- Provide thorough yet succinct oral presentations regarding patient care, using appropriate medical terminology.

- Provide thorough and complete written or electronic documentation of patient care (e.g., progress or procedure notes, history and physical exams, consultant notes,
discharge summaries), which is legible, timely and uses appropriate medical terminology.

- Demonstrate proficiency in the use of language and non-verbal skills in interactions outside of the context of patient care.

ii. Doctor Patient Relationships: PGY-1 residents should be able to:

- Establish rapport with patients from a variety of backgrounds.

- Perform a medical interview that elicits both patient-centered information, as well as testing diagnostic hypotheses.

- Effectively communicate uncomplicated diagnostic and therapeutic plans to patients or their advocates.

iii. Ethically Sound Relationships: PGY-1 residents should follow the tenets of ethics in patient care. Please refer to the Professionalism Competency Curriculum.

iv. Team Work: PGY-1 residents should be able to:

- Work as team members with senior residents and attending physicians, including the communication skills outlined above and the coordination of patient care.

- Supervise medical students including observing them, demonstrating skills to them, and giving them constructive feedback.

- Work effectively with ancillary staff to enhance patient care.

b. PGY-2: The successful PGY-2 residents meet all the criteria of the successful PGY-1 residents and, in addition, demonstrate mastery of:

i. Communication: PGY-2 residents should be able to:

- Engage patients in shared decision making for ambiguous or controversial scenarios.

- Conduct family meetings as in the setting of end of life decision making.

- Successfully negotiate most “difficult” patient encounters, such as the irate patient.

ii. Team Work: PGY-2 residents should progressively assume a leadership role, facilitating interactions between junior residents, medical students, ancillary staff, and attending physicians. This includes establishing expectations for all members of the team, overseeing patient care, ensuring participation in academic discussions, etc. They should also be the primary team members interacting with specialists regarding consults.

c. PGY-3: The successful PGY-3 residents meet all criteria of the successful PGY-2 residents and, in addition, demonstrate mastery of:

i. Communication: PGY-3 residents should be able to successfully negotiate nearly all “difficult” patient encounters with minimal direction.

ii. Team Work: PGY-3 residents should be able to function as team leaders with decreasing reliance upon attending physicians. They should also be able to function as a consultant (including completion of appropriate documentation and verbal communication with the requesting physician), whether serving as a general medicine consultant to other services or as a sub-specialist consultant when on elective rotations.
To summarize, the progressive learning goals and graded responsibilities for the core competency of Interpersonal and Communication Skills are as follows:

**PGY-1**

1. Present cases accurately and succinctly on rounds
2. Towards the end of the academic year, under supervision, present cases accurately and succinctly while on call to attendings
3. Provide timely, legible, thorough, succinct medical record documentation – histories and physical examinations, progress notes, and discharge summaries
4. Document all clinical responses to patient care needs legibly in the chart
5. Work well within team context relating to students, attendings, other housestaff, nurses, and patients
6. Communicate and establish a therapeutic relationship with patients and families
7. Develop skills to address frustration with our current healthcare system, residency scheduling or programmatic issues in a productive and constructive manner

**PGY-2**

1. Provide timely, legible, thorough and succinct resident admit and progress notes
2. Work effectively as a leader of the health care team
3. Establish the hierarchy of communication for the service team for the month
4. Demonstrate effective listening skills and reliable responsiveness to the needs of students and interns as well as the opinions and requests of multidisciplinary team members
5. Provide education and counseling to patients, families, and colleagues
6. Demonstrate skill in delivering end-of-life counseling to patients
7. Communicate effectively with consultants and primary care doctors to coordinate patient care and follow-up
8. Develop skills to address noncompliance and the frustrations of displeased patients

**PGY-3**

1. Work effectively as a leader of the health care team including a team with potential dysfunction
2. Demonstrate skill in handling all difficult patient care situations
3. Promote involvement of necessary consultants, social services and patient advocacy teams
4. Communicate near misses or mismanagement issues with the healthcare providers involved in an educational and blameless manner
5. Function effectively as a consultant for specialty and subspecialty care
6. Demonstrate the ability to provide documentation of IM consultation and appropriate level of consultative billing
I. Educational Purpose and Goals

Wright Center for Graduate Medical Education puts considerable effort into developing physicians who understand and demonstrate excellent professional values. WCGME strives to mould its residents into physicians who are competent, honest, compassionate, show respect for others, and shoulder professional and social responsibility. Moreover, professionalism is a never-ending process of self-examination and improvement.

II. Principal Teaching Methods

a. Supervised Precepting: Preceptors teach by example and also directly observe residents’ professionalism competency during the ambulatory clinics, patient care settings for each rotation, group educational sessions etc.

b. Intern Orientation: During the intern orientation the faculty and staff of the residency program and the two associated hospitals provide the new residents with the professional expectations for each institution and the available professional resources including impaired physician resources.

c. Residents as Teachers Day: Near the end of the first year of their residency training, interns participate in a half-day clinical teaching workshop. This meeting helps residents develop their teaching skills with a particular emphasis on the delivery of feedback.

d. Didactic Professionalism: The residency program conducts specific sessions, including workshops, during regular conference times on issues of medical ethics, physician impairment, professional development, substance abuse and legal medicine.

e. RAP Sessions: At the beginning of every 4-week block, residents meet with the Director and core WCGME faculty to discuss and resolve issues facing the residents. This meeting addresses professional behaviors (of staff, faculty, and residents) necessary for the residency.

f. Resident Portfolio: Residents are required to maintain an updated portfolio of their activities as a part of documenting their professional development. Portfolios document the resident’s growth in all the six ACGME competencies and also include the resident’s CV, presentations, publications, etc. This portfolio is reviewed by the Program Director or his designee at each semi-annual evaluation meeting.

III. Educational Content

a. Learning Venues: Everything a resident does as a part of their residency is a learning venue for the professionalism competency.

b. Patient Characteristics: Our residents care for patients and work with fellow residents who are members of a wide variety of cultural and ethnic groups. The patient mix of the residents is drawn from rural, suburban, and urban communities as well as areas of wide economic, educational, ethnic, religious, and social variation. Residents are expected to work with and care for people from these diverse backgrounds.
c. **Curriculum and Expectations:** Residents care for patients with socially difficult situations and presentations. They might have to care for patients with conditions and presentations that the residents themselves find contemptible, but they are expected to treat all patients with respect and dignity and provide excellent patient care regardless of their personal feelings about the patient or his/her condition.

**IV. Principal Ancillary Educational Materials**

Medical ethics is covered in the noon conferences. Palliative care curricula addressing end-of-life care is discussed under the individual rotation curricula. All this is supplemented with didactic lectures as well as practical opportunities during the various rotations.

**V. Methods of Evaluation**

a. **Resident Performance:**

i. Faculty, peers, nurses and patients complete resident evaluations, including assessment of Professionalism. Evaluation by faculty has a special professionalism checklist differentiated for each year of training (see below). Evaluations are available for online review by the residents at their convenience and are incorporated into semi-annual performance reviews.

ii. **Semi-annual Review:** The faculty member conducting the semi-annual review assesses the resident’s professional development and performance. Specific attention is paid to performance under stress and addresses potential impaired physician performance. During this meeting the faculty member also provides feedback on the resident’s portfolio on Professionalism and reviews completion status of medical records, EMR documents and conference attendance.

b. **Faculty Performance:** Residents routinely fill out faculty evaluations for each rotation they complete. These evaluations include assessments of the faculty member’s commitment to teaching and patient care, accessibility, humanism, and professional ability.

c. **Program Performance:** Every six months the residents fill out a program evaluation survey. This survey includes a resident-based global assessment of the effectiveness of the professionalism curriculum and the quality of instruction in the professionalism competency.

**VI. Specific Competency Objectives with Progressive Learning Goals and Graded Responsibilities and Checklists**

The various terms used during these evaluations are explained hereunder.

“**Essential**” objectives are those that must be done regardless of the resident or patient’s circumstance. Failure to perform one “essential” objective is a serious breach and should represent a failure to demonstrate the professionalism competency. As such, failure to perform an “essential” objective should lead to a score of “significant deficits” on the resident’s evaluation.

“**Expected**” objectives are those that residents should reliably perform day in and day out. Residents who fail to demonstrate an “expected” objective are not, at least in such instances, performing as good caregivers or colleagues. Although a score of “competent” might be possible in rare circumstances, a score of “minor deficits” is generally appropriate for residents who do not demonstrate one of the “expected” objectives for their year.

“**Appreciated**” objectives are those we would like to see our residents do all of the time, but we
understand that such performance may not be required to acceptably demonstrate the professionalism competency. If a resident is not demonstrating one of the “appreciated” professionalism objectives for his/her year, faculty should help the resident understand the objective and methods for improving performance, and their performance should be reflected by a score of “competent” or below on the professionalism evaluation.

**Virtue-Based Master List of Professionalism Objectives**

<table>
<thead>
<tr>
<th>Virtue</th>
<th>Skill, Behavior, or Attitude</th>
<th>PGY-1 Expectation</th>
<th>PGY-2 Expectation</th>
<th>PGY-3 Expectation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competence</td>
<td>Administrative competence (punctual, completes tasks as asked, follows directions, timely response to staff needs including pages and abnormal lab results, follow up on patient care issues without prompting).</td>
<td>Essential</td>
<td>Essential</td>
<td>Essential</td>
</tr>
<tr>
<td></td>
<td>Self directed learning.</td>
<td>Expected (e.g. reads about patients)</td>
<td>Expected (i.e. spontaneously presents literature and evidence related to patient care)</td>
<td>Expected (i.e. spontaneously presents literature and evidence related to patient care)</td>
</tr>
<tr>
<td></td>
<td>Able to deliver bad news.</td>
<td>Appreciated</td>
<td>Expected</td>
<td>Essential</td>
</tr>
<tr>
<td></td>
<td>Understands and is competent to work with patients regarding advanced directives, DNR status, futility issues, withholding* or withdrawing* therapy.</td>
<td>Appreciated</td>
<td>Expected</td>
<td>Essential</td>
</tr>
<tr>
<td></td>
<td>Able to assess and use informed consent and provision of care*.</td>
<td>Expected</td>
<td>Essential</td>
<td>Essential</td>
</tr>
<tr>
<td>Honesty</td>
<td>Understands and recognizes mistakes and notifies attending and patient (where appropriate) when mistakes are made.</td>
<td>Essential</td>
<td>Essential</td>
<td>Essential</td>
</tr>
<tr>
<td></td>
<td>Tells the truth and is trustworthy</td>
<td>Essential</td>
<td>Essential</td>
<td>Essential</td>
</tr>
<tr>
<td></td>
<td>Makes honest use of coding, billing, and referral principles.</td>
<td>Essential</td>
<td>Essential</td>
<td>Essential</td>
</tr>
<tr>
<td></td>
<td>Understands and appropriately maintains patient confidentiality*.</td>
<td>Essential</td>
<td>Essential</td>
<td>Essential</td>
</tr>
<tr>
<td>Compassion</td>
<td>Residents’ attitude manifests and interest in helping providing compassionate*, quality care to all patients.</td>
<td>Essential</td>
<td>Essential</td>
<td>Essential</td>
</tr>
<tr>
<td>Respect for Others</td>
<td>Demonstrates respect and compassion for all patients*.</td>
<td>Essential</td>
<td>Essential</td>
<td>Essential</td>
</tr>
<tr>
<td>Understanding and compassionately responds to issues of culture, age, sex, sexual orientation, and disability in patient care.</td>
<td>Appreciated</td>
<td>Expected</td>
<td>Essential</td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
</tr>
</tbody>
</table>

**Professional Responsibility**

<table>
<thead>
<tr>
<th>Recognizes that physicians have a responsibility for the safety and well being of patient, colleagues, and staff.</th>
<th>Essential</th>
<th>Essential</th>
<th>Essential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands that there are moral and ethical concerns about receiving gifts from patients and pharmaceutical representatives.</td>
<td>Essential</td>
<td>Essential</td>
<td>Essential</td>
</tr>
<tr>
<td>Able to discuss and defend own ethical understanding of his or her relationship with pharmaceutical representatives.</td>
<td>Appreciated</td>
<td>Expected</td>
<td>Essential</td>
</tr>
<tr>
<td>Willing to provide coverage for sick / unavailable colleagues.</td>
<td>Expected</td>
<td>Expected</td>
<td>Expected</td>
</tr>
<tr>
<td>Demonstrates intellectual curiosity.</td>
<td>Appreciated</td>
<td>Expected</td>
<td>Expected</td>
</tr>
<tr>
<td>Spontaneously teaches and exhibits concern for the educational development of fellow residents and students.</td>
<td>Appreciated</td>
<td>Expected</td>
<td>Essential</td>
</tr>
<tr>
<td>Provides leadership on teams and in the residency.</td>
<td>Appreciated</td>
<td>Expected</td>
<td>Expected</td>
</tr>
<tr>
<td>Understands that in a patient-physician relationship, the physician's prime concern is the patient's interest and not his or her own (a fiduciary relationship).</td>
<td>Expected</td>
<td>Expected</td>
<td>Essential</td>
</tr>
</tbody>
</table>

**Social Responsibility**

<table>
<thead>
<tr>
<th>Volunteers for activities that are for the “good of the institution” (e.g. recruiting interviews, committee membership, etc.).</th>
<th>Appreciated</th>
<th>Expected</th>
<th>Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in community organizations.</td>
<td>Not an Objective</td>
<td>Appreciated</td>
<td>Appreciated</td>
</tr>
<tr>
<td>Responsive to the needs of society that supercede self-interest*.</td>
<td>Expected</td>
<td>Expected</td>
<td>Expected</td>
</tr>
</tbody>
</table>

*Denotes specific ACGME requirement.
**PGY-1 Professionalism Expectations — Check each that is present**

**“Essential”** objectives are those that must be done regardless of the resident or patient’s circumstance. Failure to perform one “essential” objective is a serious breach and should represent a failure to demonstrate the professionalism competency. As such, failure to perform an “essential” objective should lead to a score of “significant deficits” on the resident’s evaluation.

- Administrative competence (punctual, completes tasks as asked, follows directions, timely responds to staff needs including pages and abnormal lab results, follows up on patient care issues without prompting).
- Understands that there are moral and ethical concerns about receiving gifts from patients and pharmaceutical representatives.
- Recognizes that physicians have a responsibility for the safety and well-being of patients, colleagues, and staff.
- Demonstrates respect and compassion for all patients.
- Understands and recognizes mistakes and notifies attending and patients (where appropriate) when mistakes are made.
- Tells the truth and is trustworthy.
- Makes honest use of coding, billing, and referral principles.
- Understands and appropriately maintains patient confidentiality.
- Resident’s attitude manifests an interest in helping providing compassionate, quality care to all patients.

**“Expected”** objectives are those that residents should reliably perform day in and day out. Residents who fail to demonstrate an “expected” objective are not, at least in such instances, performing as good caregivers or colleagues. Although a score of “competent” might be possible in rare circumstances, a score of “minor deficits” is generally appropriate for residents who do not demonstrate one of the “expected” objectives for their year.

- Willing to provide coverage for sick/unavailable colleagues.
- Responsive to the needs of society that superecede self-interest.
- Self directed learning.
- Able to assess and use informed consent and provision of care.
- Understands that in the patient-physician relationship, the physician’s prime concern is the patient’s interest and not his or her own (a fiduciary relationship).

**“Appreciated”** objectives are those we would like to see our residents do all of the time, but we understand that such performance may not be required to acceptably demonstrate the professionalism competency. If a resident is not demonstrating one of the “appreciated” professionalism objectives for his/her year, faculty should help the resident understand the objective and methods for improving performance, and their performance should be reflected by a score of “competent” or below on the professionalism evaluation.

- Able to deliver bad news.
- Understands and is competent to work with patients regarding advanced directives, DNR status, futility issues, withholding or withdrawing therapy.
- Understands and compassionately responds to issues of culture, age, sex, sexual orientation, and disability in patient care.
- Able to discuss and defend own ethical understanding of his or her relationship with pharmaceutical representatives.
- Demonstrates intellectual curiosity.
- Spontaneously teaches and exhibits concern for the educational development of fellow residents and students.
- Volunteers for activities that are for the “good of the institution” (e.g. recruiting interviews, committee membership, etc).
- Provides leadership on teams and in the residency.
### PGY-2 Professionalism Expectations – Check each that is present

**“Essential”** objectives are those that must be done regardless of the resident or patient’s circumstance. Failure to perform one “essential” objective is a serious breach and should represent a failure to demonstrate the professionalism competency. As such, failure to perform an “essential” objective should lead to a score of “significant deficits” on the resident’s evaluation.

| Administrative competence (punctual, completes tasks as asked, follows directions, timely responds to staff needs including pages and abnormal lab results, follows up on patient care issues without prompting). |
| Understands that in the patient-physician relationship, the physician’s prime concern is the patient’s interest and not his or her own (a fiduciary relationship). |
| Able to assess and use informed consent and provision of care. |
| Demonstrates respect and compassion for all patients. |
| Recognizes that physicians have a responsibility for the safety and well-being of patients, colleagues, and staff. |
| Understands and recognizes mistakes and notifies attending and patients (where appropriate) when mistakes are made. |
| Tells the truth and is trustworthy. |
| Makes honest use of coding, billing, and referral principles. |
| Understands and appropriately maintains patient confidentiality. |
| Understands that there are moral and ethical concerns about receiving gifts from patients and pharmaceutical representatives. |
| Resident’s attitude manifests an interest in helping providing compassionate, quality care to all pts. |

**“Expected”** objectives are those that residents should reliably perform day in and day out. Residents who fail to demonstrate an “expected” objective are not, at least in such instances, performing as good caregivers or colleagues. Although a score of “competent” might be possible in rare circumstances, a score of “minor deficits” is generally appropriate for residents who do not demonstrate one of the “expected” objectives for their year.

| Understands and competent to work with patients regarding advanced directives, DNR status, futility, withholding or withdrawing therapy. |
| Understands and compassionately responds to issues of culture, age, sex, sexual orientation, and disability in patient care. |
| Self directed learning (i.e. spontaneously presents literature and evidence related to patient care). |
| Able to discuss and defend own ethical understanding of his or her relationship with pharmaceutical representatives. |
| Willing to provide coverage for sick/unavailable colleagues. |
| Demonstrates intellectual curiosity. |
| Spontaneously teaches and exhibits concern for the educational development of fellow residents and students |
| Provides leadership on teams and in the residency. |
| Responsive to the needs of society that supercede self-interest. |
| Volunteers for activities for the “good of the institution” (e.g. recruiting interviews, committee membership, etc.). |
| Able to deliver bad news. |

**“Appreciated”** objectives are those we would like to see our residents do all of the time, but we understand that such performance may not be required to acceptably demonstrate the professionalism competency. If a resident is not demonstrating one of the “appreciated” professionalism objectives for his/her year, faculty should help the resident understand the objective and methods for improving performance, and their performance should be reflected by a score of “competent” or below on the professionalism evaluation.

| Participation in community organizations. |
**PGY-3 Professionalism Expectations — Check each that is present**

**“Essential”** objectives are those that must be done regardless of the resident or patient’s circumstance. Failure to perform one “essential” objective is a serious breach and should represent a failure to demonstrate the professionalism competency. As such, failure to perform an “essential” objective should lead to a score of “significant deficits” on the resident’s evaluation.

- Administrative competence (punctual, completes tasks as asked, follows directions, timely response to staff needs including pages and abnormal lab results, follows up on patient care issues without prompting).
- Spontaneously teaches and exhibits concern for the educational development of fellow residents and students.
- Able to deliver bad news.
- Understands and is competent to work with patients regarding advanced directives, DNR status, futility issues, withholding or withdrawing therapy.
- Able to assess and use informed consent and provision of care.
- Understands that in the patient-physician relationship, the physician’s prime concern is the patient’s interest and not his or her own (a fiduciary relationship).
- Understands and recognizes mistakes and notifies attending and patients (where appropriate) when mistakes are made.
- Tells the truth and is trustworthy.
- Makes honest use of coding, billing, and referral principles.
- Understands and appropriately maintains patient confidentiality.
- Resident’s attitude manifests an interest in helping providing compassionate, quality care to all patients.
- Demonstrates respect and compassion for all patients.
- Understands and compassionately responds to issues of culture, age, sex, sexual orientation, and disability in patient care.
- Recognizes that physicians have a responsibility for the safety and well being of patient, colleagues, and staff.
- Understands that there are moral and ethical concerns about receiving gifts from patients and pharmaceutical representatives.
- Able to discuss and defend own ethical understanding of his or her relationship with pharmaceutical representatives.

**“Expected”** objectives are those that residents should reliably perform day in and day out. Residents who fail to demonstrate an “expected” objective are not, at least in such instances, performing as good caregivers or colleagues. Although a score of “competent” might be possible in rare circumstances, a score of “minor deficits” is generally appropriate for residents who do not demonstrate one of the “expected” objectives for their year.

- Willing to provide coverage for sick/unavailable colleagues.
- Demonstrates intellectual curiosity.
- Provides leadership on teams and in the residency.
- Responsive to the needs of society that supercede self-interest.
- Volunteers for activities for the “good of the institution” (e.g. recruiting interviews, committee membership, etc).
- Self directed learning.

**“Appreciated”** objectives are those we would like to see our residents do all of the time, but we understand that such performance may not be required to acceptably demonstrate the professionalism competency. If a resident is not demonstrating one of the “appreciated” professionalism objectives for his/her year, faculty should help the resident understand the objective and methods for improving performance, and their performance should be reflected by a score of “competent” or below on the professionalism evaluation.

- Participation in community organizations.
SYSTEMS-BASED PRACTICE
COMPETENCY CURRICULUM

I. Educational Purpose and Goals

Physicians practice in a complex healthcare system whose members include other healthcare professionals, business organizations, special interest organizations, patients and other 'consumers,' and numerous governmental and private sector personnel. Factors impacting the healthcare system include resource allocation, cost, quality measurement, systems improvement, systems communication, and organization management. Our goal is to train physicians who are able to comprehend these system complexities, work well within the system, advocate for and lead to system improvements, and assist patients in their successful navigation of systems. These essential skills are categorized under Systems-Based Practice (SBP).

II. Principal Teaching Methods

a. Supervised Direct Patient Care: Training in SBP is a continuous process occurring with faculty supervision across the spectrum of inpatient and outpatient rotations.

   i. Teaching faculty promote SBP skills during clinical rotations.

   ii. During inpatient rotations, residents work closely with case managers to develop discharge or transfer disposition plans. This provides residents with experience in coordinating healthcare across the inpatient-outpatient continuum. Working with the case managers also allows the residents to see how practice fits into the larger healthcare system (i.e. nursing homes, assisted-living facilities) and society at large.

   iii. During outpatient rotations, particularly the HIV rotation, residents work closely with nurse managers and case managers to coordinate the care of patients. Residents advocate for quality patient care and gain insight into cost-effective healthcare and resource allocation.

b. There are other sessions where residents are exposed to and learn SBP:

   i. Morbidity and Mortality conferences focus on performing a root cause analysis and identifying potential systems errors in the case.

   ii. Residents have a broad exposure to palliative care, hospice and end-of-life issues during the palliative care rotation.

   iii. Residents participate in quality improvement projects within the Department of Medicine, providing a close look at the systems issues involved in providing patient care.

   iv. Residents also participate in a variety of hospital and departmental committees such as those for the various protocol development.

   v. Residents also participate in a variety of other hospital activities and are also elected to the WCGME board.

III. Educational Content

a. Learning Venues: Residents spend time in both the inpatient and outpatient settings during the course of their residency. During this time, they interact with the staff of various ancillary
services, including case management, nursing staff, physical / occupational / speech therapy and office administrative personnel.

b. Disease Mix: All patients are affected by systems of care. This curriculum applies to all supervised patient interactions:
   i. Working with multidisciplinary teams, case managers, and patient support services personnel
   ii. Healthcare quality and quality improvement theory / methods
   iii. Physician performance measures
   iv. Healthcare delivery systems and alternative levels of care
   v. Healthcare cost / value decisions
   vi. Resource allocation and utilization review
   vii. Inpatient - outpatient transfer coordination
   viii. Hospital transfer processes
   ix. Nursing home placement and transfer processes
   x. Continuing care resources for after-hospital care
   xi. Hospice and palliative care systems
   xii. Working with guardians and patient advocates for incapacitated persons
   xiii. Billing, coding and appropriate reimbursement documentation
   xiv. Medicare, Medicaid, VA and other governmental benefits
   xv. Durable medical equipment appropriation and management, including IV systems
   xvi. Resources for geriatric, high risk, terminally ill, disabled, and chronically ill patients
   xvii. Resources for alcoholic, drug dependent, and other addicted patients

c. Patient Characteristics: Inpatient services have a broad distribution of patients, from those with full access to healthcare resources to those underinsured and uninsured patients. The outpatient setting is predominantly weighted towards underinsured and uninsured patients, with a significant percentage requiring coordinated care from social service and allied care professionals.

IV. Principal Ancillary Educational Materials

Systems-based practice is learnt at every stage of residency training, especially during the “service blocks”. Workshops on discharge planning and other didactic lectures are held throughout the year starting from intern orientation itself. Practical training on coordinating patient care across different domains, actively interacting with sub-specialists / primary care physicians / other health care professionals occurs at every step of patient care.

V. Methods of Evaluation

a. Resident Performance: Resident performance in this core competency is evaluated in a multitude of ways including:
   i. For each clinical rotation, supervising faculty completes a web based (www.myevaluations.com) electronic resident evaluation that includes assessment of the core competency performance in SBP.
   ii. Mini-CEXs are performed on the residents by the supervising faculty, both in inpatient and outpatient settings.
   iii. Nursing evaluations are received from both the hospitals and the ICU of Moses Taylor Hospital and includes an evaluation of this competency.
   iv. Patient evaluations are obtained from both inpatient and outpatient settings.
v. Residents do self-evaluations during various times of the year including their semi-annual meeting with the Program Director or his assignee.

vi. Residents maintain a portfolio in an electronic format in the Program Administrators computer. They present their updated resident portfolio every six months at their semi-annual meeting with the Program Director or his assignee. This portfolio includes entries in all the six core competencies including SBP.

These evaluations are shared with the residents. A summary of these evaluations (including the self-evaluation and the resident portfolio) is incorporated into the semi-annual performance review done by the Program Director or his designee. In other words, formative evaluation semi-annually includes summative and self-evaluations.

b. Faculty Performance: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Specific Competency Objectives with Progressive Learning Goals and Graded Responsibilities

The ability to use clinical practice and direct patient care as a venue for systems-based improvement is a life-long process. Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. It is expected that a resident will satisfactorily function as follows:

a. Reflect on how their patient care and other professional practices affect other healthcare professionals, the healthcare organization, and the larger society and how these elements affect their own practice.

A PGY-1 resident should demonstrate the ability to:

• Work well within their core clinical team, including other residents and attending physicians, nurses, respiratory therapists and other professionals involved in the care of their patients

A PGY-2 resident should additionally:

• Work well with multidisciplinary teams
• Coordinate multi-specialty care
• Effectively work with nursing staff and case managers in team settings such as multidisciplinary rounds and family meetings
• Provide and document care in a timely and thorough manner to facilitate analysis of practice patterns and use of information by other healthcare professionals

A PGY-3 resident should additionally:

• Effectively coordinate care with other healthcare professionals as needed
• Provide leadership in management of complex care plans
• Reflect understanding of external regulations and expectations and appropriately acknowledge effects of these elements on their own practice

b. Know how types of medical practice and delivery systems differ from one another, including methods of controlling healthcare costs and allocating resources.

A PGY-1 resident should demonstrate the ability to:
During all clinical rotations, actively participate in educational sessions relating to medical practice and delivery systems

A PGY-2 resident should additionally:
• Understand medical delivery systems, including alternative care resources, ambulatory care resources, rehabilitation resources, and other resources in the continuum of care
• Understand methods of controlling healthcare costs
• Understand methods of controlling the appropriate allocation of resources

A PGY-3 resident should additionally:
• Lead the care team in discussions regarding controlling healthcare costs and allocation of resources

c. Practice cost-effective healthcare and resource allocation that does not compromise quality of care.

A PGY-1 resident should demonstrate the ability to:
• Reflect sensitivity to costs and be able to incorporate fundamental cost-effective analysis into care approaches, minimizing unnecessary care

By the completion of the PGY-3 year, residents should additionally:
• Strive to appropriately contain costs and conserve limited resources while preserving a high quality of care

d. Advocate for quality patient care and assist patients in dealing with system complexities.

A PGY-1 resident should demonstrate the ability to:
• Identify, implement, document and monitor established local patient care plans consistent with nationally published clinical practice guidelines

A PGY-2 resident should additionally:
• Demonstrate the ability to effectively guide patients through the complex healthcare environment

A PGY-3 resident should additionally:
• Act as a team leader during multidisciplinary family meetings regarding complex patient care needs

e. Know how to partner with healthcare managers and healthcare providers to assess, coordinate, and improve healthcare and know how these activities can affect system performance.

A PGY-1 resident should demonstrate the ability to:
• Regularly and effectively work with the case manager and other healthcare professionals to assess, coordinate, and improve patient care
• Reflect understanding of the benefits of such partnering activities on the operation of the healthcare system

A PGY-2 resident should additionally:
• Demonstrate ability to regularly and effectively work with other case managers, utilization review personnel, physician extenders, ambulatory practice office managers, and other providers within the larger healthcare system

A PGY-3 resident should additionally:
• Partner with case managers and other providers to identify and act on improvement opportunities for the healthcare system
To summarize, the progressive learning goals and graded responsibilities for the core competency of Systems-Based Practice are as follows:

**PGY-1**

1. Recognize the systematic complexities that affect patient outcomes
2. Demonstrate ability to effectively sign out with maintenance of quality sign out sheets
3. Function as a physician within a multidisciplinary team
4. Serve as a patient advocate in the outpatient and inpatient setting
5. Work with ancillary team members (discharge planners, case managers, and social workers) to provide high quality, non-redundant and cost-effective care
6. Develop a working knowledge of various care systems and the most appropriate disposition for certain patients dependent on patient needs and system allowances

**PGY-2**

1. Direct care in inpatient and outpatient settings as a member of a multi-disciplinary team
2. Direct sub-specialty, surgical, nutritional, podiatric and social service consultations
3. Demonstrate effective utilization of transitioning patients between systems of care for their benefit
4. Use systematic approaches to reduce errors and effectively transition patients between care settings
5. Strive to optimize patient follow-up by effective discharge planning
6. Promote medication reconciliation

**PGY-3**

1. Demonstrate knowledge of types of medical practice and health delivery systems
2. Practice effective allocation of healthcare resources to avoid compromising quality of care; reduce unnecessary testing
3. Demonstrate knowledge of business aspects of medical practice including coding and insurance
4. Recognize system deficiencies / complexities and strive for system improvement
INDIVIDUAL ROTATION CURRICULA
I. Educational Purpose and Goals

The purpose of the allergy & immunology rotation is to prepare the resident to recognize and treat commonly encountered problems in the field of allergy & immunology, to familiarize him/her with the diagnostic techniques available, and to teach him when it is appropriate to initiate a referral to an allergist & immunologist.

II. Principal Teaching Methods

Residents are expected to participate in direct patient care under the supervision of a board-certified allergy & immunology attending. Whenever possible, patients will be evaluated first by the resident, who will then present the case to the attending physician prior to implementing a plan of care.

Residents are expected to begin reading the core reading material mentioned hereunder prior to their rotation and are expected to complete it during their rotation. Attendings may also supplement cases seen with discussions of common problems not encountered during that session.

Residents are also required to attend didactic sessions on topics related to allergy & immunology that are scheduled throughout the year.

III. Educational Content / Structure of the Rotation

a. Learning Venues: The rotation is primarily an outpatient experience at the private clinic of the sub-specialist, but residents are invited to perform hospital consultations at Mercy and Moses Taylor Hospitals if any are requested while they are on the rotation.

b. Types of Clinical Encounters: Primarily outpatient in the private clinics of the supervising attending. These encounters allow the residents to become familiar with aspects of allergy & immunology care that can be managed by general internists.

c. Disease Mix: Residents are exposed to a broad range of allergy & immunology conditions, including but not limited to asthma, allergic rhinoconjunctivitis, atopic dermatitis, contact dermatitis, urticaria, angioedema, anaphylaxis, food and drug allergy and humoral immunodeficiency.

d. Patient Characteristics: Patients seen by the residents range from young adolescents to elderly patients and from mild to severe disease. Patients are from different racial and socio-economic backgrounds.

e. Services: All care will be under the direct supervision of an attending allergist & immunologist.

f. Procedures: For this rotation, they include the results of allergen skin testing and serum diagnostic testing.

g. Pathological Materials: None.
IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List:
   1. Journal of Allergy and Clinical Immunology Primer on Allergic Diseases from February 2003
   2. Allergy & Immunology section from Harrison’s Principles of Internal Medicine
   3. Allergy & Immunology topics from MKSAP
   4. Allergy & Immunology topics from Uptodate website

b. Disease Index:
   1. Asthma
   2. Allergic rhinoconjunctivitis
   3. Atopic dermatitis
   4. Contact dermatitis
   5. Urticaria and angioedema
   6. Anaphylaxis
   7. Food allergy
   8. Drug allergy
   9. Insect venom allergy
   10. Humoral immunodeficiency

V. Methods of Evaluation

a. Resident Performance: Attending evaluations will be completed on each resident towards the end of the rotation. This will include both verbal as well as electronic evaluations.

b. Faculty Performance: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. Program Performance: Residents complete a semi-annual program evaluation commenting on the faculty, facilities, and service experience. These evaluations are forwarded to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives

a. Patient Care:
   i. By the end of the rotation, PGY-1 residents will be able to complete a comprehensive allergy & immunology consultation, including relevant history and physical examination, with moderate attending input.
   
   ii. By the end of the rotation, PGY-1 residents will be able to understand the management of asthma and the interpretation of tests such as skin (RAST) tests, patch tests and common immunology serology.
   
   iii. By the end of the rotation, PGY-2 and PGY-3 residents will demonstrate the above skills and will be able to complete a comprehensive allergy & immunology consultation, including relevant history and physical examination, with minimal to none attending input. They will also be able to draft an appropriate management plan.

b. Medical Knowledge:
   
   i. By the end of the rotation, residents will be able to describe the physiological basis of
cellular and humoral immunity and the mechanism of action of commonly used drugs in the field.

c. Practice-Based Learning and Improvement:

i. By the end of the rotation, residents will be able to use the library and internet resources to search the medical literature, critically appraise articles and apply evidence based medicine in patient care.

d. Interpersonal and Communication Skills:

i. The resident will develop skills at communicating with primary care physicians as a consultant.

ii. The resident will develop skills at communicating with patients with severe allergy and immune based conditions and communicate effectively with the families of these patients.

e. Professionalism:

i. The resident will have consultations on chart within 24 hours of admission or consultation, and write a daily progress note.

ii. Resident will follow through with scholarly assignments promptly.

iii. Resident recognizes and takes steps to correct his / her deficiencies.

iv. Resident deals appropriately with personal reaction pertaining to morbidity and mortality of disease encountered in the role of medical consultant.

f. Systems-Based Practice:

i. Resident understands and can effectively initiate appropriate clinical pathways.

ii. PGY-2 and PGY-3 residents will demonstrate an understanding of cost-effective care by incorporating cost effectiveness into their diagnostic and therapeutic plans.
AMBULATORY CARE CURRICULUM

I. Educational Purpose and Goals

The goal of the ambulatory care (ambulatory medicine) curriculum is to provide residents with the academic and clinical experience necessary to learn to practice high-quality, cost-effective, compassionate and professionally satisfying outpatient general internal medicine.

Diagnoses and management of common conditions likely to be seen by a general internist will be stressed. Optimal chronic disease management will be emphasized. Preoperative medical risk assessment and clearance of patients will be reviewed and systematic preventative health care will be promoted. The overall intent of the ambulatory care experience is also to foster the development of the skills of a competent general internist through exposure in a “real life” primary care outpatient setting to the interdisciplinary fields spanning the wide range of internal medicine subspecialties, such as psychiatry, dermatology, obstetrics & gynecology, orthopedics, otorhinolaryngology, and ophthalmology. Ample opportunity for primary care procedures will be provided.

Recognizing that the educational needs of each learner will vary based on clinical experience and professional career intent, the following curriculum is comprehensive and not meant to imply its entirety is mandated for each block experience. Hopefully, if the residents’ needs and expectations are proactively outlined at the onset of each block rotation (at Mid Valley Practice) and quarterly in the continuity clinic (at Scranton-Temple Health Center), particular aspects of the curriculum can be stressed to strengthen the ambulatory care experience.

At the end of this rotation, every resident will be able to demonstrate competency in the evaluation, diagnosis and treatment of common outpatient conditions.

II. Principal Teaching Methods

a. Supervised Direct Patient Care: The residents learn ambulatory medicine through direct patient care under the supervision of a faculty member. Faculty members are responsible for supervising all resident activities and patient care. The ratio of resident to faculty is a maximum of 4:1 on any given day. Following the guidelines of the Medicare Primary Care Exemption, during the first six months of the PGY-1 year, the faculty member examines each and every patient seen by the PGY-1 resident.

Residents will have opportunity to develop patient care, practice-based learning, communication, professionalism, and systems-based practice skills through the care of patients and their families in a clinic setting that offers daily multidisciplinary team exposure to physician extenders / nurse practitioners, office nursing, medical assistants, secretarial staff, an office manager and various healthcare students. Learning the appropriate timing and indications for referral to subspecialties and communication with sub-specialists will be promoted.

b. Didactic Teaching: Morning reports on Mondays include presentation by a resident on an important ambulatory care topic followed by a discussion on the topic. A short Dermatology slide show with discussion on the lesions is also sometimes included.

c. Assigned Readings: An appropriate reading list is provided with emphasis on self directed learning.

d. Practice Management: Every opportunity will be taken to teach aspects of practice management, and a practice management curriculum will be provided to upper level residents. Coding / billing will be reviewed routinely on a case by case basis. While in MVP, available computer modules on E/M coding, practice management and available resources will be provided.
EMR abilities / reports to assess overall practice care and performance will be utilized to teach population care skills. Insurance issues including capitation, reimbursement guidelines, formulary issues and pre-certification processes as well as available disease management programs will be reviewed when opportunity allows. Nursing home and home visit experience will be available on a monthly basis in Jermyn as well.

Telephone management and triage will be taught routinely. When on call the senior residents will be responsible for STHC patient calls and documentation of these calls in MEDENT through creation of a triage that documents the problem, management and follow up needed. This triage should be routed to the clinic nurses in the respective hospital clinic.

Mail management and abnormal test results will be reviewed with the residents daily in Jermyn with their active participation in communicating the results with patients and arranging necessary management.

Residents will be expected to maintain detailed, accurate and up to date EMR and accurate coding / billing which will be reviewed on a daily basis by faculty who sign off on each progress note and on a weekly basis by the residents themselves in a chart review format that includes assessment of clinical care, coding / billing issues and template compliance.

### III. Educational Content / Structure of the Rotation

**a. Learning Venues:** Ambulatory care training is provided at two sites. Every intern and senior resident rotates through the Mid Valley Practice for at least one four week long ambulatory block experience each year of training and also has a weekly afternoon continuity clinic experience at the Scranton-Temple Health Center.

i. Scranton-Temple Health Center: Strategically located between Mercy and Moses Taylor Hospitals, this is the site where residents attend to their half-day a week “continuity clinic”. All residents must complete a minimum of 108 weekly continuity clinic sessions over the course of their three year residency training.

ii. Mid Valley Practice: Located in the town of Jermyn, this clinic is the site of ambulatory block rotations, an intense four week long outpatient experience in a private clinic setting.

**b. Types of Clinical Encounters:** In general, the patient is first independently evaluated by the resident with a subsequent presentation to the faculty mentor. During the first six months of the PGY-1 year, the faculty member examines each and every patient seen by the PGY-1 resident.

During the PGY-1 year, when averaged over the year, residents will see no fewer than 3 or greater than 5 patients per scheduled ½ day session.

During the PGY-2 year, when averaged over the year, residents will see no fewer than 4 or greater than 6 patients per scheduled ½ day session.

During the PGY-3 year, when averaged over the year, residents will see no fewer than 4 patients per scheduled ½ day session.

**c. Disease Mix:** Residents are exposed to the full spectrum of general ambulatory medical care.

**d. Patient Characteristics:** Medical care is provided for patients above 16 yrs of age. Patients of both sexes and all ethnic backgrounds are seen in the ambulatory care clinics. When English is not the primary spoken language, telephonic interpreters are available for translation services. As part of their core curriculum, residents receive training in the proper and efficient use of medical interpreters.

**e. Procedures:** Residents should become competent to perform each of the following procedures:
1. PAP smears and Pelvic exams
2. KOH and wet prep examinations of vaginal discharge
3. Genital cultures on both men and women
4. Arthrocentesis and injection of major joints
5. Cerumen disimpaction

g. Pathological Materials: Pathological material will be reviewed based upon availability and disease mix.

IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List: Recommended reading includes:
   1. MKSAP
   2. Harrison’s Principles of Internal Medicine
   3. Uptodate

b. Disease Index: The Core Curriculum of the general ACGME competencies should be referenced in addition to the curriculum below.

Internal Medicine including Subspecialties:

Cardiology:
1. Evaluation and management of chest pain, CAD, PVD, CHF, murmurs and bruits.
2. Accurate interpretation of EKGs.
3. Knowledge and application of JNC 7 guidelines for the management of hypertension.
4. Indications for and interpretation of holter monitoring and ambulatory blood pressure monitoring.
5. Knowledge and application of ATP III guidelines for the management of hyperlipidemia.
6. Familiarizing the Framingham Risk scoring / assessment scale.
7. Use of ABI’s as a diagnostic tool for peripheral vascular disease.
8. Indications, dosing and side effects of important cardiovascular drugs such as beta blockers, ACE-I, aspirin, statins.
9. Work up and management of the cardiac murmurs including use of anti-coagulation and IE prophylaxis.
10. Indications and predictive value of various stress testing modalities and the indications for echocardiography.
11. Learn the appropriate indications and utilization of BNP testing and the current clinical guidelines for the management of congestive heart failure.

Dermatology:
1. Diagnose and manage common skin conditions like urticaria, allergic dermatitis, cellulitis, impetigo, genital rashes, shingles, post herpetic neuralgia, Erythema multiforme, Steven Johnson’s syndrome.
2. Learn the indications for dermatological referral and recognize dermatological emergencies.
3. Learn the workup for alopecia and its potential management.
4. Recognize candidiasis, dermatophytosis, and onychomycoses and learn their standard management.
5. Recognize the skin manifestations of systemic diseases.
6. Assess pigmented skin lesions and nodules for malignant appearance and learn the indications for biopsy.
8. Learn to do Incision and Drainage of small abscesses in an out patient setting.
9. Familiarize with common dermatology topical meds including antifungals, Dovonex, Elidel and steroid preparations.

Endocrinology:
1. Proper clinical examination of the thyroid. Interpretation of the thyroid function tests. Evaluate and manage hypothyroidism, hyperthyroidism, thyroiditis and thyroid cancer. Evaluate anatomic thyroid abnormalities (diffuse goiter, multinodular goiter, and solitary thyroid nodules) and correctly use
nuclear medicine imaging, ultrasound studies and FNA biopsies.
3. Recognize the risk factors and perform diagnostic evaluation of osteopenia and osteoporosis. List indications for bone densitometry. Understand basic interpretation of DEXA scans. Describe treatment option for osteoporosis (postmenopausal, corticosteroid-induced) including bisphosphonates and Forteo. Diagnose and manage osteomalacia and vitamin D deficiency.
4. Understand the difference between primary and secondary hypogonadism. Diagnose and manage gynecomastia, hirsutism, amenorrhea and impotence. Manage androgen and estrogen replacement therapy. Understand the pathophysiology, diagnosis and management of polycystic ovarian syndrome (PCOs) and its associated disorders (insulin resistance, metabolic syndrome, infertility).

**Gastroenterology:**
1. Diagnose and manage common GI conditions such as GERD, gastritis, H. pylori infection, IBS, chronic constipation and diverticulitis.
2. Learn the routine workup for iron deficiency anemia, gallbladder disease, upper and lower GI bleeds as well as acute and chronic abdominal pain.
3. Learn the systematic approach to liver disorders including elevated LFTs, NASH, chronic hepatitis, alcoholic liver disease and cirrhosis.
4. Familiarize with the various presentations, complications and management of inflammatory bowel disease and celiac disease.
5. Learn the indications, limitations and potential complications of various GI tests including endoscopies, colonoscopies, capsule endoscopy and radiological imaging.

**Hematology & Oncology:**
1. Organize the diagnostic workup of anemia, polycythemia, leukopenia, leukocytosis, platelet abnormalities and bleeding disorders.
2. Learn the indications, dosing and coverage issues with Epogen, Procrit and Aranesp.
3. Learn the clinical manifestations, causes and replacement for B12 deficiency.
4. Actively participate in the care of patients with a malignancy developing a basic understanding of care of patients on active and maintenance chemotherapy, the role of suppressive therapy and Zometa and the appropriate use of tumor markers for tracking disease. Understand the roles of SERMS in the prevention and treatment of breast cancer.
5. Develop skills for addressing the needs and resources for advance directives, living wills and the determination of code status.

**Nephrology / Urology:**
1. Learn the major dos and don'ts of fluid and electrolyte balance and the use of diuretics.
2. Calculation and application of creatinine clearance with various formulas.
3. Familiarize with the National Kidney Foundations’ staging of chronic kidney disease. Appropriate w/u and management of CKD including the use of ACE-I / ARBs.
4. Indications for use of erythropoietin in patients of end stage renal disease.
5. Initiating appropriate workup to diagnose and manage secondary hypertension.
6. Indications for dialysis and when to obtain vascular access for the same in appropriate patients.
7. Appropriate knowledge and indications for urine analysis for screening for microalbuminuria.
8. Work up for microscopic and gross hematuria.
9. Learn the appropriate medical preparation for patients with renal insufficiency, vascular disease or diabetes before any studies involving a contrast dye.
10. Learn to adjust the dosage of medications based on renal function.
11. Understand the indications and therapies for bacteruria and established UTI.
12. Learn the diagnostic workup and management for nephrolithiasis
13. Review the appropriate workup and available treatment options for BPH, prostatitis, elevated PSA and impotence.

**Neurology:**
1. Demonstrate proficiency in obtaining a neurological history and performing a comprehensive
neurological examination.
2. Formulate a rational differential diagnosis, order appropriate diagnostic tests, and effectively manage patients with a wide spectrum of neurological complaints including headache, dizziness, vertigo, ambulatory dysfunction, peripheral neuropathy, radiculopathy, post-herpetic neuralgia, Parkinson’s disease and various stroke syndromes.
3. Localize the lesion anatomically in the setting of a neurological deficit based on clinical exam.
4. Read and demonstrate knowledge about the following clinical neurological presentations - abnormal speech, abnormal vision, altered sensation, confusion, disturbed coordination, gait dysfunction, dizziness, vertigo, headache, hearing loss, localized pain syndromes, loss of consciousness and coma, memory impairment, seizures, sleep disorders, tremor, and weakness (focal and generalized).
5. Understand the indications, value, limitations and incidental findings of MRI CNS imaging.
6. Effectively evaluate patients with lumbago and know various treatment options
7. Understand the state mandates for DMV notification of patients with neurological impairments including seizures and dementia that mandate license revocation or sometimes a formal drivers evaluation.
8. Assessment and management of forgetfulness and dementia in the elderly. Utilize the MMSE routinely in geriatric visits.
9. Learn the significance and workup for delirium.

**Obstetrics & Gynecology:**
1. Perform a competent breast and axillary nodal examination for both routine physical and acute breast complaints. Teach self breast exams.
2. Initiate appropriate work-up for a breast mass including mammogram, ultrasound, FNA, and stereotactically guided core biopsy.
3. Diagnose and treat common benign breast problems including nipple discharge, infection and fibrocystic conditions.
4. Screen and counsel for breast cancer issues in both normal women and breast cancer survivors. Provide counseling on the risk for breast cancer.
5. List appropriate indications and perform the following procedures competently - pelvic examination, Pap smear acquisition and interpretation, wet prep and KOH prep examinations.
6. Perform a complete gynecological and sexual history.
7. Know the risks and benefits of hormonal medications including OCPs and HRT.
8. Diagnose and manage the following gynecological problems - pelvic pain, abnormal vaginal bleeding, amenorrhea, vaginitis, contraception and symptomatic menopause.
9. Be competent to discuss, diagnose and treat STDs including GC, Chlamydia, genital Herpes, Trichomonas and PID. Learn how to address abnormal Pap smears, particularly HPV and its implications and therapies.
10. Systematically initiate the workup, management and referral for female and male infertility. Understand the complexities of PCOS and insulin resistance and the effect of glucophagy and carbohydrate sparing diets and weight loss on fertility.
11. Promote prenatal counseling and pregnancy planning with emphasis on folic acid supplementation, PNV and routine blood work for prenatal screening and immunization updates.
12. Assess and manage the more common medical problems associated with pregnancy – hypertension, diabetes, urinary tract infections. Familiarize with resources to guide safe medication use for pregnant and lactating women. Understand the risk of pregnancy induced HTN and gestational Diabetes and guidelines for screening.

**Ophthalmology:**
1. List the differential diagnosis of a red eye and differentiate between iritis and conjunctivitis.
2. Identify the most common causes of visual impairment in the elderly.
3. Define and classify age-related macular degeneration.
4. Describe the risk factors for cataracts and treatment of cataracts.
5. Perform a thorough eye examination to include visual acuity, visual fields, pupils, extraocular muscles, anterior and posterior segments. Become familiar with examination using the panophthalmoscope,
Rheumatology:
1. Effectively evaluate and treat patients with musculoskeletal syndromes and connective tissue disorders commonly seen in the outpatient setting. Know the basic evaluation, differential diagnosis and management of common rheumatological complaints.
2. Demonstrate history and physical exam skills necessary to evaluate and diagnose patients with the following connective tissue problems and to design an appropriate treatment regimen for them - rheumatoid arthritis, osteoarthritis, spondyloarthropathies, crystal induced arthropathies, chronic
3. Identify the retinal findings of systemic diseases especially hypertension and diabetes mellitus.
4. Encourage ophthalmologic exams to screen for and effectively manage glaucoma.
5. Know the clinical manifestations of vestibular dysfunction.
6. Differentiate between vertigo and other types of dizziness and understand their appropriate management.
7. Familiarize with audiometric evaluation and insufflation bulb exam.
8. Learn about the common oral lesions including the precancerous lesions like leukoplakia and erythroplasia.
9. Familiarize with the evaluation, differential diagnosis and management of common ENT disorders like rhinitis, allergies, hearing loss, vertigo, epistaxis, hoarseness, cervical lymphadenopathy and thyroid abnormalities.
10. Learn the proper technique for treating cerumen impaction and foreign body removal and nasal septal cauterization for epistaxis.

Otorhinolaryngology:
1. Diagnose and appropriately treat acute and chronic allergies, sinusitis, otitis media, external otitis, rhinitis, nasal polyps, parotid disorders and dental abscesses / complications.
2. Know the clinical manifestations of vestibular dysfunction.
3. Differentiate between vertigo and other types of dizziness and understand their appropriate management.
4. Familiarize with audiometric evaluation and insufflation bulb exam.
5. Learn about the common oral lesions including the precancerous lesions like leukoplakia and erythroplasia.
6. Learn counseling skills for tobacco cessation.
7. Familiarize with the evaluation, differential diagnosis and management of common ENT disorders like rhinitis, allergies, hearing loss, vertigo, epistaxis, hoarseness, cervical lymphadenopathy and thyroid abnormalities.
8. Learn the proper technique for treating cerumen impaction and foreign body removal and nasal septal cauterization for epistaxis.

Psychiatry:
1. Develop a knowledge base and diagnostic and therapeutic approach to the following psychiatric presentations - agitation, anxiety, confusion, delusions, hallucinations, unipolar depression, bipolar depression, pseudo-dementia, sleep disturbance, cognitive / memory impairment, suicidal ideation, paranoid ideation, somatization, and personality changes.
2. Become familiar with objective screening tools for memory impairment, major depression, anxiety and bipolar disease, as well as verbal contracts for safety and assessment of suicide risk.
3. Demonstrate proficiency in accessing community services to set up appropriate outpatient psychiatric care. Understand the role of psychiatric referral.
4. Familiarize with uses, indications and potential side effects of common medications used in psychiatry including Wellbutrin, SSRIs, NRSI, mood stabilizers and anti-psychotics.
5. Develop skills to actively screen for domestic violence. Utilize the community resources available for abuse victims and understand the mandatory reporting laws regarding child abuse and statutory rape.
6. Develop skills to screen for substance abuse and to educate patients about related medical risks and the community resources for support.

Pulmonary Medicine:
1. Indications for ordering and appropriate interpretation of pulmonary function tests, chest radiographs, CT imaging studies, sleep studies and PET scans.
2. Use and interpretation of peak expiratory flow rate (PEFR) in the office to manage asthmatics.
3. Evidence based approach to diagnosis and management of patients with common pulmonary conditions like dyspnea, COPD, acute bronchitis, community acquired pneumonia, pulmonary thromboembolism, asthma and obstructive sleep apnea.
4. Review the workup and differential diagnosis for pulmonary fibrosis, occupational respiratory diseases, sarcoidosis, lung cancer, pleural effusion and tuberculosis.
5. Learn the work up and differential diagnosis of a solitary pulmonary nodule.
6. Guidelines regarding the use and interpretation of PPD testing.
7. Demonstrate working knowledge of the guidelines for qualification, benefit and prescription for home O2 and CPAP.
8. Define the primary care indications for a pulmonary referral.

Rheumatology:
musculoskeletal pain syndromes including cervicalgia, lumbago and myofascial pain syndromes, systemic rheumatic diseases including systemic lupus erythematosus, inflammatory myopathies, systemic sclerosis, Sjogrens syndrome, PMR, temporal arteritis and mixed connective tissue disease.

3. Appropriately perform joint aspiration and injection of large synovial joints and be able to interpret synovial fluid analyses.

4. Perform trigger point and bursal injections for tenosynovitis, epicondylitis, tendonitis and DeQuervain’s / anserine / subacromial / trochanteric bursitis.

5. Comprehensive examination and effective utilization of diagnostic imaging for common rheumatic conditions including joint pain, cervicalgia and lumbago.

6. Diagnosis and management of carpal tunnel syndrome including review of secondary causes, EMG / NCV testing and conservative vs surgical management options.

7. Recognize the indications for and potential side effects of pharmacologic agents used in the treatment of rheumatic disease including NSAIDs, hydroxychloroquine, sulfasalazine, methotrexate, azathioprine, TNF inhibitors, leflunomide, corticosteroids, colchicines, probenecid and allopurinol. The dangers of chronic NSAID therapy and potential complications will be reviewed in depth.

8. Appreciate and explore the value of PMR, PT, OT, chiropractic and pain management referral for acute and chronic musculoskeletal complaints

**Preventative Medicine:**

1. Learn the standard guidelines for routine screening with female and male health exams, STD testing, mammograms, colonoscopies, bone densities, laboratory studies, EKGs.

2. Develop strategies for tobacco cessation counseling.

3. Become effective at screening for domestic violence, substance abuse and psychosocial issues and develop skills at connecting affected patients to available community resources.

4. Screen for adult risk behaviors and actively educate patients about seatbelt use, helmet use and the prevention of sexually transmitted disease.


6. Routinely update adolescent and adult vaccinations according to ACIP guidelines.

7. Promote routine supplementation of calcium with vitamin D at appropriate dosages for all patients and the routine use of folic acid in childbearing age females.

8. Order office based screening for visual and hearing impairment at appropriate intervals throughout adulthood.

9. Screen all geriatric patients at routine intervals for functional status / ADL assessment, fall risk, mood disorders and memory impairment.

10. Conduct routine sports physicals, driving evaluations and work related health assessments.

11. Develop familiarity with living will, advanced directive, code status, end of life and palliative care discussions with patients and families when appropriate.

**Practice Management:**

1. Recognize the importance of computerized patient data security. Describe the recent impact of HIPAA on patient medical record keeping.

2. Develop proficiency in EMR documentation.

3. Utilize EMR to guide implementation of Health Maintainence and Disease Management guidelines on a case basis, and also on a global practice quality assessment basis.

4. Demonstrate E and M coding competence. Participate in a weekly chart review to assess residents’ and nurse practitioner’s compliance with EMR templates and coding.

5. Describe federal regulations impacting the office practice of medicine and the hiring and firing of employees.

6. Become familiar with the ACP Online Practice Management Resources and resources for practice improvement.

7. Familiarize with the ABIM available practice improvement modules and the PBLI mandates of certification for the ABIM.

8. Identify factors influencing patient flow and referrals.

9. Read and analyze a physician employment contract for problems. Know the availability of resources from the PA Medical Society for contract evaluation and other resources for job preparation and licensing.

10. Explain the billing procedures of a well-run practice and how the medical insurance industry affects
billing and collections. Learn the meaning of capitation, billable procedures and the basics about EOB, AR and practice overhead.

11. Identify, evaluate, and utilize computer-based and internet resources for physician and patient education. Recognize these as alternatives to conventional CME.
12. Demonstrate ability to search the medical literature on-line, with focus on Uptodate, MEDLINE (through the National Library of Medicine) and OVID databases.

V. Methods of Evaluation

a. Resident Performance: Supervising faculty member evaluates each resident every quarter at the STHC and after each block rotation at MVP. This includes both verbal and written feedback.

Additional evaluation methods used during the ambulatory clinic include the Mini-CEX evaluations. These are observed clinical evaluations which provide residents with specific feedback on their clinical skills. These evaluations then become part of each resident’s permanent record.

Patient evaluations are obtained for each resident in the outpatient setting.

Weekly chart review is undertaken at both the clinics on a regular basis.

b. Faculty Performance: Residents complete a confidential ambulatory faculty evaluation.

c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and learning experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences. Residents also meet with the Program Director or his representative semi-annually to receive and provide feedback.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives

a. Patient Care

PGY-1: - effectively interviews and examines ambulatory patients.
- learns and implements disease prevention strategies.
- learns and implements management plans of common diseases.
- learns to do outpatient procedures.

PGY-2/3: In addition to the above
- triages patients and arranges for follow up by taking phone calls while on call.
- teaches procedures when certified to do so.

b. Medical Knowledge

PGY-1/2/3: - expanding knowledge base consistent with level of training.
- effectively use evidence based medicine.

c. Practice Based Learning and Improvement

PGY-1/2/3: - identify gaps in personal knowledge and skills and develop strategies to improve.

d. Interpersonal and Communication Skills

PGY-1/2: - develop culturally and economically sensitive communication skills with patients.

PGY-2/3: - communicate with members of the health care team and other providers to insure
optimal delivery of quality care.

e. Professionalism

PGY-1: - learns the aspects of professional behavior with patients, staff and colleagues.

PGY-2/3: - self reflection and participation in educating self and others.

f. System-Based Practice

PGY-1: - learns the resources available to effectively provide quality patient-centered care.
  - becomes familiar with and utilizes EMR.

ANESTHESIOLOGY CURRICULUM

I. Educational Purpose and Goals

The goal and objective of the anesthesiology rotation is to provide the resident with a general introduction to the field of Anesthesiology, primarily with general anesthesia but also with some exposure to regional blocks and to provide him/her opportunities to learn procedures such as lumbar punctures and endotracheal intubations.

II. Principal Teaching Methods

The resident will be assigned to work with the anesthesiologist on call at the Moses Taylor Hospital’s operating rooms. He/she will remain in the operating rooms and participate in direct patient care under the supervision of a board-certified anesthesiologist. Whenever possible, resident will learn to perform lumbar punctures and endotracheal intubations.

Residents are expected to begin reading the core reading material prior to their rotation and are expected to complete it during their rotation.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Anesthesiology rotation is held in the operating rooms and the post-operative recovery rooms of Moses Taylor Hospital.

b. Types of Clinical Encounters: Most encounters will take place in the operating room as the patients are begun to be given the anesthesia.

c. Disease Mix: Not relevant.

d. Patient Characteristics: Patients above 16 yrs of age, of both sexes and all ethnic backgrounds are encountered.

e. Procedures: Residents should use all available opportunities to become comfortable in performing lumbar punctures and endotracheal intubations during this rotation.

IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List: Relevant curriculum topics include:
   - anatomy of the airway (pharynx, larynx, trachea)
   - anatomy of the vertebral canal and the spinal cord
   - respiratory physiology including dead space ventilation and shunting
   - evaluation of comatose patients
   - pharmacology of inhalational agents such as nitrous oxide, iso and sevoforane ethrane and halothane; of intravenous agents such as pentathol, propofol, etomidate and others muscle relaxants such as succinylcholine, vecuronium, mivacron and others; of conscious sedation with benzodiazepines and narcotics
   - Pharmacology of inotropes such as dopamine, dobutamine and epinephrine; of vasoconstrictors such as ephedrine, phenylephrine and norepinephrine; of vasodilators such as nitroglycerine, nitropruside and apresoline; of short acting beta blockers such as labetalol and esmolol
V. Methods of Evaluation

a. Resident Performance: Attending evaluations will be completed on each resident upon completion of the rotation. Residents will receive a summarized evaluation at the end of the rotation with both verbal and written comments.

b. Faculty Performance: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives

ANESTHESIA ROTATION EXPECTATIONS
PGY-1, PGY-2, PGY-3

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<tr>
<td>Interviewing</td>
<td>• Resident will obtain a relevant history for patients presenting for a pre-anesthetic check-up, if asked by his anesthesia attending.</td>
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<td>• Residents should present cases with appropriate details of chief complaint.</td>
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<td>• Resident will use interpretation service when patient cannot communicate in spoken English.</td>
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<tr>
<td>Patient Care Physical Examination</td>
<td>• Resident will perform a focused or detailed physical examination, as appropriate to the case.</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>• Resident will understand the evaluation and treatment of common medical illnesses that affect the decision of using or not using a particular anesthetic agent.</td>
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<tr>
<td>Procedural Skills</td>
<td>• Resident will become trained in performing lumbar punctures.</td>
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<td>• Resident will learn the appropriate technique of performing endotracheal intubations.</td>
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<td>Practice-Based Learning and Improvement</td>
<td>• Resident will develop clinical judgment regarding therapeutic decisions.</td>
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<td>• Resident involves patient in discussions about further care.</td>
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<td>Professionalism</td>
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<td>• Resident offers assistance to other team members, as necessary.</td>
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ANESTHESIA ROTATION SELF DIRECTED LEARNING CHECKLIST

MEDICAL KNOWLEDGE:

__________  1. Drugs used for a routine induction of general anesthesia.

__________  2. Airway management and the ASA Difficult Airway Algorithm.

__________  3. Risks/benefits of regional vs. general anesthesia.

__________  4. Routine monitoring and appropriate use of invasive monitors.

__________  5. Extubation criteria and risks during emergence.

PROCEDURAL SKILLS:

__________  1. Perform adequate mask ventilation technique.

__________  2. Perform direct laryngoscopy and intubation of trachea.

__________  3. Observe arterial line placement technique.

__________  4. Perform central venous line placements.

__________  5. Perform lumbar punctures.
CARDOLOGY CURRICULUM

I. Educational Purpose and Goals

The cardiology rotation at WCGME exposes residents to a variety of patient care responsibilities in the field of cardiovascular disease. Residents on this rotation work directly under the supervision of cardiology attending(s). Areas of emphasis include history and presentation skills, physical examination particularly of the cardiovascular system, development of an accurate differential diagnosis which expands beyond the realm of cardiology and the appropriate use of diagnostic testing under the discretion of the attending cardiologist. Residents also develop competence in the interpretation of chest x-rays and EKGs and have exposure to stress testing, echocardiograms and cardiac catheterizations. With this experience residents develop skills to improve management and treatment of cardiovascular diseases.

II. Principal Teaching Methods

The cardiology rotation is preferably done during the PGY-2 or PGY-3 academic years. There can be more than one resident doing cardiology elective at a given time but each individual resident directly interacts with a single attending. This attending may change on a week to week basis. The residents may be asked to see new admissions or consults or old admitted patients. After seeing the patients, the residents write appropriate notes. Later the supervising cardiologist goes over the findings and management issues of the case with the resident. The resident is not responsible for all patients on the service, however he/she does round with that given attending on his patients. The residents are also involved with admissions in the emergency room when deemed appropriate by that attending.

Residents on the cardiology elective are also exposed to the outpatient cardiology clinic. Resident responsibilities in the outpatient setting include seeing private patients of cardiology attendings. The protocol usually involves them seeing the patient before the attending, presenting the case in full to the cardiology attending and observing the remainder of history and physical examination performed by the cardiology attending. They also get exposed to outpatient stress tests and echocardiograms.

Most teaching for the residents occurs on rounds or in the outpatient setting on a case to case basis. Didactic teaching does occur on a sporadic basis at variable times throughout the rotation and is attending dependent. Usually by the end of the rotation the resident experiences both an adequate variety of bedside teaching along with didactic sessions.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Inpatient cardiology training is imparted in Mercy and Moses Taylor Hospitals, including the EKG reading room, the ECHO reading room and the cath labs in the former hospital. Outpatient training occurs in the private offices of the cardiology attendings.

b. Types of Clinical Encounters: Clinical encounters in the cardiology rotation occur in both the inpatient and outpatient settings. The hospital encounters involve either consults on patients already admitted to the floor or transfers from other medical centers. The residents’ primary responsibilities are to follow these patients on a daily basis and see any consults or admissions that come in at the discretion of the cardiology attending. Outpatient settings involve private offices of the cardiologists in which patients are either new patients for a specific cardiology attending or follow up from hospitalizations.

c. Disease Mix: Patient care for residents on the cardiology rotation reflects the spectrum of diseases seen within the realm of cardiology. This is not fully limited to cardiology since many differential
diagnoses among cardiovascular diseases involve organ systems that are outside the realm of cardiovascular disease. Cardiology residents have a mix of both critical and non-critical care hospitalized patients on the cardiovascular disease service. Also, they are exposed to outpatient cardiology care.

d. **Patient Characteristics:** Patient demographics reflect the general population of the Scranton and surrounding areas. However, since Mercy Hospital is an important cardiac hospital of the region, there are patients that come in both by transfers from other centers, and under MI alerts that are outside of the Scranton area. All ethnic backgrounds are represented in the experience of the residents on cardiology rotation.

e. **Services:** Cardiology residents provide admissions and consults for the cardiology group they are posted with. This does not encompass all admissions and consults. However, the assistance of the residents with this provide adequate inpatient experiences in the realms of cardiology. The admissions and consults performed by the resident on service are at the discretion of the cardiology attending that he / she is working under during that particular week.

f. **Procedures:** The cardiology resident is encouraged to complete any and all procedures that occur during the cardiology rotation while in the hospital. This may involve central venous line placements, Swan-Ganz catheter placements and or echocardiograms. All of these procedures are observed and done under the care of the cardiology attending. All procedures completed by the residents are documented appropriately with time and date signed by the cardiology attending.

g. **Pathological Materials:** When available pathological material is reviewed by the cardiology attending and resident on service.

**IV. Principal Ancillary Educational Materials / Educational Resources**

a. **Reading List:** In addition to the selected readings that are provided by the cardiology attending with which the given resident is working during the rotation, the resident is also encouraged to read any textbooks or review books pertinent to the area of cardiovascular disease. This may include specific cardiology texts and EKG interpretation books. Residents are also encouraged and assigned to look up specific citations among journal articles on a case-by-case basis as experienced by both the attending and resident on that particular service.

b. **Disease Index:** Diverse acute and chronic cardiac conditions are encountered, both as admissions and as consults. Possible diseases include:
- Coronary Artery Disease (Stable and Unstable Angina)
- Acute Myocardial Infarction and its complications
- Congestive Heart Failure including systolic as well as diastolic dysfunctions
- Endo, Myo and Pericarditis
- Valvular Heart Disease
- Brady and Tachy Arrhythmias
- Cardiac Conduction Abnormalities
- Cardiac Pacers and ICDs
- Peripheral Vascular Disease
- Hyperlipidemia
- Cardiomyopathy
- Preoperative cardiac evaluation for cardiac and non cardiac surgery under both elective and emergency procedures
- Pulmonary Embolism
V. Methods of Evaluation

a. Resident Performance: Residents are evaluated formally by the cardiology attending(s) that they directly work under. This may involve more than one cardiology attending, frequently changing on a week-to-week basis. Attendings review the resident skills and give both written and verbal feedback and is reported and placed in the resident’s permanent record. These residents are also evaluated on their ability to perform procedures and evidence based searches based on case scenarios encountered on service under the realm of cardiovascular disease.

b. Faculty Performance: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives

a. Patient Care

i. By the conclusion of the rotation, PGY-1 residents will demonstrate ability to perform an appropriate cardiac history and physical, documenting their findings in an appropriate consultative summary, with appropriate generation of a differential diagnosis list.

ii. By the conclusion of the rotation, PGY-2/3 residents will not only perform the above skills but will also demonstrate appropriate ability to independently generate an appropriate management plan.

iii. While on the cardiology rotation, the resident will be able to demonstrate proficiency in the physical exam features of valvular heart disease and congestive heart failure.

iv. During the cardiology rotation, the resident will enhance his/her skills of obtaining and presenting a hypothesis driven history and problem-based assessment and plan of common cardiovascular presentations including acute chest pain syndromes, CHF exacerbations and syncope.

b. Medical Knowledge

i. All residents will be evaluated by the supervising faculty for appropriate analytic approach to cardiac conditions.

ii. All residents will be evaluated for satisfactory basic and clinical knowledge of cardiac anatomy and pathophysiology.

iii. The resident on the cardiology rotation will gain knowledge on current evidence-based practices in primary and secondary prevention of cardiovascular disease especially atherosclerotic disease.

iv. The resident will gain understanding into the pathophysiology and prognosis of common cardiovascular diseases and their medical and non-medical management

b. Practice-Based Learning and Improvement

i. Residents will demonstrate self-initiative in the use of information technology to access
and retrieve materials for self-education regarding cardiac cases.

ii. Residents will be expected to show progressive learning throughout the rotation, with emphasis on learning from any cognitive or procedural errors. They are also expected to facilitate any quality improvement initiatives in place.

d. Interpersonal and Communication Skills

i. Residents are expected to demonstrate professional communication skills throughout their interactions with cardiology patients.

ii. Residents are expected to act as a constructive and proactive member of the cardiology team.

e. Professionalism

i. Throughout the rotation, residents are expected to exhibit reliability in their clinical duties, as well as integrity and respect in their interactions with patients and colleagues.

ii. Residents will be able to demonstrate appropriate consultative principles of communication and responsiveness to professional consultative requests.

f. Systems-Based Practice

i. Residents are expected to interact with other health care providers and appropriately access different facets of the health care system necessary for the care of their patients. This includes but is not limited to PT/OT services and discharge planning services.
CONSULT MEDICINE CURRICULUM

I. Educational Purpose and Goals

This rotation is designed to expose residents to the field of medical consultation. While residents do rotate through a number of subspecialty consultative services, this rotation in particular imparts training in the field of general internal medicine consultation.

II. Principal Teaching Methods

Teaching occurs via supervised direct patient care. While general principles of consultative medicine are reviewed, teaching is otherwise case based and relies heavily on the mix of consults requested during the rotation.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Inpatient consult medicine is not a separate rotation for the WCGME residents but happens as a part of their general inpatient medicine rotations at Mercy and Moses Taylor Hospitals. During the day, the senior resident in charge of the service does the initial consult and later the patient is followed by the whole service team. Consults after 5 pm on weekdays and on weekends are seen by the senior resident on call.

Outpatient consults are seen in the STHC where the resident after seeing the patient goes over the whole case with the clinic attending of the day.

b. Types of Clinical Encounters: The majority of clinical encounters occur as requests for consulting care in the in-patient setting. Occasionally patients are seen pre-admission in the outpatient setting. Frequently care is directed at risk stratification and reduction prior to surgery, or for continuing care of complex medical illnesses.

c. Disease Mix: Patients with any of the classical diseases of internal medicine can be seen in consultation. These patients are typically admitted for surgical, orthopedic, ob-gyn, or urologic (or other non internal medicine) care, and require management of established or newly discovered general medical illness.

d. Patient Characteristics: Patient demographics reflect the general population of the area. Ages range from above 16-18 yrs to geriatric. Virtually all-ethnic backgrounds are represented. Translation services are available for non-English speaking patients.

e. Services: The consultative medicine cases are supervised by either the service attending of the block (or on call) or the STHC attending of the day.

f. Procedures: The consult medicine team is expected to complete any and all procedures necessary for patient care delivery. Residents must be certified and confident to complete those procedures, and the procedure must be first discussed with the attending of record. If residents are not certified to complete the required procedure, the supervising physician can be contacted to supervise and instruct the resident in the procedure.
IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List: As assigned by faculty based upon patient mix.

V. Methods of Evaluation

a. Resident Performance: Residents are formally evaluated by the service attending that they directly work under. Attendings review the resident skills and give both verbal and written feedback, which is then placed in the resident’s permanent record.

b. Faculty Performance: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives
## CONSULT MEDICINE ROTATION EXPECTATIONS
### PGY-2, PGY-3

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| **Patient Care**                         | **Interviewing**                                                                                                                                             | • Resident will obtain a detailed consultation emphasizing chronology of presentation and containing good descriptions of symptoms as they apply to the clinical question requested by the consulting service.  
  • Resident will present without notes.  
  • Resident’s presentation will include appropriate pertinent positives and negatives.  
  • Resident will use appropriate non-patient sources of data if patient cannot give a history.                                                                                                                      |
| **Physical Examination**                 |                                                                                                                                                                   | • Resident will tailor the physical examination to patient’s complaint and clinical question requested by the consulting service.                                                                                  |
| **Medical Knowledge**                    |                                                                                                                                                                   | • Resident understands the epidemiology, pathophysiology, and pharmacology of common medical illness and develops skill in the co-management of such illness with physicians of other clinical disciplines.                               |
| **Procedural Skills**                    |                                                                                                                                                                   | • Resident will achieve or demonstrate competency in all ABIM required procedures as patient case mix allows.                                                                                                  |
| **Practice-Based Learning**              | **and Improvement**                                                                                                                                             | • Resident prioritizes dx and tx decisions based on patient’s severity of illness.  
  • Resident will develop clinical judgment in the strategies used to match treatment protocols with the requirements of interdisciplinary care.                    
  • Resident will present a minimum of one EBM review based upon patient mix.                                                                                                                                     |
| **Systems-Based Practice**               |                                                                                                                                                                   | • Resident can effectively initiate the appropriate clinical pathways.  
  • Resident can effectively initiate the appropriate consultative care plan.  
  • Resident develops a multidisciplinary approach to medical care.  
  • Resident serves as a consultant to other services with minimal faculty input.  
  • Resident critically evaluates all primary and consultant evaluations including conflicting recommendation to develop an effective patient care plan.                                                     |
| **Interpersonal and Communication Skills**|                                                                                                                                                                   | • Resident communicates regularly with patient and his / her family.  
  • Resident effectively communicates with attending physicians and colleagues.  
  • Resident is respectful to the patient.  
  • Resident is concerned about the patient’s comfort.  
  • Resident deals with the challenge of communication in the setting of severe, at times hopeless, end of life care.                                                                                   |
| **Professionalism**                      |                                                                                                                                                                   | • Resident has consultations on chart within 24 hours of admission or consultation, and writes a daily progress note.  
  • Resident will follow through with scholarly assignments promptly.  
  • Resident completes medical records on time.  
  • Resident recognizes and takes steps to correct his / her deficiencies.  
  • Resident treats team members, including nurses and other non-physician health care providers, with respect.                                                                                     
  • Resident deals appropriately with personal reaction pertaining to morbidity and mortality of disease encountered in the role of medical consultant.                                                             |
DERMATOLOGY CURRICULUM

I. Educational Purpose and Goals

The dermatology elective is intended to allow WCGME residents an opportunity to understand the basic approach to common dermatologic disorders, which may be seen in the general internist’s office. Under the supervision of a board-certified dermatologist, residents will develop history and physical examination skills, competence in the use of technology, diagnostic testing, and medication prescription, and exposure to basic dermatologic conditions.

II. Principal Teaching Methods

Residents are expected to participate in direct patient care under the supervision of a board-certified dermatology attending. Whenever possible, patients will be evaluated first by the resident, who will then present the case to the attending physician prior to implementing a plan of care.

Residents are expected to begin reading the core reading material mentioned hereunder prior to their rotation and are expected to complete it during their rotation.

Residents are also required to attend dermatology grand rounds that are scheduled throughout the year.

Dermatology slides are also presented during Monday morning ambulatory care conferences.

III. Educational Content / Structure of the Rotation

a. **Learning Venues:** Dermatology for WCGME residents is mostly taught within the offices of Lackawanna Valley Dermatology in downtown Scranton.

b. **Types of Clinical Encounters:** Dermatology is primarily an outpatient specialty and hence is taught mainly in this setting.

c. **Disease Mix:** Residents will have the opportunity to examine, diagnose and treat patients with skin disorders at the private dermatology offices of the supervising attendings. Residents will not be provided a unique schedule; however, they will be able to choose patients from the schedules of the individual providers that best meet their educational needs.

d. **Patient Characteristics:** Care is provided at the private dermatology offices for patients ranging from adolescent to the geriatric age group. The racial and ethnic distribution reflects the diversity of the Scranton and surrounding areas. When English is not the primary spoken language, interpretation services are available to assist in patient care, either through direct interview or via a remote language line service.

e. **Services:** All care will be under the direct supervision of an attending dermatologist.

f. **Procedures:** Medicine residents are expected to observe and perform diagnostic skin testing considered appropriate for general internists.

g. **Pathological Materials:** KOH preps, skin biopsies and other material as available.
IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List: In addition to the selected readings that are provided by the dermatology attending with which the given resident is working during the rotation, the resident is also encouraged to read any textbooks or review books pertinent to the area of dermatology. Residents will have available to them library and internet based resources to review dermatology, especially areas of their selection and interest.


Supplemental reading list:
• Lee NP, Arriola ER. Topical corticosteroids: back to basics. West J Med. 1999 Nov-Dec;171(5-6).

V. Methods of Evaluation

a. Resident Performance: Attending evaluations will be completed on each resident upon completion of the dermatology rotation. Residents will receive a summarized evaluation at the end of the rotation with both verbal and written comments.

b. Faculty Performance: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives
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<td>Interviewing</td>
<td>• Resident will obtain focused or detailed history for patients with dermatologic conditions, as appropriate.</td>
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<td>• Resident will use interpretation service when patient cannot communicate in spoken English.</td>
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</tr>
<tr>
<td>Physical Examination</td>
<td>• Resident will perform focused or detailed physical examination, as appropriate. This includes routine examination and any pertinent procedures.</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>• Resident will understand the epidemiology, evaluation, and treatment of common dermatologic problems encountered by the general internist.</td>
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<tr>
<td>Procedural Skills</td>
<td>• Resident will develop experience and competence in the performance of common dermatologic procedures, including cryotherapy, skin tag removal, punch biopsy, shave biopsy, and KOH preps.</td>
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<td>Practice-Based Learning and Improvement</td>
<td>• Resident will prioritize diagnostic and therapeutic decisions based on the severity of illness.</td>
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<td>• Resident will be prepared to integrate information into a multidisciplinary approach to dermatologic care and services for medical patients.</td>
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DERMATOLOGY ROTATION SELF DIRECTED LEARNING CHECKLIST

Name: _______________________________  Rotation Dates: ______________

Informal Discussion / Self Directed Learning Topics:

Checklist

- Melanoma
- Basal Cell Carcinoma
- Squamous Cell Carcinoma
- Eczema
- Psoriasis
- Contact Dermatitis
- Pityriasis Rosea
- Roseacea
- Skin Manifestations of Systemic Diseases
- Other ____________________________
EMERGENCY MEDICINE CURRICULUM

I. Educational Purpose and Goals

The purpose of the Emergency Medicine rotation is to expose the WCGME residents to patients with critical and urgent medical problems commonly seen in the emergency department setting under the supervision of a full-time emergency medicine faculty. Residents will learn how to diagnose, manage, and/or triage patients with unselected medical problems; how to work within a health care team; and how to perform a variety of invasive medical procedures needed in the early management of acute illnesses.

Residents assigned to the emergency medicine department will be expected to evaluate and treat all patients regardless of the presenting complaint. Setting priorities, “rapid” assessment, early intervention when warranted, and an expedient diagnosis and treatment are all vital components of the emergency department rotation.

GENERAL EDUCATIONAL OBJECTIVES

1. Perform an accurate and appropriate history and focused physical examination on a patient presenting to the emergency department.

2. Practice the proper utilization of the clinical laboratory and radiology departments as they relate to emergency care and apply the principle of “less is more” using clinical decision rules and risk stratification.

3. Review plain radiography and CT scans of patients presenting to the emergency department.

4. Recognize the importance of the team concept in caring for a patient for e.g. a paramedic, nurse and physician working together for the patient’s benefit.

5. Describe the art of triage or determining priority of patient care, as well as ascertaining which problem gets priority treatment in a patient with multiple problems.

6. Perform emergency procedures including suturing, bandaging, splinting, wound and burn care, I & D of an abscess, peripheral and central venous access, and lumbar punctures among others. Each resident should be able to perform a simple laceration repair upon completion of the rotation.

7. Review the principles of difficult airway assessment along with basic and advanced airway management.

8. Recognize the generalities and specifics of care of the medical, surgical, trauma, pediatric, ob/gyn, and psychiatric patients that present to the emergency department for treatment.

II. Principal Teaching Methods

Residents participate in direct supervised patient care under the supervision of a board-certified emergency medicine attending. Whenever possible, patients are first evaluated by the resident, who then presents the case to the attending physician prior to implementing a plan of care. Teaching is provided on a patient-by-patient basis involving direct one-to-one interaction with the supervising attending physician. Instruction is accomplished through role modeling, discussion, observation, providing direct patient care, and independent reading and consultation with supporting departments (e.g., Radiology, Vascular Surgery, ICU Medicine, Trauma, Neurology).
Residents are expected to begin reading the core reading material prior to their rotation and are expected to complete it during their rotation.

III. Educational Content / Structure of the Rotation

a. **Learning Venues:** Emergency medicine training is provided in the Emergency Department of Mercy Hospital, Scranton. Residents will work an average of four 40-hour weeks in 9-12 hour shifts. The resident is expected to be in the emergency department during his/her scheduled shifts.

b. **Types of Clinical Encounters:** The resident's main responsibility will be to evaluate patients of age 16 and older who present themselves to the emergency department and then discuss these patients with the appropriate supervising ER physician. The number of clinical encounters experienced by the resident will be determined by the level of training and the capability of the resident as judged by the supervising ER physician as well as by the intensity of illness presenting.

c. **Disease Mix:** Residents are exposed to the full spectrum of cases that visit an average emergency room.

d. **Patient Characteristics:** The demographic characteristics of the patients using the emergency department include all races, ages, sexes, and socioeconomic strata found in the Scranton and surrounding areas. There is an over-representation of working poor and uninsured seen in the emergency department.

e. **Services:** Residents will be exposed to all the services provided in the emergency department.

f. **Procedures:** Procedures are to be directly supervised by the appropriate individuals. Qualified nurses may supervise the placement of nasogastric tubes (NGTs), Foley catheters, IVs, and blood draws. Laceration repairs must be supervised by an ER physician before and after the repair. Lumbar punctures, central line and chest tube placements and orthopedic manipulations should also be supervised by the ER physician. Airway management along with procedural sedation and analgesia should always be under the supervision of an attending physician. A consent form must be signed prior to performing any invasive procedures. When in doubt, the resident should always consult the attending ER physician.

The procedures that are either reinforced or learned during the rotation include CPR, venous phlebotomy, bladder catheterization, arterial blood sampling, central line placement, nasogastric tube placement, lumbar puncture, endotracheal intubation.

The interpretative skills that are either reinforced or learned during the rotation include EKG, chest radiographs, head CT scans, arterial blood gases, and other laboratory assays.

g. **Pathological Materials:** As available on a case-to-case basis.

IV. Principal Ancillary Educational Materials / Educational Resources

a. **Reading List:** Recommended reading includes relevant topics from:
   1. Uptodate
   2. Harrison’s Principles of Internal Medicine
   3. Evidence-based searches
   4. Any standard Emergency Medicine textbook/handbook

b. **Disease Index:** By the end of the rotation, the resident should have an enhanced understanding of the evaluation, diagnosis, and treatment of the most common emergency problems, including:
• Cough, sore throat, sore ears, and other ENT problems
• Minor eye emergencies such as foreign body and corneal abrasion
• Abdominal pain (differential diagnosis in males and females)
• Chest pain of any etiology
• Cardiac dysrhythmias
• Severe hypertension/hypotension
• Dyspnea
• Altered mental status
• Minor trauma including strains, sprains, and fractures
• Urinary tract complaints
• Gastrointestinal bleeding
• Simple wound and burn care
• Headache
• Pain management
• Psychiatric emergencies (e.g. the suicidal patient)
• Surgical emergencies including AAA, aortic dissection, bowel obstruction, appendicitis among others
• Medical emergencies including dermatologic, allergic, neurologic, cardiovascular, pulmonary, gastroenterologic, renal, rheumatologic or endocrine presentations
• Toxicology including management of drug overdoses

V. Methods of Evaluation

a. Resident Performance: All the ER physicians with whom residents come in contact with are involved in resident evaluations. The final evaluation is a composite of the individual evaluations. This final evaluation will be completed on each resident at the end of the rotation and will be discussed with the resident verbally and conveyed to the residency program electronically.

b. Faculty Performance: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives

a. Patient Care

i. Detailed and focused history taking, appropriate physical examination and problem specific laboratory testing is within the capability of residents at all levels. PGY-1 residents should seek aid from attendings in carrying out and interpreting specific testing (e.g., evaluating for paradoxical cardiac split sounds).

ii. Primary and secondary survey is a part of the initial emergency evaluation of all trauma patients and completed by residents at all levels.

iii. Procedures needed to treat Emergency Department patients will be performed by residents under the supervision of an attending till they are certified to do them alone. The procedures include venous phlebotomy, CPR, arterial blood sampling, central line access, lumbar puncture, nasogastric tube placement, thoracentesis, bladder catheterization, abdominal paracentesis etc.
b. Medical Knowledge

Residents at all levels will be familiar with interpreting laboratory and radiological data, making logical assessments and epidemiological considerations. This will permit:

- Accurate determinations of which patients need hospital admission or referral to outpatient care centers.
- Appropriate initial management for those patients requiring stabilization in the Emergency Department prior to admission.
- Discharge to home care with appropriate follow-up care arranged for those patients not requiring admission.

c. Practice-Based Learning and Improvement

i. Residents will fully support and use quality improvement protocols and tools developed and adopted by the emergency department.

ii. Residents will use library and online resources to critically appraise medical literature and apply evidence-based medicine to patient care.

iii. They will, in addition consistently seek out and analyze data on practice experience, identify areas for improvement in knowledge or patient care performance, and make appropriate adjustments. They will regularly demonstrate knowledge of the impact of study design on validity or applicability to individual practice.

d. Interpersonal and Communication Skills

Residents at all levels will be able to provide legible records of their findings and make concise but complete oral presentations. This will include history and physical examination findings, management of acute problems and follow up needed.

e. Professionalism

i. All residents will demonstrate integrity, accountability, respect, compassion, patient advocacy, and dedication to patient care that supercedes self-interest.

ii. Residents will demonstrate a commitment to excellence and continuous professional development.

iii. Residents will demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, and informed consent. Residents are expected to show sensitivity and responsiveness to patients’ culture, age, gender and disabilities.

f. Systems-Based Practice

i. Residents will be sensitive to health care costs while striving to provide quality care to their patients. They will begin to effectively coordinate care with other health care professionals as required for patient needs.

ii. PGY-2 residents, in addition, will consistently understand and adopt available clinical practice guidelines and recognize the limitations of these guidelines. They will work with patient care managers, discharge coordinators and social workers to coordinate and improve patient care and outcomes.
iii. PGY-3 residents, in addition, will enlist social and other out-of-hospital resources to assist patients with therapeutic plans. PGY-3 residents are expected to model cost-effective therapy.
I. Educational Purpose and Goals

The endocrinology rotation at WCGME allows residents to acquire cumulative skills in endocrinology, understand pathophysiology of major endocrine disorders, develop expertise and interpretation of diagnostic testing, and learn management skills by working with patients presenting with endocrine disease states.

II. Principal Teaching Methods

Residents learn endocrinology through supervised direct patient care. Residents work one on one with a board certified endocrinologist and all resident activities are directly supervised by him/her.

Residents are expected to begin reading the core reading material mentioned hereunder prior to their rotation and are expected to complete it during their rotation.

Residents are also required to attend endocrinology grand rounds that are scheduled throughout the year.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Endocrinology teaching occurs both in the inpatient and outpatient settings. Inpatient setting involves seeing admitted patients in either Mercy Hospital or Moses Taylor Hospital. These could be patients admitted directly under the care of an endocrinologist or where an endocrinology consult has been sought. Outpatient setting is the private clinic(s) of the supervising attending.

b. Types of Clinical Encounters: Encounters, as mentioned, can occur in both a hospital setting as well as an ambulatory setting. Rotation will include exposure to a diabetes educator and a nutritionist.

c. Disease Mix: Residents are exposed to the full spectrum of endocrine disease.

d. Patient Characteristics: Patient care is provided for patients above 16 years of age. Patients of both sexes and all ethnic backgrounds are seen while on the endocrinology rotation.

e. Services: Residents will work directly with board certified endocrinologists in both the inpatient or the outpatient setting.

f. Procedures: Interested residents could learn the interpretation of thyroid ultrasound and / or nuclear medicine scanning images of the thyroid along with reviewing the basic pathology of thyroid carcinoma. They may review management issues with insulin pump treatment. Interpretation of bone density data may also be covered.

IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List: Recommended reading sources include:
   i. Journal of Clinical Endocrinology and Metabolism
ii. Uptodate - Endocrinology topics
iii. Harrison's Principles of Internal Medicine - Endocrinology section
iv. American Association of Clinical Endocrinologists Consensus Documents
v. Endocrine Practice
vi. The Endocrinologist
vii. Diabetes Care

b. Disease Index: Curriculum:
1. Evaluation and management of type 1 diabetes mellitus
   a. Diagnosis
   b. Treatment strategies - including intensive insulin therapy
   c. Complications - prevention and treatment
      i. Hypoglycemia
      ii. DKA
      iii. Retinopathy
      iv. Nephropathy
      v. Neuropathy
      vi. Cardiovascular and peripheral vascular disease
   d. Technologies in diabetes care
      i. Insulin pump therapy
      ii. Glucose sensing devices
2. Evaluation and management of type 2 diabetes mellitus and the metabolic syndrome
   a. Pathophysiology
   b. Diagnosis
   c. Treatment
      i. Lifestyle modification programs
      ii. Oral agents
      iii. Insulin therapy
      iv. Novel therapies
   d. Complications
      I. Hypoglycemia
      ii. HHNK
      iii. Retinopathy
      iv. Nephropathy
      v. Neuropathy
      vi. Cardiovascular and peripheral vascular disease
3. Outpatient evaluation and management of thyroid dysfunction, nodular disease, and thyroid carcinoma
   a. Interpretation of thyroid function tests
   b. Thyroid imaging modalities
   c. Hyperthyroidism
   d. Hypothyroidism
   e. Solitary thyroid nodule
   f. Goiter and multinodular disease
   g. Thyroid cancer
   h. Thyroid hormone replacement
4. Parathyroid disease and calcium metabolism
   a. Hypercalcemia
   b. Hypocalcemia
   c. Hyperparathyroidism
   d. Kidney stone disease
5. Outpatient evaluation and management of pituitary function and tumors
   a. Structure and function of the pituitary gland
   b. Pituitary incidentaloma
   c. Evaluation of the sellar mass \ tumor
d. Disorders of pituitary hormonal excess
e. Pituitary insufficiency state
f. Dynamic testing
g. Replacement therapy

6. Outpatient evaluation and management of adrenal disorders
   a. Adrenal incidentaloma
   b. Adrenal tumors
c. Cushing’s syndrome
d. Adrenal insufficiency
e. Pheochromocytoma
f. Primary hyperaldosteronism

7. Metabolic bone disease
   a. Osteoporosis
   b. Osteomalacia
c. Vitamin D

8. PCOS
   a. Diagnosis. clinical and biochemical
   b. Treatment

9. Lipid disorders
   a. Treatment

10. Hypoglycemic disorder
    a. Diagnosis
    b. Treatment

V. Methods of Evaluation

   a. Resident Performance: Attending evaluations will be completed on each resident as per attending. Residents will receive evaluations throughout the rotation with summarize evaluation at the end of the rotation. This will include verbal as well as electronic evaluation.

   b. Faculty Performance: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

   c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives
## ENDOCRINOLOGY ROTATION EXPECTATIONS
PGY-1, PGY-2, PGY-3

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td><strong>Interviewing</strong></td>
</tr>
<tr>
<td></td>
<td>• Resident will obtain a detailed consultation centered HPI emphasizing chronology of presentation and descriptions of symptoms.</td>
</tr>
<tr>
<td></td>
<td>• Resident’s presentation will include appropriate pertinent positives and negatives.</td>
</tr>
<tr>
<td></td>
<td>• Resident will use appropriate other sources of data if patient cannot give a history.</td>
</tr>
<tr>
<td>Patient Care</td>
<td><strong>Physical Examination</strong></td>
</tr>
<tr>
<td></td>
<td>• Resident will tailor the physical examination to patient’s complaint.</td>
</tr>
<tr>
<td></td>
<td>• Resident will be able to accurately palpate the thyroid gland.</td>
</tr>
<tr>
<td></td>
<td>• Resident will be able to identify signs and symptoms of diabetes including neuropathy and retinopathy.</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>• Resident will understand the epidemiology, pathophysiology, and treatment of common endocrine disease including thyroid disorders, diabetes, disorders of calcium metabolism, metabolic bone disease, adrenal disease, pituitary disease, and hypoglycemia etc.</td>
</tr>
<tr>
<td></td>
<td>• Resident will develop experience in the management of diabetes mellitus in surgical patients and critically ill patients.</td>
</tr>
<tr>
<td>Procedural Skills</td>
<td>• Resident will develop experience in the management of diabetes in surgical and critically ill.</td>
</tr>
<tr>
<td>Practice-Based Learning and Improvement</td>
<td>• Resident will learn to prioritize decisions based on patient’s severity of illness.</td>
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<tr>
<td></td>
<td>• Resident will develop clinical judgment in the strategies used to match treatment protocols with endocrine disease.</td>
</tr>
<tr>
<td>Systems-Based Practice</td>
<td>• Resident can effectively initiate appropriate clinical pathways.</td>
</tr>
<tr>
<td></td>
<td>• Resident can effectively initiate the appropriate care of a consultant.</td>
</tr>
<tr>
<td></td>
<td>• Resident develops a multidisciplinary approach to Endocrinology.</td>
</tr>
<tr>
<td>Interpersonal and Communication Skills</td>
<td>• Resident will communicate with patient and his / her family in an appropriate manner.</td>
</tr>
<tr>
<td></td>
<td>• Resident is expected to interact as a consultant with the involved medical team.</td>
</tr>
<tr>
<td>Professionalism</td>
<td>• Resident has a completed and dictated consultation on chart and writes a daily progress note.</td>
</tr>
<tr>
<td></td>
<td>• Resident will follow through with scholarly assignments and teaching.</td>
</tr>
<tr>
<td></td>
<td>• Resident recognizes and takes steps to correct his / her weakness(es).</td>
</tr>
</tbody>
</table>
I. Educational Purpose and Goals

To enable osteopathic interns to learn and apply the following aspects of the osteopathic family practice problem-solving process:
- Consideration of probability in decision making
- Use of intuition in decision making
- The time dimension in the diagnosis and treatment of disease/illness
- Self-awareness and self-knowledge in decision making
- Practical data gathering
- Systems awareness, especially family and work dimensions, in decision making
- Managing multiple health problems within the same patient

II. Principal Teaching Methods

Osteopathic interns learn family practice through supervised direct patient care. They work one-on-one with an AOA certified DO attending and all intern activities are directly supervised by him/her.

Osteopathic interns are expected to begin reading the core reading material mentioned hereunder prior to their rotation and are expected to complete it during their rotation.

Osteopathic interns are also required to attend the various sessions on Osteopathic Philosophy and Osteopathic Manipulative Medicine that are scheduled throughout the year.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Each osteopathic intern will spend one four-week block at a community family practice office learning and working closely with an AOA certified osteopathic family physician.

b. Types of Clinical Encounters: Primarily outpatient in the office(s) of the DO family practice physician. Each intern will have primary responsibility for the care and management of at least four patients per half day with a maximum of nine. All patients will be precepted by the attending.

c. Disease Mix: Residents are exposed to the full spectrum of diseases as seen in a community family practice setting.

d. Patient Characteristics: Patient care is provided for patients of all ages, both sexes and all ethnic backgrounds.

e. Procedures: The interns will be taught the osteopathic manipulations by the DO attending, who will then supervise the interns when they carry them out on the patients.

IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List: The intern will be responsible for the list of suggested readings for the family practice rotation in addition to any provided by the family practice attending.
b. Disease Index: Specific goals of the family practice rotation are as follows:

1. To understand the benefit of preventive medicine in specific populations.

2. To understand the role of nutrition in health and disease.

3. To understand screening test characteristics.

4. To understand screening for the specific disorders of:
   - Skin cancer
   - Breast cancer
   - Colorectal cancer
   - Prostate cancer
   - Cervical cancer
   - Cardiovascular disease
   - Substance abuse
   - HIV infection
   - Tuberculosis

5. To understand the screening needs of special patient groups such as:
   - Adolescents
   - Geriatric patients
   - Homosexual patients
   - Travelers and immigrants

6. To understand the medical care of the pregnant patient, including patients with:
   - HIV infection
   - Hypertension
   - Diabetes
   - Hepatitis and other liver diseases
   - Urinary tract infections
   - Systemic lupus erythematosus and other connective tissue diseases
   - Prosthetic heart valves
   - Thromboembolic disorders

7. To understand the epidemiology and medical effects of tobacco use and effective approaches to its cessation.

8. To understand the general principles of the diagnosis and management of patients with addiction of:
   - Alcohol
   - Cocaine
   - Prescription drugs

9. To understand the diagnosis, management and treatment of obese patients.

10. To understand the general recommendations concerning the prevention, diagnosis and treatment of travel-related illnesses including specifically:
    - Air travel
    - Motion sickness
    - Altitude sickness
    - Traveler’s diarrhea
    - Malaria
    - Immunizations
- Immigrants

11. To understand the diagnosis, initial evaluation and ongoing management of both type 1 and type 2 diabetes mellitus.

12. To understand the diagnosis, initial evaluation and ongoing management of thyroid disorders.

13. To understand the diagnosis and management of acute and chronic musculoskeletal disorders:
   - Low back pain
   - Occupational injuries
   - Sports-related injuries
   - “Overuse” syndromes
   - Degenerative joint disease

14. To understand the diagnosis and initial management of common rheumatic disorders:
   - Rheumatoid arthritis
   - Systemic lupus erythematosus
   - Fibromyalgia
   - Polymyalgia rheumatica
   - Disorders of the feet, knee, elbow, shoulders

15. To understand the diagnosis and initial management of common dermatologic problems:
   - Hypersensitivity reactions
   - Cutaneous infections
   - Dermatologic manifestations of systemic diseases
   - Psoriasis
   - Contact dermatitis
   - Acne
   - Rosacea
   - Pityriasis rosea
   - Pemphigus vulgaris
   - Bullous pemphigoid
   - Lichen planus
   - Lichen simplex

16. To understand the diagnosis and initial management of common ophthalmologic problems:
   - Vision screening
   - Corneal abrasions
   - Subconjunctival hemorrhage
   - Local infections
   - Conjunctivitis
   - Allergic manifestations

17. To understand the diagnosis and management of upper respiratory infections.

18. To understand the diagnosis and management of influenza.

19. To understand the diagnosis and management of psychiatric problems which frequently present to the family physician:
   - Depression
   - Anxiety
   - Eating disorders – anorexia and bulimia
   - Dealing with the difficult patient
   - Mood disorders
- Adjustment disorders
- Somatoform disorders
- Obsessive compulsive disorders

20. To understand the diagnosis and management of chronic pain syndromes.

21. To understand the diagnosis and initial management of women’s health issues:
   - Dysmenorrhea
   - Amenorrhea, both primary and secondary
   - Contraception
   - Menopause
   - Dysfunctional uterine bleeding
   - Premenstrual syndrome
   - Fibrocystic breast disease
   - Endometriosis

22. To understand the diagnosis and initial management of common urological problems:
   - Impotence
   - Benign prostatic hypertrophy
   - Incontinence
   - Scrotal masses
   - Acute testicular pain, including testicular torsion and epididymitis
   - Hematuria
   - Urethritis

23. To understand normal adolescent psychological, physical and sexual development and the general principles of adolescent health care.

24. To understand the diagnosis and initial management of sexual problems.

25. To understand the implications and management of long-term medication use, including:
   - Side effects
   - Monitoring
   - Compliance
   - Interactions

26. To understand the diagnosis, management and prevention of osteoporosis.

27. To understand the diagnosis and management of common gastrointestinal problems:
   - Irritable bowel syndrome
   - Constipation
   - Diverticulitis
   - Rectal fissures
   - Diarrhea
   - Dyspepsia
   - Cholelithiasis
   - Flatulence
   - Gastroesophageal reflux disease
   - Peptic ulcer disease
   - Lactose intolerance
   - Hemorrhoids

28. To understand the diagnosis and initial management of common otolaryngologic problems:
   - Allergic rhinitis / perennial rhinitis / vasomotor rhinitis
   - Sinusitis

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- Otitis externa
- Otitis media
- Pharyngitis
- Post-nasal drip
- Tinnitus
- Hearing loss
- Vertigo

29. Lifelong Learning Habit Objectives
- The intern should be able to evaluate new screening and preventive medical techniques for appropriateness and cost-effectiveness in his/her population.
- The intern should respect the health beliefs of other cultures and understand how differing health beliefs affect behavior and medical care.

30. Learn the effective use of consultants and referral mechanisms on behalf of patients and their families.

31. To learn and practice the following communication skills with patients and their families:
- Developing and carrying out advance directives
- Facilitating family meetings
- Patient and family education
- Eliciting the patient’s illness story
- Cross-cultural skills
- Facilitating treatment adherence

32. To identify the relationships among biomedical, psychosocial, economic, cultural and environmental problems and to incorporate this information into the care and management plan.

33. To understand and appreciate the continuing, comprehensive responsibility and relationship of the family physician to his/her patients and their families in a community setting.

34. To develop knowledge and skill in the following family practice office procedures and protocols:
- Office laboratory
- Risk factor identification
- Health maintenance protocols
- Tolerance of ambiguity
- Osteopathic manipulation

V. Methods of Evaluation

- **Resident Performance:** Attending evaluations will be completed on each resident upon completion of the rotation. Residents will receive a summarized evaluation at the end of the rotation with both verbal and written comments.

- **Faculty Performance:** Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

- **Program Performance:** Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.
## VI. Rotation Specific Progressive Learning Goals and Competency Objectives

### FAMILY PRACTICE ROTATION EXPECTATIONS

**PGY-1**

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
</table>
| **Patient Care Interviewing**          | • Resident will obtain a complete history for patients presenting for care.  
• Residents should present cases with appropriate details of chief complaint.  
• Resident will use interpretation service when patient cannot communicate in spoken English.                                                                 |
| **Patient Care Physical Examination**  | • Resident will perform a focused or detailed physical examination, as appropriate to the case.                                                                                                                         |
| **Medical Knowledge**                  | • Resident will understand the epidemiology, evaluation, and treatment of common illnesses encountered by the family practitioner.                                                                                       |
| **Procedural Skills**                  | • Resident will gain confidence in performing the various osteopathic manipulations.                                                                                                                                       |
| **Practice-Based Learning and Improvement** | • Resident will prioritize diagnostic and treatment decisions based on the severity of illness.  
• Resident will develop clinical judgment regarding therapeutic decisions.  
• Resident will participate as part of the team in providing care.  
• Resident will seek and accept feedback.                                                                                                               |
| **Systems-Based Practice**             | • Resident can effectively initiate the appropriate clinical pathways.  
• Resident can appropriately use further consultants in the care of the patient.  
• Resident will be prepared to integrate information into a multidisciplinary approach to urologic care for medical patients.                                                                                           |
| **Interpersonal and Communication Skills** | • Resident communicates effectively with patients and his/her family members.  
• Resident is respectful to the patient.  
• Resident is concerned about patient comfort.  
• Resident involves patient in discussions about further care.                                                                                           |
| **Professionalism**                    | • Resident completes all work prior to leaving the clinic.  
• Resident offers assistance to other team members, as necessary.  
• Resident completes assigned required reading.  
• Resident recognizes and takes steps to correct perceived deficiencies.  
• Resident treats staff and other team members with respect.                                                                                           |
I. Educational Purpose and Goals

The gastroenterology rotation allows residents to acquire history and physical examination skills, develop expertise in the use of diagnostic testing, and learn management skills in diagnosis and treatment of patients presenting with gastrointestinal and hepatic diseases.

II. Principal Teaching Methods

Residents learn gastroenterology through supervised direct patient care. Residents work one-on-one with a staff / faculty gastroenterologist who directly supervises all resident activities.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Inpatient training occurs at Mercy and Moses Taylor Hospitals, including observation of UGI endoscopies and colonoscopies in the GI labs and ERCPs in the radiology rooms of both the hospitals. Outpatient GI is taught in the private clinics of the supervising gastroenterologist.

b. Types of Clinical Encounters: Both in the inpatient and outpatient setting as mentioned above.

c. Disease Mix: Residents are exposed to the full spectrum of gastrointestinal disease. Patient care is provided in the inpatient setting, and seen either as primary patients admitted under the gastroenterologists care / service or as consults requested by other doctors.

d. Patient Characteristics: Patient care is provided for adolescent through geriatric age patients. Patients of both sexes and all ethnic backgrounds are seen while on the gastroenterology rotation. When English is not the primary language, interpreters are available for translation service in all patient care settings.

e. Services: Residents will work directly with board certified gastroenterologists. No clinical activity will occur without being supervised.

f. Procedures: Residents will learn indications and contraindications of endoscopy and other GI related procedures. Any paracenteses that become available while on the gastroenterology service may be performed under supervision of the gastroenterologist. In addition, residents who anticipate performing flexible sigmoidoscopy upon completion of residency will develop confidence in the use of a sigmoidoscope. Interpretation of radiographs as they apply to gastroenterology will also be stressed.

g. Pathological Materials: Pathological material will be reviewed, based upon availability, which in general will include histopathology as it applies to gastrointestinal disease.

IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List: Recommended reading includes:
   1. Sleisinger & Fordtran’s Gastrointestinal and Liver Disease
   2. Uptodate – Gastroenterology topics
   3. Harrison’s Principles of Internal Medicine – Gastroenterology section
b. **Disease Index:** In addition to the materials listed above, radiographic studies will be reviewed as they pertain to gastroenterology.

V. **Methods of Evaluation**

a. **Resident Performance:** Attending evaluations will be completed on each resident upon completion of the dermatology rotation. Residents will receive a summarized evaluation at the end of the rotation with both verbal and written comments.

b. **Faculty Performance:** Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. **Program Performance:** Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. **Rotation Specific Progressive Learning Goals and Competency Objectives**
<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
</table>
| Patient Care Interviewing         | • Resident will obtain a detailed HPI emphasizing chronology of presentation and containing good descriptions of symptoms.  
• Resident’s presentation will include appropriate pertinent positives and negatives.  
• Resident will use appropriate non-patient sources of data if patient cannot give a history.                                                                 |
| Patient Care Physical Examination | • Resident will tailor the physical examination to patient’s complaint.  
• Resident will be able to identify and characterize the signs and symptoms of cirrhosis and pancreatitis.                                                                 |
| Medical Knowledge                 | • Resident understands the epidemiology, pathophysiology, and pharmacology of common gastrointestinal diseases including abdominal pain, jaundice, hepatitis, cirrhosis, pancreatitis, PUD, inflammatory bowel disease. |
| Procedural Skills                 | • Resident will demonstrate developing competency in paracentesis.  
• Resident may demonstrate developing competency in sigmoidoscopy.                                                                                         |
| Practice-Based Learning and Improvement | • Resident prioritizes diagnostic and therapeutic decisions based on patient’s severity of illness.  
• Resident will develop clinical judgment in the strategies used to match treatment protocols with gastrointestinal illness.  
• Resident will use major textbooks, review articles, and current literature to facilitate patient care.  
• Resident actively seeks and accepts feedback.                                                                                                           |
| Systems-Based Practice            | • Resident can effectively initiate the appropriate clinical pathways.  
• Resident can effectively initiate the appropriate consultative services.  
• Resident develops a multidisciplinary approach to gastroenterology.  
• Resident serves as a consultant to other services with moderate faculty input.                                                                         |
| Interpersonal and Communication Skills | • Resident communicates regularly with patient and his/her family.  
• Resident is respectful to the patient.  
• Resident is concerned about the patient’s comfort.  
• Resident addresses patient care issues such as end of life decisions with moderate faculty input.                                                       |
| Professionalism                   | • Resident has history and physical or consult on chart within 24 hours of admission or consultation, and writes a daily progress note.  
• Resident will follow through with scholarly assignments promptly.  
• Resident completes medical records on time.  
• Resident recognizes and takes steps to correct his/her deficiencies.  
• Resident treats team members, including nurses and other health care providers, with respect.  
• Resident adheres to all ACGME mandated duty hour restrictions.                                                                                   |
Competency at each year includes continued demonstration of the preceding year’s competency goals.

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Interviewing</td>
<td>• Resident will obtain a detailed HPI emphasizing chronology of presentation and containing good descriptions of symptoms. • Resident will present without notes. • Resident's presentation will include appropriate pertinent positives and negatives. • Resident will use appropriate non-patient sources of data if patient cannot give a history.</td>
</tr>
<tr>
<td>Patient Care Physical Examination</td>
<td>• Resident will tailor the physical examination to patient’s complaint. • Resident will be able to identify and characterize the signs and symptoms of cirrhosis, inflammatory bowel disease, pancreatitis, and malignancy involving the gastrointestinal tract.</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>• Resident understands the epidemiology, pathophysiology, and pharmacology of common gastrointestinal disease including abdominal pain, jaundice, hepatitis, cirrhosis, pancreatitis, PUD, inflammatory bowel disease, malabsorption, and malignancy of the gastrointestinal tract.</td>
</tr>
<tr>
<td>Procedural Skills</td>
<td>• Resident will demonstrate competency in paracentesis. • Resident may develop experience in flexible sigmoidoscopy.</td>
</tr>
<tr>
<td>Practice-Based Learning and Improvement</td>
<td>• Resident prioritizes diagnostic and therapeutic decisions based on patient’s severity of illness. • Resident will develop clinical judgment in the strategies used to match treatment protocols with gastrointestinal illness. • Resident integrates current evidence-based literature into patient care and teaching responsibilities. • Resident actively seeks and accepts feedback.</td>
</tr>
<tr>
<td>Systems-Based Practice</td>
<td>• Resident can effectively initiate the appropriate clinical pathways. • Resident can effectively initiate the appropriate consultative services. • Resident develops a multidisciplinary approach to Gastroenterology. • Resident serves as a consultant to other services with minimal faculty input. • Resident critically evaluates all consultant evaluations including conflicting recommendation to develop an effective patient care plan.</td>
</tr>
<tr>
<td>Interpersonal and Communication Skills</td>
<td>• Resident communicates regularly with patient and his/her family. • Resident is respectful to the patient. • Resident is concerned about the patient’s comfort. • Resident is able to deal with challenging patients and their families. • Resident effectively coordinates team to optimize patient care and functions as an effective team leader.</td>
</tr>
<tr>
<td>Professionalism</td>
<td>• Resident has the history and physical or consult completed within 24 hours of contact, and writes a daily progress note. • Resident will follow through with scholarly assignments promptly. • Resident completes medical records on time. • Resident recognizes and takes steps to correct his/her deficiencies. • Resident treats team members, including nurses and other health care providers, with respect. • Resident identifies ethical issues and employs available resources to solve them. • Resident counsels junior team members on issues of professionalism including personal reactions to the morbidity and mortality associated with the care of gastroenterologic disease. • Resident sets a tone of respect and collegiality for the team. • Resident adheres to all ACGME mandated duty hour restrictions.</td>
</tr>
</tbody>
</table>

GENERAL INPATIENT MEDICINE CURRICULUM

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I. Educational Purpose and Goals

The general inpatient medicine rotation ("service block") allows residents to refine their history and physical examination skills, develop expertise in the proper use of diagnostic testing, and learn management skills on a wide variety of general internal medicine patients. This rotation not only provides residents with exposure to the common medical problems of hospitalized patients, but also allows residents the opportunity to interact with sub-specialists, and teaches them the complexities of discharge care planning.

II. Principal Teaching Methods

a. Supervised Direct Patient Care: Residents encounter patients admitted to the teaching services through the outpatient clinics, the emergency departments and as transfer from outside facilities. Faculty supervises residents in the completion of admission (including histories and physicals), daily management and discharge plans.
   i. Management Rounds: The management rounds are conducted daily. The management team generally includes one attending physician, one or two PGY-1 residents, and either a PGY-2 or PGY-3 senior resident, as well as participating medical students. Management rounds emphasize fundamental skills of management of hospitalized patients.
   ii. Teaching Attending Rounds: Depending upon the attending, teaching rounds will occur in combination with management rounds or may be held separately. A minimum of 4.5 hours of formal teaching will occur weekly. In general, residents present the history and physical and demonstrate bedside examination. The sessions include discussion on basic scientific foundations of clinical disease presentations, appropriate interpretation of clinical data, discussions of pathophysiology, and use of evidence based medicine. Teaching rounds will also include demonstration of history and physical examination skills.

b. Educational Forums:
   i. Morning Report: Morning reports are held from 8:00 am to 9:00 am three times per week. These sessions are attended by all residents, unless excused. In general a case admitted to the teaching services is discussed and facilitated by a faculty member. During morning report sessions residents are expected to explain their clinical thoughts as a differential diagnosis and a treatment plan is developed based on clinical presentation of an individual patient. At the discretion of the attending physician, topics to be searched using evidence based approach may be assigned to individual residents for presentation at follow up morning report sessions.
   ii. ICU Journal Club: ICU journal club is held monthly on a Thursday morning at 8:00 am in Moses Taylor Hospital. Articles of importance are discussed after a formal presentation by a resident and/or faculty member.
   iii. Grand Rounds: Grand rounds are held from noon to 1:00 pm. These are traditional grand rounds highlighting nationally recognized speakers or assigned faculty members from either hospitals. Occasionally residents present case-based grand rounds. Towards the end of their residency, PGY-3 residents present research at one grand rounds session ("senior presentation").
   iv. Department of Medicine Meeting: Held on the forth Tuesday of every month at noon at Mercy Hospital, it includes a case presentation (by a resident) which involves some quality improvement issue.
   v. STHC Noon Conferences: These conferences are held every Tuesday (except the forth as mentioned above) from noon to 1:00 pm. Each week a classical subspecialty of internal medicine is designated the topic for the core curriculum.
vi. **Tumor Board:** Held every Thursday at Mercy Hospital from noon to 1:00 pm.

### III. Educational Content / Structure of the Rotation

#### a. Learning Venues:
Patients aged 16 years and older with varying ethnicities and economic status are managed on the general inpatient medicine teaching services at Mercy and Moses Taylor Hospitals for a wide diversity of diseases. Admissions to these services are arranged from the STHC or the MVP as direct admissions or through the emergency rooms of both the hospitals where they may present as established WCGME patients or as unattached ("no doc") patients. Patients are also occasionally transferred from an outside institution when transfer is accepted by the service attending. All patients admitted are to be seen on a timely basis, and the process of admitting patients should be incorporated into daily teaching rounds, whenever possible.

Learning on this service is patient-based and requires extensive reading on the diseases encountered. Multidisciplinary team management is encouraged. The general competencies are expected to be developed by all intern and resident participants and graded responsibility is encouraged based on level of professional development. All interns and residents at change of shift are to participate in quality, face-to-face sign-out rounds to optimize seamless patient care. Duty hour regulations are to be abided.

Teaching rounds are expected to be conducted with the service attending, minimally 4.5 hours a week with no less than 75% of this time spent at the bedside. Each intern may follow up to a maximum of 12 patients on service. Interns are to admit up to 5 patients in a 24 shift and up to 8 patients within a 48 hour time period.

All interns and residents are expected to complete medical record documentation in a timely manner. Discharge summaries are the responsibility of the senior resident until December 31 and then of the service interns. Documentation of completed procedures in the MyEvaluations system is mandatory. Identification of one’s key learning objectives at the beginning of the month is encouraged. Timely completion of the rotation evaluations assigned through MyEvaluations is essential. Two Mini-CEXs and two patient surveys should be pursued by each intern and resident while on service.

#### b. Types of Clinical Encounters:
See above.

#### c. Disease Mix:
Patients admitted to the general inpatient medicine service represent the full spectrum of general internal medicine pathology. Residents on service act as the primary inpatient physicians and as medical consultants for patients admitted to non-medical specialty services requiring consultative care.

#### d. Patient Characteristics:
Residents encounter patients admitted to the teaching services through the outpatient clinics, the emergency departments of either hospitals and as transfer from outside facilities. Consultations generally completed by senior residents are generated from the Surgical, Urologic, Orthopedic, Obstetrics & Gynecology, and other sub-specialty services. The demographics and ethnic mix of admissions approximate that of the Scranton and surrounding areas.

#### e. Procedures:

1. Procedures that are learned on general inpatient medicine rotations include, but are not limited to:
   1. Basic and advanced cardiac life support
   2. Lumbar puncture
   3. Abdominal paracentesis
   4. Thoracentesis
5. Arthrocentesis
6. Nasogastric intubation
7. Central line placement
8. Arterial puncture

ii. Interpretive skills that are reinforced or learned include, but are not limited to:
   1. Interpretation of serum electrolytes and routine chemistry panels
   2. Urinalysis and microscopic examinations of urine
   3. Liver function testing
   4. Evaluation of coagulation studies
   5. Arterial blood gas interpretation
   6. Chest x-ray interpretation
   7. Electrocardiogram interpretation
   8. Interpretation of radiological studies including CT, MR, and angiogram
   9. Peripheral smear
   10. Sputum gram stain

iii. Consultative skills: Residents serve as supervised consultants to other specialties requesting medical consultation. This is explained in detail under Consult Medicine Curriculum.

f. Pathological Materials: As available on a case-to-case basis.

IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List:
   i. All residents are expected to review the general inpatient medicine and the core competency curricula (available online) prior to the start of rotation.
   ii. Residents are also assigned topics to be reviewed by the teaching attending throughout the rotation.
   iii. Educational materials are available 24/7 to the WCGME residents. Both hospitals offer twenty-four hour library services with on-site medical librarians during the daytime. In addition, there are a number of computer based medical databases available both in the library and on all medical floors. These databases include:
      • Drug information including side effects and drug-drug interactions
      • Electronic medical records
      • Electronic textbooks of medicine and reference websites such as UptoDate, MDConsult and multiple evidence based search engines
      • Internet access to medical sites on the World Wide Web
      • Laboratory and radiologic results retrieval
      • Patient education material
   iv. In addition, all residents are provided with MKSAP booklets for self-study.

b. Disease Index: The global WCGME curriculum of the general ACGME competencies should be referenced in addition to the curriculum below.

   Obtain a comprehensive history and perform a detailed physical examination to enable the detection of the following illnesses and learn the standard of care management options and supportive evidence for each:
   - DVT / thromboembolism
   - Diabetes mellitus, type 1 and 2, including diabetic ketoacidosis
   - Community-acquired pneumonia, aspiration pneumonia, and health care associated pneumonia
   - Acute and chronic renal failure
   - Cellulitis / erysipelas / osteomyelitis / diabetic foot ulcers
- Asthma and COPD exacerbations
- Urinary tract infections, pyelonephritis
- Hypertensive urgencies and emergencies
- Hypotension, cardiogenic and septic shock
- Endocarditis
- Meningitis, encephalitis
- Coronary artery disease
- Use of non-invasive testing
- Atrial fibrillation
- Anasarca, CHF, ascites, nephrotic syndrome
- Anemia
- Hypothyroidism, hyperthyroidism
- Acid-base disorders
- Hyponatremia, hypernatremia, hypokalemia, hyperkalemia
- Decubitus ulcers
- Acute and chronic arthritis
- Abdominal pain, obstipation, bowel obstruction
- CVA
- Depression
- Alcohol withdrawal syndromes
- Diverticulitis
- Exacerbations of systemic lupus erythematosus
- Seizure
- Sickle cell anemia

Apply current best evidence to patient care and risk factor modification for the following hospital-acquired conditions:
- Nosocomial urinary tract infections
- Health care associated pneumonia including aspiration pneumonia
- Decubitus ulcers
- Ileus / obstipation
- Acute renal failure
- CHF (systolic, diastolic), cor pulmonale
- Acute coronary syndromes
- Mental status changes, delirium
- DVT

Residents will understand the basic tenets of evidence-based medicine through ongoing review of the medical literature. Training will be structured to integrate clinical expertise with the best available clinical evidence, including practice guidelines where available. Residents will gain knowledge of important strategies for review of the medical literature:
- Converting information needs into answerable questions
- Strategies for finding the best evidence to answer clinical questions
- Strategies for critical appraisal of the evidence for validity and utility
- Application of results into clinical practice
- Evaluation of performance of evidence based practice

V. Methods of Evaluation

a. Resident Performance: During and at the end of the rotation, faculty attending gives verbal evaluation(s) to the resident and completes the resident evaluation online at www.myevaluations.com website. These evaluations are competency based and are shared with the resident online. The evaluation is incorporated into the semi-annual performance review completed by the Program Director.
Residents complete two mini-CEXs and two patient evaluations during the rotation. During PGY-1 year of training, all residents must complete a minimum of four mini-CEX evaluations.

PGY-1 residents evaluate their senior residents on service, and senior residents evaluate their PGY-1 residents.

Residents are required to track all procedures completed. These results are used ultimately to document competence and certification in the required procedures.

b. Faculty Performance: Residents also complete a confidential formal evaluation of faculty. Evaluations are reviewed by the Program Director and attending physicians receive anonymous annual copies of aggregate completed evaluations. These serve as a tool for assessment of faculty development needs and for continuous quality improvement within the teaching pool.

c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives

Intern Responsibilities (PGY-1)

1. To perfect data acquisition skills demonstrating the ability to gather primary information from the patient, family members, caretakers, ancillary staff and review of the past medical records. To synthesize this information into a legible comprehensive history.
2. To perform and document a comprehensive physical exam.
3. To formulate a basic differential diagnoses for the problems encountered.
4. To learn the indications, risks, benefits, limitations and cost-effectiveness of diagnostic testing.
5. To formulate a management plan and order appropriate laboratory and ancillary testing with supervision.
6. To develop skills to obtain true patient informed consent and to effectively communicate management plans and test results with patients.
7. To be able to explain and employ the use of intravenous fluids, antibiotics, and other pharmacologic and therapeutic agents in patient care.
8. To demonstrate the ability to listen to patients’ and multidisciplinary team members’ concerns and to be responsive to them.
9. To track and seek results of testing ordered and be sure that results are addressed and followed up.
10. To assume the role of the first line central caregiver for patients, under the careful supervision of senior residents and faculty members. Interns are expected to actively seek supervision to optimize patient care.
11. To develop a knowledge base required to systematically approach the management of patients hospitalized for acute and chronic medical conditions.
12. To directly review patient admissions with the on-call attending starting in June under direct senior resident supervision.
13. To develop clinical skills to assess the gravity of acute medical issues and appropriate triage with senior supervision.
14. To develop competence in the immediate care of the unstable patient.
15. To learn skills to approach noncompliant, disenchanted and angry patients.
16. To develop skills for palliative care and end of life discussions and code status determination.
17. To participate in discharge planning, medication reconciliation, patient education and communication promoting seamless patient care transfer from the acute inpatient setting.
18. To develop a working knowledge of our local healthcare system to optimize patient care and satisfaction.
19. To lead case conferences during their third service experience with senior supervision.

**Senior Resident Responsibilities (PGY-2, PGY-3)**

1. To provide leadership in creating an environment which emphasizes safe, quality and seamless patient care through multidisciplinary team management and active patient education and participation.
2. To directly supervise and educate interns and medical students in the delivery of high quality medical care. To remain available, engaging and responsive.
3. To collaborate care with physician extenders, nursing, pharmacy and case managers.
4. To utilize consultants appropriately during hospitalization and to coordinate care with them.
5. To ensure effective team communication with the patient and family.
6. To recognize and promote the importance of nutrition in medical illnesses.
7. To explain and demonstrate the prevention of nosocomial infections and other iatrogenic complications in the acute care setting.
8. To refine the knowledge of diseases requiring hospital management and to share this knowledge base with interns and medical students.
9. To do medical consultations in a timely, professional and quality manner and to communicate recommendations with the referring doctor promptly. Then to dictate the consult within a 24 hour period.
10. To comprehend and apply medical economics, i.e., charges, fees, LOS and cost containment in patient care.
11. To utilize optimal systems based practice for transitioning patients between the acute, subacute, rehabilitative and mental health services of the hospitals with active communication with case managers.
12. To promote seamless patient transition from the hospital to the outpatient or long-term care setting by effective discharge planning and patient education and communication with the primary care / accepting physician about hospital course and discharge instructions.
13. To orchestrate team participation in daily conferences with organized presentations and preparation of interns for their participation.
14. To communicate with on-call attending about admissions and educate the interns about this process. To promote intern to attending phone calls starting in June by reviewing the assessment and care-plan in depth and remaining immediately available if the attending requests.
15. To demonstrate competence in palliative and end of life discussions with patients and their families with commitment to optimal code status determination and avoidance of medical futility.

**a. Patient Care**

i. History taking. Residents at all levels of training are expected to collect thorough histories by soliciting patient information and by consulting other sources of primary data in a logical and organized fashion. History taking to be hypothesis driven with documentation of clinical thought resulting in development of a differential diagnosis. Residents at all levels of training are expected to develop competence in completion of comprehensive physical examination. This includes an understanding of the anatomic basis for normal and abnormal physical findings. The primary responsibility for completion of all histories and physicals is that of the PGY-1 resident.
ii. Charting. Residents at all levels of training are expected to record data in a legible, thorough, and systematic manner.

iii. Procedures.
1. PGY-1 residents are expected to develop understanding of the indications and contra-indications for all procedures, necessary equipment, specimen handling, patient after-care, and understanding of risks and benefits of the procedure. The PGY-1 resident will be expected to collect informed consent and assist patients with decision making skills. PGY-1 residents are expected to develop appropriate skills in interpreting test results. PGY-1 residents will be supervised by PGY-2/3 residents (who have appropriate certification) or attending physicians until such time as they have documented competence and are capable of performing procedures independently.
2. PGY-2 residents are expected to refine their skills of certified procedures as well as completing the pending procedures. PGY-2 residents who have received certification are expected to facilitate learning of PGY-1 residents and supervise their safe completion of procedures.
3. PGY-3 residents are expected to demonstrate extensive knowledge and expertise in the performance of procedures, understand and identify systems based issues either facilitating or impeding completion of procedures, and assist junior residents in the acquisition of skills required for certification in procedures.

1. All residents are expected to demonstrate continuous improvement in skills of simulating information they have gathered from the history and physical examination.
2. PGY-1 residents are expected to develop competence in the RIME Assessment System. This includes developing competence in reporting / collating pertinent history and physical findings by the sixth month of the academic year. PGY-1 residents are expected to be competent in identifying “sick versus non-sick” patients. In addition, they are expected to interpret reported findings to develop individual care plans for patients. They are expected to manage those patients under their care effectively, and assume primary responsibility for education centered around patient education.
3. PGY-2 residents are expected to know pertinent history and physical finding for all patients on the team. They are expected to oversee care plans for all patients on the rounding team as developed by the PGY-1 residents in a supervisory role with delegation of specific care delivery to the first year resident. The PGY-2 educational responsibilities include education of first year resident and medical students in patient management skills and history and physical diagnosis. Developing progressive expertise in skills of clinical teaching, identifying patient driven topics for reading and group presentations, and demonstrating an obvious grasp of classical textbook knowledge.
4. PGY-3 residents are expected to perform all described responsibilities for PGY-2 residents in addition to incorporating evidence base medicine and peer review medical literature into clinical rounding. PGY-3 residents are also expected to demonstrate greater expertise in clinical reasoning in ambiguous situations.

b. Medical Knowledge

i. PGY-1 residents are expected to apply classical concepts of basic science to clinical problem solving. They will demonstrate satisfactory knowledge of common medical conditions and demonstrate sufficient management skills for patient complaints with supervision. PGY-1 residents are additionally expected to confirm clinical thought and
decision making with supervising residents, and understand limitations of their knowledge base.

ii. PGY-2 residents will demonstrate progressive clinical and basic medical knowledge and analytic thinking.

iii. PGY-3 residents are expected to demonstrate competence in applying clinical and medical knowledge to patient care. They are expected to refine clinical teaching skills, and develop comfort with the use of evidence based medicine and peer review literature in the development of patient care plans.

c. Interpersonal and Communication Skills

i. PGY-1 residents are expected to refine communication skills with individual patients. This includes effective written and verbal communication skills. They are expected to exhibit appropriate listing skills and sensitivity to patient specific and culturally generated patient care issues. This will include recognition of verbal as well as nonverbal cues.

ii. PGY-2 residents are expected to develop leadership skills for team management. These include communication skills and teaching skills. PGY-2 residents will be expected to develop comfort and expertise in communications centered around end of life discussions with patients.

iii. PGY-3 residents will continue to demonstrated skills as required of the PGY-2 resident in addition to increasing team leadership skills with decreased reliance on attending physician. PGY-3 residents are additionally expected to develop those skills necessary to interact with "difficult" patients and ambiguous clinical presentations.

d. Professionalism

i. All residents regardless of training year are expected to demonstrate integrity, accountability, respect, compassion, patient advocacy, and dedication to patient care that supercedes self-interest. Residents will be punctual and well prepared for teaching sessions. They will demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, patient confidentiality, and use of informed consent. All residents are expected to show sensitivity and responsiveness to patients’ culture, age, gender and disabilities.

e. Practice-based Learning and Improvement

i. All residents are expected to identify individual learning plans to facilitate their acquisition of clinical and basic science knowledge.

ii. PGY-1 residents are expected to develop fluency with use of computer-based technologies facilitating learning.

iii. PGY-2 residents, in addition to the above, are expected to seek out and analyze data on practice experience, identify areas of improvement and knowledge, and demonstrate knowledge of the impact of study design or applicability to individual practice.

iv. PGY-3 residents, in addition to the above, are expected to model adult and life long learning principles.

f. Systems-Based Practice
i. PGY-1 residents will be sensitive to health care costs. They will begin to effectively coordinate care with other health care professionals as required to patient needs.

ii. PGY-2 residents, in addition, will understand and adopt clinical practice guidelines and recognize the limitation of these guidelines. They will work with allied health care providers such as patient care managers, discharge coordinators, and social workers to coordinate and improve patient care and outcomes.

iii. PGY-3 residents will develop increased expertise in the use of social and other out-of-hospital resources to assist patients with therapeutic plans and care.
I. Educational Purpose and Goals

Globally there are 605 million persons over age 65 in the year 2004. The world population of older adults will increase to over 2 billion by 2050. In the U.S. the population age 85 and older is currently the fastest growing segment of the older population. The size of this age group is especially important for the future of our health care system, because these individuals tend to be in poorer health and require more services than the younger patients. Projections by the U.S. Census Bureau suggest that the population age 85 and older could grow from about 4 million in 2000 to 19 million by 2050. In Pennsylvania, the 85 year old and older age group grew nearly 38 percent over the past 10 years.

The purpose of the geriatrics rotation is to introduce the nuances of the care of the elderly to the PGY-3 residents by providing a four-week formal rotation in Geriatric Medicine. Emphasis will be placed upon the implementation of preventive care strategies and the recognition and management of the geriatric syndromes.

a. Improve the prevention, recognition, treatment and management of the major geriatric syndromes at all levels of care. These geriatric syndromes are symptoms of functional decline, generally resulting from several factors rather than one cause. When combined with a decrease in host resistance, these factors lead to illness or injury. Furthermore, the presenting symptoms may appear in other body systems before becoming apparent in the affected system.

These syndromes include:
- Dementia / Dementia with neuro-psychiatric and behavioral disturbances
- Delirium
- Depression
- Urinary incontinence
- Gait disturbances / Falls
- Dizziness / Syncope
- Hearing impairment
- Visual impairment
- Osteoporosis
- Back pain
- Eating and feeding problems / Malnutrition
- Pressure ulcers
- Sleep problems

Opportunities:
- Directly provide or coordinate linkages to expert consultation, e.g. neurology consult for memory loss / dementia, metabolic bone team consult for osteoporosis, urology consult for incontinence, gero-psychiatry consult, etc.
- Provide community education (and diagnostic screenings when appropriate) in prevention and treatment of geriatric syndromes.
- Provide education of medical, nursing and other professional staff regarding prevention, recognition and treatment of the geriatric syndromes.
- Implement Hospital Elder Life Program (HELP) to reduce delirium, functional and cognitive decline in the hospitalized elderly.

b. Improve patients, families and professionals ability to discuss, plan and prepare for a dignified death.
Opportunities:
- Palliative care educational sessions for professional staff.
- Palliative care and hospice consults.

c. Maintain independence, functional status and quality of life for the frail elderly in all settings: community, assisted living and nursing homes. Frailty is defined as possessing one or more of the following characteristics: extreme old age (>85), inability to perform Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL), and possessing multiple chronic diseases, such as mental confusion, sleep deprivation, visual and hearing loss, and dehydration.

Opportunities:
- Expand direct provision of physician and nurse practitioner care in nursing homes.
- Provide consultative services to improve care provided through home health agencies, adult day care centers and nursing homes.
- Improve linkages to community-based services, e.g., Area Agencies on Aging Waiver Program, Meals-on-Wheels, Parish Nurses, etc.
- Provide education and support to family caregivers.
- Implement a Program for All-Inclusive Care of the Elderly (PACE).

d. Increase the number of providers trained in geriatric care and the quality of the training programs available.

Opportunities:
- Through implementation of HELP, increase the base among medical students who may be influenced to select careers in geriatrics.
- With expansion of consultations for geriatric syndromes, community and nursing home services and implementation of HELP and PACE, increased opportunities for geriatric care education in multiple sites will be created for physicians, nurses and other health professionals, including four-week rotation in Geriatric Medicine for PGY-3 residents.

II. Principal Teaching Methods

Residents learn geriatrics through supervised direct patient care. For a four-week block, residents work one-on-one with a faculty geriatrician who directly supervises all resident activities, both in the inpatient and outpatient setting.

In addition to this geriatrics rotation in their 3rd year of training, residents are exposed to and take care of elderly patients all throughout their 3 years of training at WCGME since north-eastern Pennsylvania has a large geriatric population.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Inpatient training occurs primarily at the Moses Taylor Hospital. Outpatient training under the supervision of a geriatrician occurs primarily in his outpatient office. Residents also have the opportunity to work with a variety of providers of geriatric care (nurse practitioners, social workers, physical therapists, case managers, dieticians, etc.)

b. Types of Clinical Encounters: Both in the inpatient and outpatient setting as mentioned above.
c. **Disease Mix:** Northeastern Pennsylvania has one of the highest concentrations of geriatric age group population in the USA. This exposes our residents to a wide spectrum of geriatric problems.

d. **Patient Characteristics:** During the rotation under the supervision of the faculty geriatrician, residents take care of the private geriatric patients of the attending who are admitted to the teaching service at Moses Taylor Hospital. The demographics and ethnic mix of admissions approximate that of the Scranton and surrounding areas.

e. **Services:** Residents will work directly with the faculty geriatrician in both the inpatient and the outpatient setting. No clinical activity will occur without being supervised.

IV. **Principal Ancillary Educational Materials / Educational Resources**

a. **Reading List:**
   1. Geriatric topics as provided / suggested by the attending
   2. Articles from current literature

b. **Disease Index:** Includes the syndromes mentioned above.

V. **Methods of Evaluation**

a. **Resident Performance:** Attending evaluation will be provided to each resident at the end of his/her geriatric rotation. This will include both a face-to-face verbal as well as an electronic evaluation submitted online at www.myevaluations.com.

b. **Faculty Performance:** Upon completion of the rotation, residents complete a confidential web-based electronic faculty evaluation.

c. **Program Performance:** Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. **Rotation Specific Progressive Learning Goals and Competency Objectives**

The **principal educational goals for the PGY-3 geriatric rotation** are listed for each of the six ACGME competencies.

a. **Patient Care**
   • Perform an efficient focused interview and physical examination of an elder patient.
   • Recognize, evaluate and initiate appropriate treatment for geriatric syndromes.
   • Promote wellness and maintenance of function in elderly patients, by becoming knowledgeable in the implementation of effective preventive care strategies.
   • Appropriately prescribe medications in the elderly patients.
   • Refer patients appropriately for outpatient geriatric assessment, and rehabilitation services.

b. **Medical Knowledge**
   • Expand clinically applicable knowledge base of the basic and clinical sciences underlying the care of elderly patients.
   • Access and critically evaluate current medical information and scientific evidence relevant to elderly patients.
• Understand the concept of wellness and appreciate the importance of maintenance of function in elderly patients.
• Understand the importance of medication use in the elderly in order to avoid or diminish medication side affects.

c. Practice-Based Learning and Improvement
• Identify and acknowledge gaps in personal knowledge and skills in the care of elderly patients.
• Develop Evidence-based strategies for filling gaps in personal knowledge and skills in the care of elderly patients.

d. Interpersonal and Communication Skills
• Communicate effectively with elderly patients and their families.
• Recognize and deal effectively with the communication challenges resulting from cognitive impairment in elderly patients.
• Communicate effectively with physician colleagues and members of other health care professions to assure timely, comprehensive care for elderly patients at various levels of care.
• Provide sensitive and comprehensive terminal care including support for family and other caregivers.

e. Professionalism
• Behave professionally towards patients, families, colleagues, and all members of the health care team.

f. Systems-Based Practice
• Understand and utilize the multidisciplinary resources necessary to care optimally for elderly patients.
• Collaborate with other members of the health care team to assure comprehensive care for elderly patients.
• Use evidence-based, cost-conscious strategies in the care of elderly patients.
• Understand the full range of living options for elderly persons and the cognitive and functional abilities required for successful living in these various settings.
• Understand the implications and benefits of a home visit, including environmental assessment and safety evaluation.
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<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
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<tbody>
<tr>
<td><strong>Patient Care</strong></td>
<td></td>
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<tr>
<td><strong>Interviewing</strong></td>
<td>• Resident will obtain a detailed HPI emphasizing chronology of presentation and containing good descriptions of symptoms. &lt;br&gt;  • Resident will present without notes. &lt;br&gt;  • Resident’s presentation will include appropriate pertinent positives and negatives. &lt;br&gt;  • Resident will use appropriate additional sources of data if patient cannot give a history.</td>
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<td><strong>Physical Examination</strong></td>
<td>• Resident will tailor the physical examination to the patient’s complaint. &lt;br&gt;  • Resident will be able to complete a functional assessment. &lt;br&gt;  • Resident will be able to identify and characterize the signs and symptoms of common medical illness presenting in the elderly.</td>
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<td><strong>Medical Knowledge</strong></td>
<td>• Resident understands the impact of age on presentation of common medical illness. &lt;br&gt;  • Resident will be able to understand the nutritional needs of the elderly. &lt;br&gt;  • Resident will develop an understanding of the risk of polypharmacy in the elderly. &lt;br&gt;  • Resident understands the epidemiology, pathophysiology, and pharmacology of common geriatric diseases including dementia and delirium, depression, sensory impairment, and gait abnormalities. &lt;br&gt;  • Resident will develop experience in the completion of a comprehensive geriatric assessment including the evaluation of living options and environmental and safety assessments.</td>
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<td><strong>Practice-Based Learning and Improvement</strong></td>
<td>• Resident prioritizes diagnostic and therapeutic decisions based on patient's severity of illness. &lt;br&gt;  • Resident will develop clinical judgment in the strategies used to match treatment protocols with disease presentation in the elderly. &lt;br&gt;  • Resident will utilize recommended readings to enhance their understanding of geriatric medicine. &lt;br&gt;  • Resident will actively seek and accept feedback.</td>
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<td><strong>Systems-Based Practice</strong></td>
<td>• Resident can effectively initiate the appropriate clinical pathways. &lt;br&gt;  • Resident can effectively initiate the appropriate consultative services. &lt;br&gt;  • Resident develops a multidisciplinary approach to geriatric care. &lt;br&gt;  • Resident serves as a consultant to other services with minimal faculty input. &lt;br&gt;  • Resident critically evaluates all consultant evaluations including conflicting recommendation to develop an effective patient care plan.</td>
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<td><strong>Interpersonal and Communication Skills</strong></td>
<td>• Resident communicates regularly with patient and his / her family. &lt;br&gt;  • Resident is respectful to the patient. &lt;br&gt;  • Resident is concerned about the patient’s comfort. &lt;br&gt;  • Resident is able to negotiate with challenging patients and families. &lt;br&gt;  • Resident addresses patient care issues such as end of life decisions with minimal faculty input.</td>
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<td><strong>Professionalism</strong></td>
<td>• Resident has the history and physical / consultation completed within 24 hours of contact, and writes a daily progress note. &lt;br&gt;  • Resident will follow through with scholarly assignments promptly. &lt;br&gt;  • Resident completes medical records on time. &lt;br&gt;  • Resident recognizes and takes steps to correct his / her deficiencies. &lt;br&gt;  • Resident treats team members, including nurses and other health care providers, with respect. &lt;br&gt;  • Resident identifies ethical issues and employs available resources to solve them. &lt;br&gt;  • Resident counsels junior team members on issues of professionalism including personal reactions to the morbidity and mortality associated with the care of geriatric patients. &lt;br&gt;  • Resident sets a tone of respect and collegiality for the team. &lt;br&gt;  • Resident adheres to all ACGME mandated duty hour restrictions.</td>
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</table>
HEMATOLOGY & ONCOLOGY CURRICULUM

I. Educational Purpose and Goals

The Hematology & Oncology rotation allows residents to acquire history and physical examination skills, develop expertise in the use of diagnostic testing, and learn management skills working with patients presenting with hematologic and oncologic diseases.

II. Principal Teaching Methods

Residents learn Hematology & Oncology through supervised direct patient care. For a four-week block, residents work one-on-one with a faculty hematologist-oncologist who directly supervises all resident activities, both in the inpatient and outpatient setting. In general, this rotation is offered to one resident per block. While PGY-2/3 are preferred, PGY-1 residents can also request the rotation.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Mercy and Moses Taylor Hospitals are the sites for inpatient training. Hospitalized patients may be admitted directly under the care of a hematologist-oncologist but most patient encounters occur in the form of a consult. Outpatient training occurs in the private office(s) of the hematologist-oncologist.

b. Types of Clinical Encounters: As described above.

c. Disease Mix: Residents are exposed to the full spectrum of hematologic-oncologic disorders.

d. Patient Characteristics: Patient care is provided for adolescent through geriatric age patients. Patients of both sexes and all ethnic backgrounds as reflected by the general population of the Scranton area are seen while on the heme-onc rotation. When English is not the primary language, interpreters are available for translation service in all patient care settings.

e. Services: Residents will work directly with faculty hematologist-oncologists in either the inpatient or the outpatient setting. No clinical activity will occur without being supervised.

f. Procedures: Residents are expected to observe and, if interested to learn, perform bone marrow aspiration and biopsy. In addition, residents will learn the indications for performing this procedure. Marrow smears will be reviewed with the attending and/or a pathologist.

g. Pathological Materials: Pathological material will be reviewed based upon patient mix. In general this will include bone marrows and histopathology as applies to hematologic and oncologic diseases. In addition, the residents will have exposure to pathologic material at the tumor board conferences held at Mercy Hospital on Thursdays at noon time.

IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List: Recommended reading includes:
   1. Uptodate – Hematology and Oncology topics
   2. Harrison's Principles of Internal Medicine section on Oncology and Hematology
   3. Peer review current literature
   4. Reading assignments as give by the attending
V. Methods of Evaluation

a. Resident Performance: Attending evaluations will be completed on each resident upon completion of the hematology & oncology rotation. Residents will receive a summarized evaluation at the end of the rotation with both verbal and written comments.

b. Faculty Performance: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives
<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
</table>
| Patient Care Interviewing         | • Resident will obtain a detailed HPI emphasizing chronology of presentation and containing good descriptions of symptoms.  
• Resident will present without notes.  
• Resident’s presentation will include appropriate pertinent positives and negatives.  
• Resident will use appropriate non-patient sources of data if patient cannot give a history.                                                                 |
| Patient Care Physical Examination | • Resident will tailor the physical examination to the patient’s complaint.  
• Resident will be able to accurately identify skin manifestations of hematologic and oncologic diseases.  
• Resident will be able to identify and characterize adenopathy and will be able to palpate the liver and spleen, and assess their size. |
| Medical Knowledge                 | • Resident understands the epidemiology, pathophysiology, and pharmacology of common hematologic-oncologic diseases including anemia, leukemia, lymphoma, inherited hemoglobin abnormalities, solid tumors, and bleeding disorders.  
• Residents will develop competency in the appropriate triage and resuscitation strategies in life threatening circumstances. |
| Procedural Skills                 | • Resident will develop experience in the completion (optional) and interpretation of bone marrow aspiration and biopsy.  
• Resident will develop familiarity with peripheral blood smear interpretation.                                                                                      |
| Practice-Based Learning and Improvement | • Resident prioritizes diagnostic and therapeutic decisions based on patient’s severity of illness.  
• Resident will develop clinical judgment in the strategies used to match drug treatment protocols with hematologic-oncologic diseases.  
• Resident will attend scheduled conferences and core lecture series.  
• Resident will seek and accept feedback.                                                                                                                                  |
| Systems-Based Practice            | • Resident can effectively initiate the appropriate clinical pathways.  
• Resident can effectively initiate appropriate use of consultant in the care of patients suffering from hematologic-oncologic disease.  
• Resident develops a multidisciplinary approach to Hematology & Oncology.  
• Resident will serve as a consultant to other services with moderate faculty input.                                                                                       |
| Interpersonal Skills and Communication | • Resident communicates regularly with patient and his / her family.  
• Resident is respectful to the patient.  
• Resident is concerned about the patient’s comfort.  
• Resident addresses patient care issues such as end of life decisions with moderate faculty input.                                                                           |
| Professionalism                   | • Resident has history and physical / consult on chart within 24 hours of admission or consultation, and writes a daily progress note.  
• Resident will follow through with scholarly assignments promptly.  
• Resident completes medical records on time.  
• Resident recognizes and takes steps to correct his / her deficiencies.  
• Resident treats team members, including nurses and other health care providers, with respect.  
• Resident adheres to all ACGME mandated duty hour restrictions.                                                                                                               |
# PGY-2, PGY-3

Competency at each year includes continued demonstration of the preceding year’s competency goals.

<table>
<thead>
<tr>
<th>Competency Domain</th>
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<tbody>
<tr>
<td><strong>Patient Care</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Interviewing                     | • Resident will obtain a detailed HPI emphasizing chronology of presentation and containing good descriptions of symptoms.  
• Resident will present without notes.  
• Resident’s presentation will include appropriate pertinent positives and negatives.  
• Resident will use appropriate non-patient sources of data if patient cannot give a history. |
| **Patient Care**                 |                                                                                                                                                              |
| Physical Examination             | • Resident will tailor the physical examination to the patient’s complaint.  
• Resident will be able to accurately identify skin manifestations of hematologic and oncologic diseases.  
• Resident will be able to identify and characterize adenopathy and will be able to palpate the liver and spleen, and assess their size. |
| **Medical Knowledge**            | • Resident understands the epidemiology, pathophysiology, and pharmacology of common hematologic-oncologic diseases including anemia, leukemia, lymphoma, inherited hemoglobin abnormalities, solid tumors, and bleeding disorders.  
• Residents will develop competency in the appropriate triage and resuscitation strategies in life threatening circumstances. |
| **Procedural Skills**            | • Resident will develop experience in the completion (optional) and interpretation of bone marrow aspiration and biopsy.  
• Resident will be comfortable with peripheral blood smear interpretation. |
| **Practice-Based Learning**      | • Resident prioritizes diagnostic and therapeutic decisions based on patient’s severity of illness.  
• Resident will develop clinical judgment in the strategies used to match drug treatment protocols with hematologic-oncologic diseases.  
• Resident will attend scheduled conferences and core lecture series.  
• Resident will seek and accept feedback. |
| and Improvement                  |                                                                                                                                                              |
| **Systems-Based Practice**       | • Resident can effectively initiate the appropriate clinical pathways.  
• Resident can effectively initiate appropriate use of consultant in the care of patients suffering from hematologic-oncologic disease.  
• Resident develops a multidisciplinary approach to Hematology & Oncology.  
• Resident will serve as a consultant to other services with minimal faculty input. |
| **Interpersonal and Communication Skills** | • Resident communicates regularly with patient and his / her family.  
• Resident is able to deal with challenging patients and families.  
• Resident effectively coordinates team to optimize patient care and functions as an effective team leader. |
| **Professionalism**              | • Resident has history and physical / consultation completed within 24 hours of contact, and writes a daily progress note.  
• Resident will follow through with scholarly assignments promptly.  
• Resident completes medical records on time.  
• Resident recognizes and takes steps to correct his / her deficiencies.  
• Resident treats team members, including nurses and other health care providers, with respect.  
• Resident identifies ethical issues and employs available resources to solve them.  
• Resident counsels junior team members on issues of professionalism including personal reactions to the morbidity and mortality associated with the care of hematologic-oncologic disease.  
• Resident sets a tone of respect and collegiality for the team.  
• Resident adheres to all ACGME mandated duty hour restrictions. |
HEMATOLOGY & ONCOLOGY ROTATION SELF DIRECTED LEARNING CHECKLIST

Name: ___________________________      Rotation Date: _____________

Informal Discussion / Self Directed Learning Topics:

Checklist

- Breast Cancer
- Colon Cancer
- Lung Cancer
- Prostate Cancer
- Principles of Chemotherapy
- Anemia
- Platelet problems
- Coagulopathy
- Leukemia
- Lymphoma
INFECTIONOUS DISEASES CURRICULUM

I. Educational Purpose and Goals

The infectious diseases rotation at WCGME is designed to provide residents with an understanding of the pathophysiologic basis of infectious diseases. Emphasis is placed on active resident’s participation in the diagnosis and management of patients with infectious disease based upon an understanding of the physiologic changes that occur in the disease process. The residents will learn to function as a consultant recommending care for infectious diseases as presenting in the adult population.

II. Principal Teaching Methods

Residents learn the pathophysiology and management of infectious diseases through direct consultative care provided to patients as well as a flexible didactic curriculum offered by core WCGME faculty. Residents will work one on one with a board certified ID faculty member.

Infectious diseases specialist directly supervises all resident activities at all times. No clinical activity will occur without being supervised.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Inpatient infectious diseases training occurs at Mercy and Moses Taylor Hospitals by supervised direct patient care. Residents take care of patients on whom ID consults have been asked for by other specialties. Outpatient exposure occurs at the HIV / ID clinics being run at the STHC on Tuesday and Thursday afternoons.

b. Types of Clinical Encounters: As described above.

c. Disease Mix: Residents are exposed to the full spectrum of infectious diseases diagnosis and management.

d. Patient Characteristics: Patient care is provided from adolescent to geriatric age patients. Patients of both sexes and all ethnic backgrounds are seen while on the infectious diseases rotation. When English is not the primary language, interpreters are available for translation service in all patient care settings.

e. Services: Residents will work directly with an infectious diseases specialist in both the inpatient and the outpatient settings. No clinical activity will occur without being supervised.

f. Procedures: Residents are expected to develop familiarity with the interpretation of gram stains. When possible residents will complete procedures including lumbar puncture, paracentesis and, or thoracentesis.

g. Pathological Materials: As available on a case-to-case basis.

IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List: Recommended reading sources include:
   1. Infectious Diseases volume of MKSAP
   2. Infectious Diseases section of Harrison’s Principles of Internal Medicine
3. Infectious Disease in 30 Days
4. UpToDate – Infectious Diseases topics
5. Relevant articles from NEJM as assigned
6. ID journals as assigned

V. Methods of Evaluation

a. Resident Performance: Residents will receive continuous formative evaluations throughout the rotation with a mid-rotation review as well as a summarized evaluation at the end of the rotation. This will include verbal as well as written (online) evaluation.

b. Faculty Performance: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives
### INFECTIOUS DISEASES ROTATION EXPECTATIONS

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<td>• Resident will obtain a detailed HPI emphasizing chronology of presentation and containing good descriptions of symptoms.</td>
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<td>• Resident will present without notes.</td>
</tr>
<tr>
<td></td>
<td>• Resident’s presentation will include appropriate pertinent positives and negatives.</td>
</tr>
<tr>
<td></td>
<td>• Resident will use appropriate non-patient sources of data if patient cannot give a history.</td>
</tr>
<tr>
<td><strong>Patient Care Physical Examination</strong></td>
<td>• Resident will tailor the physical examination to the patient’s complaint.</td>
</tr>
<tr>
<td></td>
<td>• Resident will be able to accurately identify skin manifestations of infectious disease.</td>
</tr>
<tr>
<td></td>
<td>• Resident will be able to identify and characterize the signs and stages of shock.</td>
</tr>
<tr>
<td></td>
<td>• Resident will be able to identify signs of infection involving each of the major organ systems.</td>
</tr>
<tr>
<td><strong>Medical Knowledge</strong></td>
<td>• Resident understands the epidemiology, pathophysiology, and pharmacology of common infectious diseases including hospital and community acquired pneumonia, meningitis, endocarditis, GU sepsis, and septic arthritis.</td>
</tr>
<tr>
<td></td>
<td>• Resident will develop an understanding of the major antibiotic classes and their use.</td>
</tr>
<tr>
<td></td>
<td>• Resident will develop competency in the interpretation of infectious disease presentations on chest x-ray.</td>
</tr>
<tr>
<td><strong>Procedural Skills</strong></td>
<td>• Resident will develop familiarity with the interpretation of gram stains.</td>
</tr>
<tr>
<td><strong>Practice-Based Learning and Improvement</strong></td>
<td>• Resident prioritizes diagnostic and therapeutic decisions based on patient’s severity of illness.</td>
</tr>
<tr>
<td></td>
<td>• Resident will develop clinical judgment in the strategies used to match drug treatment protocols with infectious disease presentation.</td>
</tr>
<tr>
<td><strong>Systems-Based Practice</strong></td>
<td>• Resident can effectively initiate the appropriate clinical pathways.</td>
</tr>
<tr>
<td></td>
<td>• Resident involves the appropriate services to move the patient through the system.</td>
</tr>
<tr>
<td></td>
<td>• Resident develops a multidisciplinary approach to infectious disease.</td>
</tr>
<tr>
<td><strong>Interpersonal and Communication Skills</strong></td>
<td>• Resident communicates regularly with patient and his / her family.</td>
</tr>
<tr>
<td></td>
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</tr>
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<td></td>
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</tr>
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<td><strong>Professionalism</strong></td>
<td>• Resident has history and physical on chart within 24 hours of admission or consultation, and writes a daily progress note.</td>
</tr>
<tr>
<td></td>
<td>• Resident will follow through with scholarly assignments promptly.</td>
</tr>
<tr>
<td></td>
<td>• Resident completes medical records on time.</td>
</tr>
<tr>
<td></td>
<td>• Resident recognizes and takes steps to correct his / her deficiencies.</td>
</tr>
<tr>
<td></td>
<td>• Resident treats team members, including nurses and other non-physician health care providers, with respect.</td>
</tr>
<tr>
<td></td>
<td>• Resident deals appropriately with personal reaction as pertains to morbidity and mortality of infectious disease.</td>
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</table>
### PGY-2, PGY-3
Competency at each year includes continued demonstration of the preceding year’s competency goals.

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  • Resident will present without notes.  
  • Resident’s presentation will include appropriate pertinent positives and negatives.  
  • Resident will use appropriate non-patient sources of data if patient cannot give a history.  
  • Resident teaches junior residents/medical students the fundamentals of time sensitive interviewing technique.                                                                                                                                                                                                                                                                                                                                                       |
| Patient Care Physical Examination  | • Resident will tailor the physical examination to the patient’s complaint.  
  • Resident will be able to accurately identify skin manifestations of infectious disease.  
  • Resident will be able to identify and characterize the signs and stages of shock.  
  • Resident will be able to identify signs of infection involving each of the major organ systems.  
  • Resident teaches junior residents/medical students the fundamentals of time sensitive physical examination.                                                                                                                                                                                                                                                                                            |
| Medical Knowledge                  | • Resident understands the epidemiology, pathophysiology, and pharmacology of common infectious diseases including hospital and community acquired pneumonia, meningitis, endocarditis, GU sepsis, and septic arthritis.  
  • Resident will develop an understanding of the major antibiotic classes and their use.  
  • Resident will develop competency in the interpretation of infectious disease presentations on chest x-ray.                                                                                                                                                                                                                                                                                                      |
| Procedural Skills                  | • Resident will develop familiarity with the interpretation of gram stains.                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Practice-Based Learning and Improvement | • Resident prioritizes diagnostic and therapeutic decisions based on patient’s severity of illness.  
  • Resident will develop clinical judgment in the strategies used to match drug treatment protocols with infectious disease presentation.  
  • Residents will use major textbooks, review articles, and current literature to facilitate patient care.                                                                                                                                                                                                                                                                                                      |
| Systems-Based Practice             | • Resident can effectively initiate the appropriate clinical pathways.  
  • Resident involves the appropriate services to move the patient through the system.  
  • Resident develops a multidisciplinary approach to infectious disease.  
  • Resident serves as a consultant to other services with minimal faculty input.                                                                                                                                                                                                                                                                                                               |
| Interpersonal and Communication Skills | • Resident communicates regularly with patient and his/ her family.  
  • Resident addresses patient care issues such as end of life decisions with minimal faculty input.  
  • Resident provides feedback to junior team members.  
  • Resident functions as an effective team leader.                                                                                                                                                                                                                                                                                                                          |
| Professionalism                    | • Resident has history and physical on chart within 24 hours of admission or consultation, and writes a daily progress note.  
  • Resident will follow through with scholarly assignments promptly.  
  • Resident completes medical records on time.  
  • Resident recognizes and takes steps to correct his/ her deficiencies.  
  • Resident treats team members, including nurses and other non physician health care providers, with respect.  
  • Resident counsels junior team members on issues of professionalism including personal reactions to the morbidity and mortality associated with the care of infectious diseases.  
  • Resident adheres to all ACGME mandated duty hour restrictions.                                                                                                                                                                                                                                                                                                                   |
INTENSIVE CARE UNIT CURRICULUM

I. Educational Purpose and Goals

This is a required rotation for all the residents. At its completion it is expected that every resident will be able to demonstrate competency in the evaluation, diagnosis and treatment of common critical medical conditions.

II. Principal Teaching Methods

a. Supervised Direct Patient Care: Residents take care of the patients at Moses Taylor Hospital ICU under the guidance of private and faculty internists and sub-specialists along with the supervision of a board certified critical care intensivist. Whenever possible, patients will be evaluated first by the resident, who will then present the case to the attending physician prior to implementing a plan of care.

b. Multi Disciplinary Rounds: Residents are expected to perform as an important part of a multi-disciplinary team in the care of the patients. Multidisciplinary bedside work rounds are performed daily at 8:00 am and consist of residents, nursing, and pharmacy. During this time, all new admissions, pertinent changes overnight, concerns, and daily care plan are discussed. These multi-disciplinary rounds are led by the senior resident.

c. Patient Care Rounds: Direct patient care under the supervision of the critical care faculty and a senior resident. The daily care of patients including disease recognition and management, cost-effective and evidence-based therapeutics, and discharge / transfer planning is the residents’ responsibility. Daily progress notes are to be comprehensive and legible. They should include patient’s current status and pertinent changes, vitals (including weights, I/Os), medications, physical, and assessment and plan. Orders are also the responsibility of the residents. Residents are expected to interpret CXRs, EKGs, ABGs, and laboratory values and apply this knowledge appropriately. It is expected that ICU residents keep a detailed up-to-date list and give accurate and comprehensive sign-outs to oncoming physicians. They are expected to demonstrate effective communication skills with patients, families, and other health care personnel.

d. Didactics: Residents are expected to begin reading the core reading material prior to the start of their rotation and are expected to complete it during the rotation.

e. ICU Grand Rounds: These are held throughout the year and all residents are expected to attend these.

f. ICU Journal Club: This is held once a month on a Thursday morning. All residents are expected to participate in it. Residents are expected to review and learn to apply Evidence Based Medicine (EBM) skills, to learn the process of critical appraisal of the literature and specific studies, as well as to learn the principles of ICU care.

III. Educational Content / Structure of the Rotation

a. Learning Venues: The intensive care unit at Moses Taylor Hospital is a closed unit with 12 acute care beds run by the residents under attending supervision and with extensive nursing support. This differs from the service rotations, in that the attendings include private doctors of the area as well as teaching attendings. ICU service / resident staffing differs depending on the time of year. In the first few blocks of the academic year the ICU is staffed by two senior residents,
while later in the academic year it is staffed by a senior resident and two interns.

b. **Types of Clinical Encounters:** The residents are responsible for all ICU admissions and discharges, in-house transfers, and hospital-to-hospital transfers to the intensive care unit. All admissions are to be performed in a timely manner, documented and discussed with appropriate attending. The residents are to perform comprehensive history and physicals and develop evidence based differentials and plans. Residents also dictate all history and physicals performed on ICU admissions within 24 hrs. Residents are expected to evaluate all unstable patients on the floor if requested by the responsible attendings. All interactions should be documented and attendings notified despite outcome or triage. Residents are expected to recognize criteria indicating appropriate ICU transfer and act accordingly. Residents are to become competent in ordering appropriate tests that may help in this decision.

c. **Disease Mix:** Residents are exposed to the full spectrum of intensive care diagnosis and management.

d. **Patient Characteristics:** As mentioned above.

e. **Services:** Residents are expected to perform as an important part of a multi-disciplinary team in the care of the patients. Multidisciplinary bedside work rounds are performed daily at 8:00 am and consist of residents, nursing, and pharmacy. During this time, all new admissions, pertinent changes overnight, concerns, and daily care plan are discussed. These multi-disciplinary rounds are led by the senior resident.

The daily care of patients including disease recognition and management, cost-effective and evidence based therapeutics, and discharge / transfer planning is the residents’ responsibility. Daily progress notes are to be comprehensive and legible. They should include patient’s current status and pertinent changes, vitals (including weights, I/Os), medications, physical, and assessment and plan. Orders are also the responsibility of the residents. Residents are expected to interpret CXRs, EKGs, ABGs, and laboratory values and apply this knowledge appropriately. It is expected that ICU residents keep a detailed up-to-date list and give accurate and comprehensive sign-outs to oncoming physicians. They are expected to demonstrate effective communication skills with patients, families, and other health care personnel. By the end of their rotation, they should feel comfortable and competent in end of life discussions and care.

It is mandatory for all residents to attend codes despite location in the hospital. They are expected to become comfortable and competent in code situations and should “run” codes dependant on their skill and comfort level. All code activities should be documented. Attending physicians should be notified at the time of the code, and responsible family members should be kept up to date by responsible residents as well.

f. **Procedures:** The ICU is the main site for procedures. It is expected that throughout your rotation, when feasible, you will try to learn and perform as many procedures as possible. The procedures are to be discussed with the attending prior to being performed and thoroughly documented in myevaluations.com. Detailed Procedures Curriculum is referred to at the end of the ICU curriculum though it is understood that the residents will utilize every opportunity that comes their way, during their years of training at WCGME, to become competent in the various procedures.

g. **Pathological Materials:** As available on a case-to-case basis.

**IV. Principal Ancillary Educational Materials / Educational Resources**
a. Reading List: Suggested reading includes appropriate topics from:


Residents are expected to utilize the excellent ICU resource of “Resident ICU Course (RICU)” during their ICU rotations. Its web address is [http://sccmwww.sccm.org/ricu/RICUWelcome.aspx](http://sccmwww.sccm.org/ricu/RICUWelcome.aspx) and password to access the website will be provided to them.

b. Disease Index: By the end of the rotation, residents should be able to identify and manage:

- Respiratory distress (including basic knowledge of ventilators and NIV)
- Acute coronary syndromes and their complications (MI, arrhythmias, CHF)
- Stroke syndromes
- Sepsis
- Post-op care
- Work-up and management of mental status changes
- End-of-life care
- Acute renal failure and indications for dialysis
- Metabolic disorders (acid/base, electrolytes, DKA)
- Hypotension / hypertension
- GI bleeds
- Drug overdoses
- Management of delirium

It is also expected that the residents have a solid knowledge base of critical care pharmacology, nutrition options, ventilator and fluid management.

V. Methods of Evaluation

a. Resident Performance: The rotation attending, using the standard resident evaluation form, will formally evaluate the residents at the conclusion of the rotation. The completed evaluation is then forwarded to the program director for review. Attempt will be made to directly discuss the resident’s performance at mid-term and at conclusion of the rotation.

Nursing evaluation for each resident is also obtained.

b. Faculty Performance: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives
Intern Responsibilities (PGY-1)

1. To be the “first responder” to all ED ICU admissions, floor to ICU transfers, and ICU calls. Initially, the intern is required to evaluate the patients under the supervision of the senior resident but as comfort level and skill progress, he / she may first see the patient alone.

2. To obtain a detailed and pertinent history and physical exam, utilizing all available data (old records, nursing home reports, family and caretaker reports, and ancillary staff records) and synthesize a comprehensive and legible history and physical.

3. To develop a differential and plan, based on existing knowledge and results and apply evidence based practice under the supervision of a senior resident. Depending on comfort level, initial order set may be written and then discussed with the senior.

4. Along with the other intern, PGY-1s are responsible for seeing all patients in the ICU, writing their daily progress notes, and discussing them with their senior resident and / or attending. This is to be done efficiently and based on the format stated above. They are also expected to thoroughly know all aspects of their patients and be able to present cases if called upon to do so.

5. They are responsible to follow-up on any tests, procedures, etc. throughout the day and continue to modify the plan and treatment.

6. To be able to appropriately manage disease states, under the supervision of the senior, including fluid management, medications, lab and diagnostic testing, nutrition, and discharge planning.

7. To start to understand the indications, risks vs. benefits, and cost of different diagnostic testing.

8. To order daily labs and medications under guidance from senior/ attending.

9. To dictate all history and physicals and, after Dec 31st, all discharge summaries in the ICU.

10. To further their medical knowledge by taking an active approach to reading and learning about the medical problems encountered in the ICU.

11. To actively seek out procedures and learning opportunities when available.

12. To learn how to effectively participate and communicate within a multi-disciplinary team.

13. Interns are responsible for updating the ICU patient list daily, including code status, meds, problems, and plan.

14. To become comfortable in code situations and to become an active member in the code, eventually progressing to be able to “run” the code.

15. To begin to learn skills in communication and discussion of end-of-life care and education of family, etc.

16. To be receptive to constructive criticism and seek out ways to continue to improve.

17. To have knowledge of the different protocols and know when they need to be implemented.

18. To prepare a case for Thursday ICU morning report including pertinent X-rays, scans, etc. Also, if appropriate, to apply journals and evidence-based teaching materials to the topic. If asked, resident is to participate in ICU journal club as well.

Senior Resident Responsibilities (PGY-2, PGY-3)

1. To oversee all intern interactions, including admissions, transfers, and discussions with attendings as well as to review all H&Ps, orders, and management plans. They are to call the attendings to discuss care plan until it is felt that the intern is capable of performing this task alone.

2. When there are two seniors in the ICU, they are to equally split the responsibilities in the ICU as well as with any transfers/ admissions. They are to perform all the activities stated above for the intern. They are solely responsible for all aspects of the care of their patients, however they still must discuss management plan with the concerned attending.

3. When there is a senior with two interns in the ICU, even though the seniors are not writing notes
on the patients, however, they are responsible for knowing each patient and must be able to
discuss their care with the attending. It is expected that the senior should personally examine
and review labs on every patient in the ICU.

4. Seniors are expected to be available and approachable at all times for the interns. They should
teach as much as possible with special emphasis on development of differentials, appropriate
management of disease states, involvement in obtaining procedures, and overall patient care.

5. Seniors should teach interns how to read EKGs, CXRs, and evaluate acid / base disturbances.

6. Seniors should lead and organize the daily multidisciplinary rounds. They should have knowledge
of the general plan for the day of each patient and work to be sure it is implemented. They are
to coordinate all aspects of the patient’s management and utilize appropriate systems to ensure
safety, quality, and seamless patient care.

7. Seniors are advised to continue to expand their knowledge base with various modalities such as
journals, uptodate, MKSAP, and board review questions. They are expected to practice evidence-
based medicine and teach others as well. Seniors are responsible for the teaching of medical
students and the interns and they should employ bedside teaching whenever possible.

8. Seniors are expected to help interns with the case they choose to present for the ICU morning
report and to have additional cases / journal review ready, if necessary.

9. Seniors are to continue to learn system-based practices as well as start to apply medical
economics (i.e. LOS, cost / benefit ratios) to the cases they see. They are expected to show the
interns how this pertains to their patients and how the outcome affects everyone.

10. Senior residents are expected to lead the discussions in end-of life care until intern gains the
comfort level and skill. Seniors also need to know well the indications and procedures involved
with terminal weaning, sedation etc., so that they can effectively and compassionately explain
this to the patient’s family.

11. By the time a resident is PGY-3, it is felt they should be certified and be able to teach all ABIM
procedures. It is their responsibility to complete this and also to assist the interns in obtaining
these skills.

12. Seniors should be competent in the evaluation and management of disease states as described
above. They should also be comfortable with routine ventilator care including adjustments based
on ABGs as well as indications. They should be able to evaluate EKGs and CXRs with confidence
and use this information to aid in decision making. They should be able to choose appropriate
medications based on clinical decision making and be able to explain to others why they chose
them. They should know when to involve consultants and be able to present cases effectively
and completely. They should also be very comfortable in code situations and be able to lead and
instruct others.

ICU ROTATION EXPECTATIONS
<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
</table>
| **Patient Care Interviewing**     | • Resident will obtain a detailed HPI emphasizing chronology of presentation and containing good descriptions of symptoms.  
• Resident will present without notes.  
• Resident’s presentation will include appropriate pertinent positives and negatives.  
• Resident will use appropriate non-patient sources of data if patient cannot give a history.                                                                                                                                                                                                                       |
| **Patient Care Physical Examination** | • Resident will tailor the physical examination to the patient’s complaint.  
• Resident will be able to accurately identify and characterize the signs and stages of septic, cardiovascular, and hypovolemic shock.  
• Resident will be able to identify and characterize cardiac murmurs and sounds.  
• Resident will be able to identify and characterize pulmonary auscultatory findings.                                                                                                                                                                                                                   |
| **Medical Knowledge**             | • Resident understands the epidemiology, pathophysiology, and pharmacology of common critical illness including ARDS, MODS, pulmonary embolus, shock, vegetative state and brain death, ketoacidosis and hyperosmolar coma, asthma and COPD, and psychosis and delirium in the ICU setting.  
• Resident will develop experience in the use of vasoactive drugs.                                                                                                                                                                                                                                       |
| **Procedural Skills**             | • Resident will develop competency in the placement of central venous and arterial catheters.  
• Resident will demonstrate developing competency in the use of ventilatory support.                                                                                                                                                                                                                                                                     |
| **Practice-Based Learning and Improvement** | • Resident prioritizes diagnostic and therapeutic decisions based on patient’s severity of illness.  
• Resident will develop clinical judgment in the strategies used to match treatment protocols with critical illness.  
• Resident will attend all ICU conferences including morning reports, journal clubs.  
• Resident will achieve RIME specific criteria for PGY-1 resident.                                                                                                                                                                                                                                         |
| **Systems-Based Practice**        | • Resident can effectively initiate the appropriate clinical pathways.  
• Resident can effectively initiate the appropriate consultative services.  
• Resident develops a multidisciplinary approach to medical intensive care.                                                                                                                                                                                                                                                                                    |
| **Interpersonal and Communication Skills** | • Resident communicates regularly with patient and his / her family.  
• Resident is respectful to the patient.  
• Resident is concerned about the patient’s comfort.  
• Resident communicates effectively with other members of the health care team.                                                                                                                                                                                                                          |
| **Professionalism**               | • Resident completes the history and physical / consultation within 24 hours of contact, and writes a daily progress note.  
• Resident will follow through with scholarly assignments promptly.  
• Resident completes medical records on time.  
• Resident recognizes and takes steps to correct his / her deficiencies.  
• Resident treats team members, including nurses and other health care providers, with respect.  
• Resident acknowledges personal reaction to morbidity and mortality associated with the ICU setting.  
• Resident adheres to all ACGME mandated duty hour restrictions.                                                                                                                                                                                                                                   |
PGY-2

Competency at each year includes continued demonstration of the preceding year’s competency goals.

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>• Resident will obtain a detailed HPI emphasizing chronology of presentation and containing good descriptions of symptoms.</td>
</tr>
<tr>
<td>Interviewing</td>
<td>• Resident will present without notes.</td>
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<tr>
<td></td>
<td>• Resident’s presentation will include appropriate pertinent positives and negatives.</td>
</tr>
<tr>
<td></td>
<td>• Resident will use appropriate non-patient sources of data if patient cannot give a history.</td>
</tr>
<tr>
<td>Patient Care</td>
<td>• Resident will tailor the physical examination to the patient’s complaint.</td>
</tr>
<tr>
<td>Physical Examination</td>
<td>• Resident will be able to accurately identify and characterize the signs and stages of septic, cardiovascular, and hypovolemic shock.</td>
</tr>
<tr>
<td></td>
<td>• Resident will be able to identify and characterize cardiac murmurs and sounds.</td>
</tr>
<tr>
<td></td>
<td>• Resident will be able to identify and characterize pulmonary auscultatory findings.</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>• Resident understands the epidemiology, pathophysiology, and pharmacology of common critical illness including ARDS, MODS, pulmonary embolus, shock, vegetative state and brain death, ketoacidosis and hyperosmolar coma, asthma and COPD, and psychosis and delirium in the ICU setting.</td>
</tr>
<tr>
<td></td>
<td>• Resident will demonstrate competency in the use of vasoactive drugs.</td>
</tr>
<tr>
<td>Procedural Skills</td>
<td>• Resident will achieve or demonstrate competency in all ABIM required procedures as patient case mix allows.</td>
</tr>
<tr>
<td></td>
<td>• Resident will demonstrate competency in the use of ventilatory support.</td>
</tr>
<tr>
<td>Practice-Based Learning and</td>
<td>• Resident prioritizes diagnostic and therapeutic decisions based on patient’s severity of illness.</td>
</tr>
<tr>
<td>Improvement</td>
<td>• Resident will develop clinical judgment in the strategies used to match treatment protocols with critical illness.</td>
</tr>
<tr>
<td></td>
<td>• Resident will attend all ICU conferences including morning reports, journal clubs.</td>
</tr>
<tr>
<td></td>
<td>• Resident will achieve RIME specific criteria for PGY-2 resident.</td>
</tr>
<tr>
<td>Systems-Based Practice</td>
<td>• Resident can effectively initiate the appropriate clinical pathways.</td>
</tr>
<tr>
<td></td>
<td>• Resident can effectively initiate the appropriate consultative services.</td>
</tr>
<tr>
<td></td>
<td>• Resident develops a multidisciplinary approach to medical intensive care.</td>
</tr>
<tr>
<td></td>
<td>• Resident serves as a consultant to other services with moderate faculty input.</td>
</tr>
<tr>
<td>Interpersonal Skills and</td>
<td>• Resident communicates regularly with patient and his / her family.</td>
</tr>
<tr>
<td>Communication</td>
<td>• Resident is respectful to the patient.</td>
</tr>
<tr>
<td></td>
<td>• Resident is concerned about the patient’s comfort.</td>
</tr>
<tr>
<td></td>
<td>• Resident addresses patient care issues such as end-of-life decisions with moderate faculty input.</td>
</tr>
<tr>
<td></td>
<td>• Resident provides feedback to junior team members.</td>
</tr>
<tr>
<td></td>
<td>• Resident functions as an effective team leader.</td>
</tr>
<tr>
<td>Professionalism</td>
<td>• Resident has history and physical / consultation on chart within 24 hours of admission or consultation, and writes a daily progress note.</td>
</tr>
<tr>
<td></td>
<td>• Resident will follow through with scholarly assignments promptly.</td>
</tr>
<tr>
<td></td>
<td>• Resident completes medical records on time.</td>
</tr>
<tr>
<td></td>
<td>• Resident recognizes and takes steps to correct his / her deficiencies.</td>
</tr>
<tr>
<td></td>
<td>• Resident treats team members, including nurses and other health care providers, with respect.</td>
</tr>
<tr>
<td></td>
<td>• Resident counsels junior team members on issues of professionalism including personal reactions to the morbidity and mortality associated with the care of patients requiring intensive medical management.</td>
</tr>
<tr>
<td></td>
<td>• Resident adheres to all ACGME mandated duty hour restrictions.</td>
</tr>
</tbody>
</table>
### ICU Rotation Expectations

**PGY-3** Competency at each year includes continued demonstration of the preceding year’s competency goals.

**PROCEDURES CURRICULUM**

<table>
<thead>
<tr>
<th><strong>Patient Care</strong></th>
<th><strong>Interviewing</strong></th>
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<tr>
<th><strong>Patient Care</strong></th>
<th><strong>Physical Examination</strong></th>
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<tr>
<td>• Resident will tailor the physical examination to the patient’s complaint.</td>
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<th><strong>Medical Knowledge</strong></th>
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<td>• Resident understands the epidemiology, pathophysiology, and pharmacology of common critical illness including ARDS, MODS, pulmonary embolus, shock, vegetative state and brain death, ketoacidosis and hyperosmolar coma, asthma and COPD, and psychosis and delirium in the ICU setting.</td>
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<th><strong>Procedural Skills</strong></th>
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<td>• Resident will achieve or demonstrate competency in all ABIM required procedures as patient case mix allows.</td>
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<td>• Resident will demonstrate competency in the use of ventilatory support.</td>
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<tr>
<th><strong>Practice-Based Learning and Improvement</strong></th>
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<td>• Resident prioritizes diagnostic and therapeutic decisions based on patient’s severity of illness.</td>
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<td>• Resident will develop clinical judgment in the strategies used to match treatment protocols with critical illness.</td>
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<td>• Resident will attend all ICU conferences including morning reports, journal clubs.</td>
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<td>• Resident will achieve RIME specific criteria for PGY-3 resident.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Systems-Based Practice</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Resident can effectively initiate the appropriate clinical pathways.</td>
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<td>• Resident can effectively initiate the appropriate consultative services.</td>
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<tr>
<td>• Resident develops a multidisciplinary approach to medical intensive care.</td>
</tr>
<tr>
<td>• Resident serves as a consultant to other services with minimal faculty input.</td>
</tr>
<tr>
<td>• Resident critically evaluates all consultant evaluations including conflicting recommendation to develop an effective patient care plan.</td>
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</tbody>
</table>

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<th><strong>Interpersonal and Communication Skills</strong></th>
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<td>• Resident communicates regularly with patient and his/her family.</td>
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<td>• Resident is respectful to the patient.</td>
</tr>
<tr>
<td>• Resident is concerned about the patient’s comfort.</td>
</tr>
<tr>
<td>• Resident is able to deal with challenging patients and families.</td>
</tr>
<tr>
<td>• Resident effectively coordinates team to optimize patient care and functions as an effective team leader.</td>
</tr>
</tbody>
</table>

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<th><strong>Professionalism</strong></th>
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<tr>
<td>• Resident has the history and physical / consultation completed within 24 hours of contact, and writes a daily progress note.</td>
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<td>• Resident will follow through with scholarly assignments promptly.</td>
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<td>• Resident completes medical records on time.</td>
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<td>• Resident recognizes and takes steps to correct his/her deficiencies.</td>
</tr>
<tr>
<td>• Resident treats team members, including nurses and other health care providers, with respect.</td>
</tr>
<tr>
<td>• Resident identifies ethical issues and employs available resources to solve them.</td>
</tr>
<tr>
<td>• Resident counsels junior team members on issues of professionalism including personal reactions to the morbidity and mortality associated with the care of patients requiring intensive medical management.</td>
</tr>
<tr>
<td>• Resident sets a tone of respect and collegiality for the team.</td>
</tr>
<tr>
<td>• Resident adheres to all ACGME mandated duty hour restrictions</td>
</tr>
</tbody>
</table>
Knowledge competency

All residents must develop fundamental knowledge regarding the procedures below. They must develop an understanding of and be able to effectively communicate to patients the indications, contraindications, risks and benefits of a given procedure in the process of obtaining informed consent. They must demonstrate knowledge of sterile technique and pain management, specimen handling, as well as interpretation of results and communication of this information to patients. They must also know the frequency of and how to recognize and manage the common complications of the procedure.

Arterial line insertion
Arthrocentesis
Central line insertion including the use of ultrasound guidance
I & D of an abscess
Lumbar puncture
Nasogastric tube insertion
Pulmonary artery catheter insertion
Paracentesis
Thoracentesis

Knowledge and Performance competency

Mandatory procedures for which all WCGME Internal Medicine residents must develop both knowledge and performance competency:

ACLS
Aseptic technique
Drawing arterial blood
Pap smear and endocervical culture
Drawing venous blood
Placing IV line

Once a resident has demonstrated competency in a given procedure, he/she should not be required to perform routine procedures such as placing IVs and drawing blood, but may be asked to perform these procedures under emergent circumstances.

Procedures opportunity

Procedures for which all the residents should have the opportunity to achieve procedural competency, if the resident identifies such competency as relevant to his/her future practice needs:

Arterial line insertion
Arthrocentesis
Central line insertion including the use of ultrasound guidance
I & D of and abscess
Lumbar puncture
Nasogastric tube insertion
Pulmonary artery catheter insertion
Paracentesis
Thoracentesis
Cryosurgical removal of skin lesion
Skin biopsy
Elective cardioversion
Endotracheal intubation
Soft tissue and joint injection
Temporary pacemaker placement  
Treadmill exercise testing

All procedures require direct supervision until it is documented that the resident is certified with enough experience, as outlined below, to safely perform the procedure. The number of satisfactory observations required depends upon the complexity of the skill and the likelihood of complications. Supervision may be by an attending physician, subspecialist or a more advanced, certified resident. Residents must successfully complete the minimal number of a particular procedure under direct supervision before they can supervise other residents’ performance. At Mercy hospital, the hospitalists are willing to teach and supervise resident procedures if consulted.

Simulations for review through the MyEvaluations.com/ELSEVIER ProceduresConsult.com software are available to enhance residents’ procedural knowledge prior to patient exposure. Certification in all the mentioned procedures is no longer mandated by the ABIM, but WCGME is committed to providing universal residential exposure to common internal medicine procedures and ample opportunity to perform procedures to all residents interested in certification.

Residents are expected to complete the knowledge education and test in all above required procedures and to document knowledge and procedural competency for the short list of mandatory procedures above by the end of their training. Residents are encouraged to make procedural requirements a focus of their educational activities during the ICU rotations. During the Moses Taylor Hospital ICU experience, residents must document certification in aseptic techniques under the direct supervision of Ms. Diane Ross. During the ICU experience, residents must also complete the knowledge modules for ultrasound guidance of central line placements and participate in an educational session from the vascular radiology department gaining familiarity with the ultrasound machine used for this purpose.

Only procedures documented in the procedure area of our on line evaluation system will be counted at the completion of training to promote certification and verify certification to requesting future employers. If paper log books are used by the individual resident for tracking, the supervising resident or attending must be documented in the procedure log book and entered into the electronic database at a later time by the resident. All procedures documented must be electronically signed by or on behalf of the supervising doctor by an appointed designee. In addition, the indication for the procedure as well as complications must also be recorded.

**Minimum number of each procedure required for certification**

**Five**
- Drawing arterial blood
- Pap smear and endocervical culture
- Placing IV line
- Central line insertion (Jugular vein-5, Subclavian vein-5, Femoral vein-5)
- Lumbar puncture
- Paracentesis
- Thoracentesis

**Three**
- Drawing venous blood
- Arterial line insertion
- I & D of an abscess
- Arthrocentesis
- Nasogastric tube insertion
- Pulmonary artery catheter insertion
- Aseptic technique
MEDICAL OPHTHALMOLOGY CURRICULUM

I. Educational Purpose and Goals

The medical ophthalmology elective is intended to allow internal medicine residents opportunities to develop history and physical examination skills, competence in the use of technology, diagnostic testing, and medication prescription, and exposure to basic ophthalmologic care under the supervision of a board-certified ophthalmologist.

At the completion of this clinical experience, the learner will:

• Understand the pathophysiology and common ocular manifestations of systemic disorders such as diabetic and hypertensive retinopathy, thyroid eye disease, and neurologic disease (particularly, pupillary and visual field abnormalities associated with neurologic disease).
• Understand basic management principles in patients with glaucoma.
• Be able to perform an initial evaluation of a patient with visual disturbance and to recognize sight and life threatening ocular emergencies, specifically, temporal arteritis, angle closure glaucoma, retinal detachment, amaurosis fugax, retinal detachment.
• Acquire basic skills in slit lamp exam to allow diagnosis and basic management of common anterior segment ocular problems such as the red eye, dry eye, foreign body, superficial corneal abrasions.

II. Principal Teaching Methods

Residents are expected to participate in direct patient care under the supervision of a board-certified ophthalmology attending physician. Residents will spend two to four weeks in the offices of Northeastern Eye Institute. The supervising attending may vary on a day-to-day or a weekly basis. Whenever possible, patients will be evaluated first by the resident, who will then present the case to the ophthalmology attending prior to implementing a plan of care. The decision regarding which patients are most suitable for medicine residents is left to the discretion of the ophthalmology attending, to allow the resident to become familiar with aspects of ophthalmologic care that can be diagnosed and managed by general internists.

Residents are expected to obtain a focused and pertinent history prior to performing a physical examination. After discussion with the attending physician, a physical examination, including a dilated eye exam, is expected to be performed, as appropriate, under supervision. Residents are expected to develop a differential diagnosis, as well as an appropriate plan of care, including further studies, testing, and medication, as appropriate.

Residents are expected to begin reading the core reading material prior to the start of their rotation, and are expected to complete it during their rotation. Ophthalmology attendings also may supplement cases seen with discussions of common problems not encountered during that session.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Medical ophthalmology experience is gained at the outpatient offices of the Northeastern Eye Institute in downtown Scranton.

b. Types of Clinical Encounters: Medical ophthalmology training for internal medicine residents is mainly in the outpatient setting and allows the residents to become familiar with aspects of ophthalmologic care that can be diagnosed and managed by general internists.
c. **Disease Mix:** Residents will be exposed to the full spectrum of ophthalmologic disease presenting for care at the attending ophthalmologist’s private outpatient office. Residents will not be provided a unique schedule; however, they will be able to interview and examine patients from the daily schedules at the attending physicians’ discretion to best meet their educational needs.

d. **Patient Characteristics:** Care is provided at the attending physician’s offices for patients ranging from adolescence to geriatric ages. The racial and ethnic distribution closely matches that of surrounding area. When English is not the primary spoken language, interpreters should be available to assist in the patient care setting, either through direct interview or via a remote language line service.

e. **Services:** All care will be under the direct supervision of a board-certified attending ophthalmologist.

f. **Procedures:** Medicine residents are expected to observe, perform, and interpret routine ophthalmologic tests and examinations.

g. **Pathological Materials:** None

**IV. Principal Ancillary Educational Materials / Educational Resources**

a. **Reading List:**
   
   
   

b. **Educational Resources:** In addition to the reading list provided, residents will have available to them library resources at both Mercy and Moses Taylor Hospitals along with internet-based resources to review medicine and otorhinolaryngology topics.

**V. Methods of Evaluation**

a. **Resident Performance:** Attending evaluations will be completed on each resident upon completion of the medical ophthalmology rotation. Residents will receive a summarized evaluation at the end of the rotation with both verbal and written comments.

b. **Faculty Performance:** Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. **Program Performance:** Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

**VI. Rotation Specific Progressive Learning Goals and Competency Objectives**
<table>
<thead>
<tr>
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<th>Expected Behaviors / Skills</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
<tr>
<td>Interviewing</td>
<td>• Resident will obtain a focused or a complete H&amp;P, as appropriate, for all ophthalmology patients.</td>
</tr>
<tr>
<td></td>
<td>• Residents should present cases with appropriate details of chief complaint.</td>
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<tr>
<td></td>
<td>• Resident will use interpretation service when patient cannot communicate in spoken English.</td>
</tr>
<tr>
<td>Patient Care</td>
<td></td>
</tr>
<tr>
<td>Physical Examination</td>
<td>• Resident will perform focused or detailed physical examination, as appropriate. This includes, but is not limited to, fundus examination and slit lamp examination.</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>• Resident will understand the epidemiology, evaluation, and treatment of common ophthalmologic diseases encountered by the general internist.</td>
</tr>
<tr>
<td>Procedural Skills</td>
<td>• Resident will develop experience and competence in the performance of eye examinations, including fundoscopic and slit lamp exams.</td>
</tr>
<tr>
<td>Practice-Based Learning and Improvement</td>
<td>• Resident will prioritize diagnostic and treatment decisions based on the severity of illness.</td>
</tr>
<tr>
<td></td>
<td>• Resident will develop clinical judgment regarding therapeutic decisions.</td>
</tr>
<tr>
<td></td>
<td>• Resident will participate as part of the team in providing care.</td>
</tr>
<tr>
<td></td>
<td>• Resident will seek and accept feedback.</td>
</tr>
<tr>
<td>Systems-Based Practice</td>
<td>• Resident can effectively initiate the appropriate clinical pathways.</td>
</tr>
<tr>
<td></td>
<td>• Resident can appropriately use further consultants in the care of the patient.</td>
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<tr>
<td></td>
<td>• Resident will be prepared to integrate information into a multidisciplinary approach to ophthalmologic care.</td>
</tr>
<tr>
<td>Interpersonal and Communication Skills</td>
<td>• Resident communicates effectively with patients and his / her family members.</td>
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<td>• Resident is concerned about patient comfort.</td>
</tr>
<tr>
<td></td>
<td>• Resident involves patient in discussions about further care.</td>
</tr>
<tr>
<td>Professionalism</td>
<td>• Resident completes all work prior to leaving ophthalmologist's office.</td>
</tr>
<tr>
<td></td>
<td>• Resident offers assistance to other team members, as necessary.</td>
</tr>
<tr>
<td></td>
<td>• Resident completes assigned required reading.</td>
</tr>
<tr>
<td></td>
<td>• Resident recognizes and takes steps to correct perceived deficiencies.</td>
</tr>
<tr>
<td></td>
<td>• Resident treats staff and other team members with respect.</td>
</tr>
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</table>
MEDICAL OPHTHALMOLOGY ROTATION SELF DIRECTED LEARNING CHECKLIST

Name: _______________________________  Rotation Dates: ____________

Informal Discussion / Self Directed Learning Topics:

<table>
<thead>
<tr>
<th>Checklist</th>
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<tbody>
<tr>
<td>Glaucoma</td>
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<tr>
<td>Vision Impairment</td>
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<tr>
<td>Dry Eyes</td>
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<td>Red Eye</td>
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<tr>
<td>Cataract</td>
</tr>
<tr>
<td>Foreign Bodies</td>
</tr>
<tr>
<td>Eye Manifestations of Systemic Disease</td>
</tr>
<tr>
<td>Other</td>
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</tbody>
</table>

Clinical Exposure:

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<tbody>
<tr>
<td>Physical Examination of the Eye</td>
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<tr>
<td>Observed Fundus Examination</td>
</tr>
<tr>
<td>Observed Slit Lamp Examination</td>
</tr>
<tr>
<td>Fluorescein Eye Staining</td>
</tr>
<tr>
<td>Interpreting Visual Fields</td>
</tr>
</tbody>
</table>

130
I. Educational Purpose and Goals

The nephrology rotation is designed to provide residents with an understanding of the pathophysiologic basis of renal disease. Emphasis is placed on active resident participation in the diagnosis and management of patients with renal disease based on an understanding of the physiologic changes that occur in the disease process. Understanding normal physiology of fluid and electrolyte balance and the alterations that occur in disease states will be an integral part of rotation. Diagnosis and management of primary and secondary hypertension will also be included.

II. Principal Teaching Methods

Residents learn nephrology through supervised direct patient care. For a four-week block, residents work one-on-one with a faculty nephrologist who directly supervises all resident activities, both in the inpatient and outpatient setting.

In general, this rotation is offered to one resident per block. While PGY-2/3 are preferred, PGY-1 residents can also request the rotation.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Patient care responsibilities will mainly be centered on the inpatient setting at either Mercy Hospital or Moses Taylor Hospital. Inpatients are seen either as primary patients admitted under the nephrologists’ care or as consults requested through other specialties. Outpatient nephrology training occurs in the private clinic(s) of the staff nephrologist.

b. Types of Clinical Encounters: Mainly inpatient but also outpatient encounters in the private offices of the faculty nephrologists. Residents will write all nephrology orders and progress notes on the inpatients which they follow along with the faculty nephrologist. No clinical activity will occur without being supervised.

c. Disease Mix: Residents are exposed to the full spectrum of renal disease diagnosis and management.

d. Patient Characteristics: Patient care is provided for adolescent through geriatric age patients. Patients of both sexes and all ethnic backgrounds are seen while on nephrology rotation. When English is not the primary language, interpreters are available for translation service in all patient care settings.

e. Services: Residents will work directly with the faculty nephrologist in both the inpatient and the outpatient settings. No clinical activity will occur without being supervised.

f. Procedures: Residents may be exposed to the following procedures during their nephrology rotation:
   1. Urinalysis, especially looking at cellular elements and sediments under the microscope
   2. Observing percutaneous renal biopsy
   3. Assisting in the placement of central venous access for renal replacement therapy.

g. Pathological Materials: Renal biopsies may be reviewed, if available, during the rotation.
IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List:
   A. UpToDate: Sections on the following topics should especially be reviewed during the course of the rotation:
      1. Renal failure, acute and chronic
      2. Acid base disorders, simple and mixed
      3. Hyponatremia, hypernatremia
      4. Hypokalemia, hyperkalemia
      5. Hypertension, primary and secondary
      6. Diabetic nephropathy
      7. Uremia
      8. Types of renal replacement therapies with their advantages and disadvantages
      9. Secondary hyperparathyroidism


   E. Peer reviewed current literature based upon patient mix and reading assignments

V. Methods of Evaluation

   a. Resident Performance: Residents will receive continuous formative evaluations throughout the rotation with a mid rotation review as well as a summarized evaluation at the end of the rotation. This will include verbal as well as written (online) evaluation. Residents will also receive feedback regarding any presentations completed while on rotation.

   b. Faculty Performance: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

   c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
</table>

132
| Patient Care Interviewing | • Resident will obtain a detailed HPI emphasizing chronology of presentation and containing good descriptions of symptoms.  
• Resident will present without notes.  
• Resident’s presentation will include appropriate pertinent positives and negatives.  
• Resident will use appropriate non-patient sources of data if patient cannot give a history. |
|--------------------------|--------------------------------------------------------------------------------------------------|
| Patient Care Physical Examination | • Resident will learn to tailor the physical examination to the patient’s complaint.  
• Resident will be able to identify most signs and symptoms of nephrotic syndrome, chronic kidney disease, and various fluid and electrolyte disturbances. |
| Medical Knowledge | • Resident demonstrates basic understanding of the epidemiology, pathophysiology, and pharmacology of common nephrologic disease including nephrotic syndrome, nephritic syndrome, glomerulonephritis, acute renal failure, chronic kidney disease, common electrolyte abnormalities and acid-base disorders associated with renal disease, infections of the GU system, and renal manifestations of systemic disease.  
• Resident demonstrates an understanding of the impact of renal disease on other major organ systems, i.e. secondary hyperparathyroidism, anemia of chronic kidney disease.  
• Resident demonstrates understanding of the diagnosis and management of acute and chronic medical problems in patients with chronic kidney disease.  
• Resident demonstrates an understanding of the management of hypertension.  
• Resident demonstrates understanding of the physiology of calcium / phosphate metabolism, particularly as it relates to renal bone disease. |
| Procedural Skills | • Resident will demonstrate basic understanding of the microscopic examination of urine and the identification of cellular elements and sediments. |
| Practice-Based Learning and Improvement | • Resident prioritizes diagnosis and treatment decisions based on patient’s severity of illness.  
• Resident will develop clinical judgment in the strategies used to match treatment protocols with renal disease. |
| Systems-Based Practice | • Resident will learn to initiate the appropriate clinical pathways.  
• Resident can effectively initiate appropriate use of consultant in the care of patients suffering from renal disease.  
• Resident will serve as a consultant to other services with moderate faculty input. |
| Interpersonal and Communication Skills | • Resident communicates regularly with patient and his / her family.  
• Resident is respectful to the patient.  
• Resident is concerned about the patient’s comfort.  
• Resident addresses patient care issues such as end of life decisions with moderate faculty input. |
| Professionalism | • Resident has history and physical / consultation on chart within 24 hours of admission or consultation, and writes a daily progress note.  
• Resident will follow through with scholarly assignments promptly.  
• Resident completes medical records on time.  
• Resident recognizes and takes steps to correct his / her deficiencies.  
• Resident treats team members, including nurses and other health care providers, with respect.  
• Resident adheres to all ACGME mandated duty hour restrictions. |

**NEPHROLOGY ROTATION EXPECTATIONS**  
**PGY-1**

**NEPHROLOGY ROTATION EXPECTATIONS**  
**PGY-2, PGY-3**
Competency at each year includes continued demonstration of the preceding year’s competency goals.

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
</table>
| Patient Care Interviewing          | • Resident will obtain a detailed HPI emphasizing chronology of presentation and containing good descriptions of symptoms.  
• Resident will present without notes.  
• Resident’s presentation will include appropriate pertinent positives and negatives.  
• Resident will use appropriate non-patient sources of data if patient cannot give a history.                                                                                                                                                                                                  |
| Patient Care Physical Examination  | • Resident will tailor the physical examination to the patient’s complaint.  
• Resident will be able to identify signs and symptoms of nephrotic syndrome, chronic kidney disease, and various fluid and electrolyte disturbances.                                                                                                                                                   |
| Medical Knowledge                  | • Resident demonstrates understanding of the epidemiology, pathophysiology, and pharmacology of common nephrologic disease including nephrotic syndrome, nephritic syndrome, glomerulonephritis, acute renal failure, chronic kidney disease, common electrolyte abnormalities and acid-base disorders associated with renal disease, infections of the GU system, and renal manifestations of systemic disease.  
• Resident demonstrates understanding of the significance and limitations of laboratory tests employed for the assessment of renal function.  
• Resident demonstrates an understanding of the impact of renal disease on other major organ systems, i.e. secondary hyperparathyroidism, anemia of chronic kidney disease.  
• Resident demonstrates understanding of the diagnosis and management of acute and chronic medical problems in patients with chronic kidney disease.  
• Resident demonstrates an understanding of the management of hypertension and the diagnosis of secondary forms of hypertension.  
• Resident demonstrates understanding of the physiology of calcium / phosphate metabolism, particularly as it relates to renal bone disease.                                                                                                                                 |
| Procedural Skills                  | • Resident will demonstrate competence in the microscopic examination of urine and the identification of cellular elements and sediments, and demonstrate the ability to relate these findings to the patient’s clinical picture.  
• Resident will be competent to place central venous catheters.                                                                                                                                                                                                                                       |
| Practice-Based Learning and Improvement | • Resident prioritizes diagnosis and treatment decisions based on pt’s severity of illness.  
• Resident will develop clinical judgment in the strategies used to match treatment protocols with renal disease.                                                                                                                                                                                                 |
| Systems-Based Practice             | • Resident can effectively initiate the appropriate clinical pathways.  
• Resident can effectively initiate appropriate use of consultants in the care of patients suffering from renal diseases.  
• Resident will serve as a consultant to other services with minimal faculty input.                                                                                                                                                                                                                           |
| Interpersonal and Communication Skills | • Resident communicates regularly with patient and his / her family.  
• Resident is able to deal with challenging patients and families.  
• Resident effectively coordinates team to optimize patient care and functions as a team leader.                                                                                                                                                                                          |
| Professionalism                    | • Resident has the history and physical / consultation completed within 24 hours of contact, and writes a daily progress note.  
• Resident will follow through with scholarly assignments promptly.  
• Resident completes medical records on time.  
• Resident recognizes and takes steps to correct his / her deficiencies.  
• Resident treats team members, including nurses and other health care providers, with respect.  
• Resident counsels junior team members on issues of professionalism including personal reactions to the morbidity and mortality associated with the care of patients suffering from renal disease.  
• Resident sets the tone of respect and collegiality for the team.  
• Resident adheres to all ACGME mandated duty hour restrictions.                                                                                                                                                                                                                     |
I. Educational Purpose and Goals

Internists commonly encounter patients with various neurological disorders including those related to changes in mentation, sensation and strength. The basis of diagnosing neurological disorders is a careful, comprehensive history and a detailed physical examination. The goal of the neurology rotation is that at its completion it is expected that every resident will be able to demonstrate competency in the evaluation, diagnosis and treatment of common neurologic disorders.

II. Principal Teaching Methods

Residents learn neurology through supervised direct patient care. For a four-week block, residents work one-on-one with a faculty neurologist who directly supervises all resident activities, both in the inpatient and outpatient setting. Residents also have regular didactic sessions with the supervising attending on assigned topics as well as those encountered during patient rounds. Self-directed reading is expected on the topics encountered by the resident. The attending neurologist observes and critiques the resident while undergoing history and physical examination during both inpatient and outpatient settings.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Patient care responsibilities will mainly be centered on the inpatient setting at either Mercy Hospital or Moses Taylor Hospital. Inpatients are seen either as primary patients admitted under the neurologists’ care or as consults requested through other specialties. Outpatient neurology training occurs in the private clinic(s) of the staff neurologist.

b. Types of Clinical Encounters: Mainly inpatient but also outpatient encounters in the private offices of the faculty neurologists. Residents will write all neurology orders and progress notes on the inpatients which they follow along with the faculty neurologist. No clinical activity will occur without being supervised.

c. Disease Mix: Residents are exposed to the full spectrum of neurologic disease diagnosis and management.

d. Patient Characteristics: Patients evaluated on the neurology rotation range from adolescent to geriatric, belonging to both sexes and all ethnic backgrounds. Disorders may be subtle and slowly progressive, stable and inactive or acute and life threatening. Patients from all socioeconomic categories are encountered. Types of clinical encounters include inpatient and outpatient consultation as well as follow-up of chronic neurologic conditions. Patients are supervised by the faculty neurologist through joint inpatient consultations. The resident assists with the evaluation and management of patients in the private neurologist’s office, supervised by on-site faculty neurologists.

e. Services: Residents will work directly with the faculty nephrologist in both the inpatient and the outpatient settings. No clinical activity will occur without being supervised.

f. Procedures: Residents will be exposed to the proper utilization of electroencephalograms (EEG), electromyography (EMG), nerve conduction velocity (NCV) studies, muscle and nerve biopsy and interpretation of spinal fluid studies.
g. Pathological Materials: Residents are encouraged to review results of all biopsies performed on patients for whom they have consulted.

IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List:
   1. Neurology booklet of MKSAP
   2. Neurology section of Harrison’s Principles of Internal Medicine
   3. Neurology topics from Uptodate
   4. Relevant articles from NEJM and neurology journals

b. Disease Index: Topics emphasized during the neurology rotation include:
   1. Mastering the neurologic examination.
   2. Determining whether a neurologic problem is located in the neuroaxis or in the periphery.
   3. Distinguishing acute and subacute CNS conditions from chronic problems.
   4. Evaluation and management of cerebrovascular disease.
   5. Seizure disorders including status epilepticus, etiology and treatment.
   7. Acute encephalopathy.
   8. CNS infections including meningitis, encephalitis and abscesses.
   10. Guillian-Barre’ Syndrome
   11. Acute spinal cord syndromes including transverse myelitis and cord compression.
   12. Acute and subacute neuromuscular disorders.
   14. Headache, including migraine and chronic daily headache.
   15. Proper use of neurological imaging and other diagnostic modalities.
   17. Multiple sclerosis.
   19. Sleep disorders.

V. Methods of Evaluation

a. Resident Performance: Attending evaluations will be completed on each resident upon completion of the neurology rotation. Residents will receive a summarized evaluation at the end of the rotation with both verbal and written comments.

b. Faculty Performance: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives

NEUROLOGY ROTATION EXPECTATIONS
PGY-1, PGY-2, PGY-3
<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
</table>
| Patient Care Interviewing         | • Resident will obtain a detailed HPI emphasizing chronology of presentation and containing good descriptions of symptoms.  
• Resident will present without notes.  
• Resident’s presentation will include appropriate pertinent positives and negatives.  
• Resident will use appropriate non-patient sources of data if patient cannot give a history.                                                                 |
| Patient Care Physical Examination | • Resident will tailor the physical examination to the patient's complaint.  
• Resident will be able to identify signs and symptoms of cerebrovascular accidents, peripheral neuropathy, meningitis, encephalitis etc.                               |
| Medical Knowledge                 | • Resident demonstrates understanding of the epidemiology, pathophysiology, and pharmacology of common neurologic disease including cerebrovascular accidents, peripheral neuropathy, meningitis, encephalitis etc.  
• Resident demonstrates understanding of the significance and limitations of radiological tests employed for the assessment of neurologic disorders. |
| Procedural Skills                 | • Resident will be competent to do lumbar punctures.                                                                                                                                                                      |
| Practice-Based Learning and Improvement | • Resident prioritizes diagnosis and treatment decisions based on patient’s severity of illness.  
• Resident will develop clinical judgment in the strategies used to match treatment protocols with neurologic disease.                                           |
| Systems-Based Practice            | • Resident can effectively initiate appropriate use of consultants in the care of patients suffering from neurologic diseases.  
• Resident will serve as a consultant to other services with minimal to moderate faculty input.                                                                                                                   |
| Interpersonal and Communication Skills | • Resident communicates regularly with patient and his / her family.  
• Resident is able to deal with challenging patients and families.  
• Resident effectively coordinates team to optimize patient care and functions as a team leader.                                                                                                                   |
| Professionalism                   | • Resident has the history and physical / consultation completed within 24 hours of contact, and writes a daily progress note.  
• Resident will follow through with scholarly assignments promptly.  
• Resident completes medical records on time.  
• Resident recognizes and takes steps to correct his / her deficiencies.  
• Resident treats team members, including nurses and other health care providers, with respect.  
• Resident counsels junior team members on issues of professionalism including personal reactions to the morbidity and mortality associated with the care of patients suffering from neurologic disease.  
• Resident sets the tone of respect and collegiality for the team.  
• Resident adheres to all ACGME mandated duty hour restrictions.                                                                                                                                 |
NIGHT FLOAT CURRICULUM

I. Educational Purpose and Goals

The night float rotation exposes residents to patient care during non-traditional care hours. Areas of emphasis include history and physical examination skills, development of accurate differential diagnosis, appropriate use of diagnostic testing and evidence-based patient management. Residents also develop confidence in the interpretation of both chest X-rays and EKGs as well as appropriate case presentation to attendings.

II. Principal Teaching Methods

Every resident will have patient care experience during non-traditional care hours in the form of a night float rotation at Moses Taylor Hospital. The night float service is composed of an intern and an upper level resident who are both supervised by the on call faculty attending. This service provides coverage to all Moses Taylor Hospital teaching service admissions, already admitted teaching service patients and all ICU patients, new or already admitted. The night float team also responds to all codes and documents its active participation in detailed code notes. Every patient encounter should be promptly noted in the chart after discussion with an internal medicine attending and medical record requirements should be up to date.

The night float intern and senior resident are expected to be active multidisciplinary team players participating in daily, face-to-face quality sign out rounds at the beginning and end of the shift. Multidisciplinary ICU team sign outs will occur on a daily basis at 8:00 am with the senior night float member. For the floor service, the intern night float member will sign out to the service intern between 7:00 and 8:00 am. Night float responsibilities will begin with sign outs between 8:30 and 9:00 pm.

Night float attendance at morning report will depend on sleep status and duty hour compliance. In addition to learning through direct patient care, night float histories and physicals are used as content for the Friday morning report. The night float team leads the Friday morning report with case presentations from the senior resident early in the year and from the intern starting in October. Review of the night float's history and physical examination, management plans, lab studies, X-rays and EKGs is encouraged at this conference. Periodic feedback from the ward teams about adequacy of initial evaluation and case outcome should be expected by the night float team and ensured by the teaching service senior and attending.

The night float experience should improve competency:
• to proficiently evaluate, admit and manage medical inpatients in various hospital settings
• to accurately document patient assessment and care interventions
• to complete all procedures necessary for patient care with certified supervision
• to efficiently order and personally review necessary laboratory, radiological and EKG data
• to ensure seamless, safe patient care by actively promoting and participating in detailed and professional sign-out rounds.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Night float for both interns and senior residents is held at the Moses Taylor Hospital.
b. **Types of Clinical Encounters:** All clinical encounters occur either in the hospital or in the emergency room department. PGY-1 residents have primary responsibility for first response to all floor calls and to complete all admission history and physicals. PGY-2 or PGY-3 residents have responsibility for all ICU calls and they also supervise the interns initial evaluation of patients requiring admission.

c. **Disease Mix:** Patient care for the night float rotation reflects the full spectrum of hospitalized internal medicine.

d. **Patient Characteristics:** Patient demographics reflect the general population of the area. Age range is from adolescent to geriatric. All ethnic backgrounds are represented. Translation services are available for non-speaking English patients.

e. **Services:** Night float residents provide coverage as discussed above.

f. **Procedures:** The night float team is expected to complete any and all procedures necessary for patient care delivery. Residents must be certified and confident to complete those procedures, and the procedure must be first discussed with the attending on call. If residents are not certified to complete the required procedure, the appropriate sub-specialist will be contacted to perform the procedure or, if he is willing, to supervise and instruct the resident in the procedure.

g. **Pathological Materials:** When available, are incorporated into the morning report.

IV. **Principal Ancillary Educational Materials / Educational Resources**

a. **Reading List:** In addition to selected reading, addressing frequent clinical scenarios encountered during the night float rotation, residents are encourage to review updated material on all the diagnoses they actually encounter during the night float.

b. **Disease Index:** Kindly refer to the General Inpatient Medicine curricula.

V. **Methods of Evaluation**

a. **Resident Performance:** Night float portfolio, an essential part of the resident portfolio, is one of the ways used to evaluate the night float team members. It includes the following:
   1. Documentation of feedback and critique on a history and physical and assessment and plan done during the night and presented during the Friday morning report. One for each night float block (Patient Care, Medical Knowledge, Interpersonal and Communication Skills).
   2. Documentation of two or more episodes (per night float block) with literature citation where evidence based methods were used to answer patient management related questions (Practice-Based Learning and Improvement).
   3. Residents must document follow up on five cases they admitted during the night comparing initial and final diagnosis (Patient Care, Practice-Based Learning and Improvement).
   4. Night float team to attend morning reports and discuss management issues (Medical Knowledge, Practice-Based Learning and Improvement, Systems-Based Practice).
   5. Each senior resident is required to assess an intern twice (using Mini-CEX) during each night float block on new admissions. This Mini-CEX activity to be filed by both the intern and the senior resident in their portfolios (Professionalism, Interpersonal and Communication Skills).
   6. Resident is required to write a short narrative of a particularly stressful event or area of conflict that occurred during the rotation (Interpersonal and Communication Skills, Professionalism, and System-Based Practice).
   7. Case based example of application or lack of application of SBAR technique of sign-outs (Interpersonal and Communication Skills).
b. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives

**Intern Responsibilities (PGY-1)**

1. Assess new patient admissions quickly and completely by obtaining complete history and physical examination data and utilizing ancillary data sources as necessary. Construct a complete differential diagnosis, and produce a management plan with senior supervision. History and physical exams with an outlined management plan should be dictated promptly.
2. Demonstrate an appropriate knowledge base concerning the more common medical illnesses requiring hospital admission and admission criteria. Utilize appropriate clinical pathway guidelines.
3. Demonstrate competence in assessing the gravity of illness. Recognize acutely and potentially critically ill patients and call for senior support to promote patient safety.
4. Accept the primary responsibility for first response to all floor calls.
5. Access computer-based resources such as Uptodate and other current medical literature to improve patient care.
6. Personally review all EKGs, test reports and actual radiological studies.
7. Demonstrate effective patient transfers to the ward teams and maintain highly legible medical records.
8. Demonstrate receptivity to feedback from the senior night float member, the teaching service team and attending about errors in initial patient management and apply this knowledge to subsequent admissions.
9. Demonstrate professional behavior in interactions with the ED personnel, non-internal medicine physicians, other health care personnel, patients and families.
10. When able, actively seek out procedures and shared ICU experience with the senior night float member.

**Senior Resident Responsibilities (PGY-2, PGY-3)**

1. To supervise and teach the interns in a case-based fashion by reviewing the history and physical examination and admission orders for all patients admitted to the teaching service.
2. To immediately respond to all intern requests for help and to encourage these requests.
3. To call the attending to review the admissions to service personally.
4. To coordinate all consultations appropriately and communicate with the consultants personally.
5. To perform the history and physical exam as well as care plan formulations on all patients admitted to the ICU and to review this with the admitting attending and the involved consultants.
6. To promptly dictate all admitting history and physical exams for the ICU patients.
7. To personally attend to all care requirements in the ICU, check on all ICU patients’ status during the shift and to personally assess all patients on the floors or ER who are potential ICU admissions.
8. Demonstrate competence in the acute stabilization and management of critically ill patients.
9. To seek every opportunity to perform procedures under supervision. To engage the interns in actively performing procedures once they themselves are certified.
10. To routinely utilize available clinical guidelines and Uptodate searches to practice evidence based medicine.
11. To actively engage available attending specialty consultants for clinical guidance and feedback.
12. To demonstrate professional interactions with all ICU staff.
13. To promote open communication education with patients and families to engage them in care
and empower them for informed decisions.

14. To comfortably engage patients and families in code status, end of life and palliative care discussions when indicated.

### NIGHT FLOAT ROTATION EXPECTATIONS

**PGY-1**

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Interviewing</td>
<td>• Resident will obtain a detailed HPI emphasizing chronology of presentation and containing good descriptions of symptoms.</td>
</tr>
<tr>
<td></td>
<td>• Resident’s presentation will include appropriate pertinent positives and negatives.</td>
</tr>
<tr>
<td></td>
<td>• Resident will use appropriate non-patient sources of data if patient cannot give a history.</td>
</tr>
<tr>
<td></td>
<td>• Resident will learn to complete history collection in a time efficient manner.</td>
</tr>
<tr>
<td>Patient Care Physical Examination</td>
<td>• Resident will tailor the physical examination to the patient’s complaint.</td>
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<tr>
<td></td>
<td>• Resident will be able to identify and characterize the signs and symptoms of common medical conditions presenting for acute hospital admission.</td>
</tr>
<tr>
<td></td>
<td>• Resident will learn to complete a physical examination in a time efficient manner.</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>• Resident understands the epidemiology, pathophysiology, and pharmacology of common general medical diseases leading to the need for acute admission to the hospital. These include, but are not limited to, asthma exacerbation, pulmonary embolism, pneumonia, COPD exacerbation, CAD, CHF, renal failure, sepsis, dehydration, and altered mental status.</td>
</tr>
<tr>
<td></td>
<td>• The resident will develop competence in the acute stabilization and management of these conditions.</td>
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<tr>
<td></td>
<td>• The resident will demonstrate competence in determining &quot;sick vs non-sick&quot; by midyear of the PGY-1 academic calendar.</td>
</tr>
<tr>
<td>Procedural Skills</td>
<td>• Resident will demonstrate developing competence in the completion of all procedures encountered during the rotation.</td>
</tr>
<tr>
<td>Practice-Based Learning and Improvement</td>
<td>• Resident prioritizes diagnostic and therapeutic decisions based on the patient’s severity of illness.</td>
</tr>
<tr>
<td></td>
<td>• Resident will develop clinical judgment in the strategies used to match treatment protocols with disease presentation.</td>
</tr>
<tr>
<td>Systems-Based Practice</td>
<td>• Resident can effectively initiate the appropriate clinical pathways.</td>
</tr>
<tr>
<td></td>
<td>• Resident can effectively initiate the appropriate consultative services.</td>
</tr>
<tr>
<td>Interpersonal and Communication Skills</td>
<td>• Resident will develop competence in the transfer of accurate information to colleagues at the change of shift.</td>
</tr>
<tr>
<td></td>
<td>• Resident communicates regularly with patient and his / her family.</td>
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<tr>
<td></td>
<td>• Resident is respectful to the patient.</td>
</tr>
<tr>
<td></td>
<td>• Resident is concerned about the patient’s comfort.</td>
</tr>
<tr>
<td></td>
<td>• Resident communicates effectively with other members of the health care team.</td>
</tr>
<tr>
<td>Professionalism</td>
<td>• Resident completes the history and physical / consultation within 24 hours of contact, and writes a progress note as appropriate.</td>
</tr>
<tr>
<td></td>
<td>• Resident will follow through with scholarly assignments promptly.</td>
</tr>
<tr>
<td></td>
<td>• Resident completes medical records on time.</td>
</tr>
<tr>
<td></td>
<td>• Resident recognizes and takes steps to correct his / her deficiencies.</td>
</tr>
<tr>
<td></td>
<td>• Resident treats team members with respect, including nurses and other health care providers.</td>
</tr>
<tr>
<td></td>
<td>• Resident acknowledges personal reaction to morbidity and mortality associated with medical illness presenting during the night float rotation.</td>
</tr>
<tr>
<td></td>
<td>• Resident adheres to all ACGME mandated duty hour restrictions.</td>
</tr>
</tbody>
</table>
### NIGHT FLOAT ROTATION EXPECTATIONS
**PGY-2, PGY-3**

Competency at each year includes continued demonstration of the preceding year’s competency goals.

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Care Interviewing</strong></td>
<td>• Resident teaches junior residents the fundamentals of time sensitive interviewing technique.</td>
</tr>
<tr>
<td><strong>Patient Care Physical Examination</strong></td>
<td>• Resident teaches junior residents the fundamentals of time sensitive physical examination.</td>
</tr>
</tbody>
</table>
| **Medical Knowledge**                   | • Resident understands the epidemiology, pathophysiology, and pharmacology of common general medical diseases leading to the need for acute admission to the hospital. These include, but are not limited to, asthma exacerbation, pulmonary embolism, pneumonia, COPD exacerbation, CAD, CHF, renal failure, sepsis, dehydration, and altered mental status.  
  • The resident will demonstrate competence in the acute stabilization and management of these conditions.  
  • The resident will demonstrate developing competence in the completion of procedures encountered during the rotation. |
| **Procedural Skills**                   | • Resident will demonstrate developing competence in the rotation.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| **Practice-Based Learning and Improvement** | • Resident prioritizes diagnostic and therapeutic decisions based on the patient’s severity of illness.  
  • Resident will develop clinical judgment in the strategies used to match treatment protocols with disease presentation.  
  • Resident actively seeks and accepts feedback from supervising faculty.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| **Systems-Based Practice**              | • Resident can effectively initiate the appropriate clinical pathways.  
  • Resident can effectively initiate the appropriate consultative services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| **Interpersonal and Communication Skills** | • Resident will demonstrate competence in the transfer of accurate information to colleagues at the change of shift.  
  • Resident communicates regularly with patient and his / her family.  
  • Resident is respectful to the patient.  
  • Resident is concerned about the patient’s comfort.  
  • Resident communicates effectively with other members of the health care team.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| **Professionalism**                     | • Resident will follow through with scholarly assignments promptly.  
  • Resident completes medical records on time.  
  • Resident recognizes and takes steps to correct his / her deficiencies.  
  • Resident treats team members with respect, including nurses and other non-physician health care providers.  
  • Resident acknowledges personal reaction to morbidity and mortality associated with medical illness presenting during the night float rotation.  
  • Resident adheres to all ACGME mandated duty hour restrictions.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
NON-OPERATIVE ORTHOPEDICS CURRICULUM

I. Educational Purpose and Goals

The non-operative orthopedic elective is intended to allow interested internal medicine residents opportunities to develop history and physical examination skills, competence in the use of technology, diagnostic testing, and medication prescription, and exposure to basic non-operative orthopedics under the supervision of a board-certified orthopedic surgeon. In addition, residents will be exposed to a variety of important aspects of physical diagnosis related to the musculoskeletal system.

At the completion of this clinical experience, the learner will:
• Be able to appropriately diagnose and begin treatment for common non-operative orthopedic problems encountered in the primary care office.
• Be able to perform a complete musculoskeletal evaluation of the patient with musculoskeletal injury, including examination maneuvers, and testing for knee, shoulder, elbow, hip, ankle, and foot injuries.
• Be comfortable with the appropriate use of diagnostic imaging for musculoskeletal complaints.
• Be comfortable in performing appropriate procedures, including major joint injections, for patients with musculoskeletal injuries.

II. Principal Teaching Methods

Residents are expected to participate in direct patient care under the supervision of an orthopedic surgeon attending physician. Residents will spend two weeks in the outpatient offices of the orthopedic attending. The supervising attending may vary on a day-to-day or a weekly basis. Whenever possible, patients will be evaluated first by the resident, who will then present the case to the attending prior to implementing a plan of care. The decision regarding which patients are most suitable for medicine residents is left to the discretion of the orthopedic attending, to allow the resident to become familiar with aspects of orthopedic care that can be diagnosed and managed by general internists.

Residents are expected to obtain a focused and pertinent history prior to performing a physical examination. They are then expected to develop a differential diagnosis, as well as an appropriate plan of care, including further studies, testing, and medication, as appropriate.

Residents are expected to begin reading the core reading material prior to the start of their rotation, and are expected to complete it during their rotation. Orthopedic attendings also may supplement cases seen with discussions of common problems not encountered during that session.

Residents will report for all scheduled sessions and conferences, as indicated on their schedule, unless exempt.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Non-operative orthopedics experience is gained at the outpatient offices of the attending orthopedic surgeon attending.

b. Types of Clinical Encounters: Non-operative orthopedic training for internal medicine residents is mainly in the outpatient setting and allows the residents to become familiar with aspects of orthopedic care that can be diagnosed and managed by general internists.
c. **Disease Mix:** Residents will be exposed to the spectrum of non-operative orthopedic disease presenting for care at the attending orthopedician's private outpatient office. Residents will not be provided a unique schedule; however, they will be able to interview and examine patients from the daily schedules at the attending physicians’ discretion to best meet their educational needs. Residents will also be able to choose patients that best meet their educational needs.

d. **Patient Characteristics:** Care is provided at private orthopedic offices for patients from adolescence to geriatric ages. The racial and ethnic distribution reflects the diversity of the surrounding area. When English is not the primary spoken language, interpretation services are available to assist in the patient care setting, either through direct interview or via a remote language line service.

e. **Services:** All care will be under the direct supervision of an attending orthopedic surgeon.

f. **Procedures:** Medicine residents are expected to observe and perform diagnostic testing appropriate for non-operative orthopedics.

g. **Pathological Materials:** None.

### IV. Principal Ancillary Educational Materials / Educational Resources

a. **Reading List:**

b. **Educational Resources:** In addition to the reading list provided, residents will have available to them library resources at both Mercy and Moses Taylor Hospitals along with internet-based resources to review medicine and non-operative orthopedic topics.

### V. Methods of Evaluation

a. **Resident Performance:** Attending evaluations will be completed on each resident upon completion of the non-operative orthopedic rotation. Residents will receive a summarized evaluation at the end of the rotation with both verbal and written comments.

b. **Faculty Performance:** Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. **Program Performance:** Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.
## VI. Rotation Specific Progressive Learning Goals and Competency Objectives

### NON-OPERATIVE ORTHOPEDICS ROTATION EXPECTATIONS

**PGY-1, PGY-2, PGY-3**

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Care</strong></td>
<td><strong>Interviewing</strong></td>
</tr>
<tr>
<td></td>
<td>• Resident will obtain focused or complete H&amp;P for patients with musculoskeletal injuries, as appropriate.</td>
</tr>
<tr>
<td></td>
<td>• Residents should present cases with appropriate details of chief complaint.</td>
</tr>
<tr>
<td></td>
<td>• Resident will use interpretation service when patient cannot communicate in spoken English.</td>
</tr>
<tr>
<td><strong>Physical Examination</strong></td>
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</tr>
<tr>
<td></td>
<td>• Resident will perform focused or detailed physical examination, as appropriate. This includes routine examination and any pertinent maneuvers or procedures.</td>
</tr>
<tr>
<td><strong>Medical Knowledge</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Resident will understand the epidemiology, evaluation, and treatment of common non-operative orthopedic problems encountered by the general internist.</td>
</tr>
<tr>
<td><strong>Procedural Skills</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Resident will develop experience and competence in the performance of joint and / or soft tissue injections.</td>
</tr>
<tr>
<td><strong>Practice-Based Learning and</strong></td>
<td><strong>Improvement</strong></td>
</tr>
<tr>
<td></td>
<td>• Resident will prioritize diagnostic and treatment decisions based on the severity of illness.</td>
</tr>
<tr>
<td></td>
<td>• Resident will develop clinical judgment regarding therapeutic decisions.</td>
</tr>
<tr>
<td></td>
<td>• Resident will participate as part of the team in providing care.</td>
</tr>
<tr>
<td></td>
<td>• Resident will seek and accept feedback.</td>
</tr>
<tr>
<td><strong>Systems-Based Practice</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Resident can effectively initiate the appropriate clinical pathways.</td>
</tr>
<tr>
<td></td>
<td>• Resident can appropriately use further consultants in the care of the patient.</td>
</tr>
<tr>
<td></td>
<td>• Resident will be prepared to integrate information into a multidisciplinary approach to non-operative orthopedic care and services for medical patients.</td>
</tr>
<tr>
<td><strong>Interpersonal and</strong></td>
<td><strong>Communication Skills</strong></td>
</tr>
<tr>
<td></td>
<td>• Resident communicates effectively with patients and his / her family members.</td>
</tr>
<tr>
<td></td>
<td>• Resident is respectful to the patient.</td>
</tr>
<tr>
<td></td>
<td>• Resident is concerned about patient comfort.</td>
</tr>
<tr>
<td></td>
<td>• Resident involves patient in discussions about further care.</td>
</tr>
<tr>
<td><strong>Professionalism</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Resident completes all work prior to leaving the orthopedic practice.</td>
</tr>
<tr>
<td></td>
<td>• Resident offers assistance to other team members, as necessary.</td>
</tr>
<tr>
<td></td>
<td>• Resident completes assigned required reading.</td>
</tr>
<tr>
<td></td>
<td>• Resident recognizes and takes steps to correct perceived deficiencies.</td>
</tr>
<tr>
<td></td>
<td>• Resident treats staff and other team members with respect.</td>
</tr>
</tbody>
</table>
NON-OPERATIVE ORTHOPEDICS ROTATION SELF DIRECTED LEARNING
CHECKLIST

Name: ___________________________________ Rotation Dates: _________

Informal Discussion / Self Directed Learning Topics:

Checklist

Evaluation of Knee Injuries ___________
Evaluation of Shoulder Injuries _________
Evaluation of Ankle and Foot Injuries _________
Evaluation of Elbow Injuries _________
Evaluation of Neck Pain _________
Evaluation of Low Back Pain _________
Other ___________
I. Educational Purpose and Goals

The office/ambulatory gynecology rotation is intended to allow internal medicine residents opportunities to develop history and physical examination skills, competence in the use of technology, diagnostic testing, and medication prescription, and exposure to basic gynecologic pathology under the supervision of a board-certified gynecologist.

At the completion of this clinical experience, the learner will:

• Be able to diagnose and treat the most common causes of vaginitis and sexually transmitted diseases.
• Know how to properly collect, interpret and triage a cervical cytology smear based on the Bethesda 2001 Consensus Guidelines for the Management of Women with Cervical Cytological Abnormalities.
• Be able appropriately prescribe oral contraceptive pills and manage their most common side effects (be familiar with the common side effects of oral contraceptives; be familiar with the health benefits and risks of oral contraceptives; be able to prescribe emergency contraception).

II. Principal Teaching Methods

Residents are expected to participate in direct patient care under the supervision of a board-certified gynecology attending physician. Patients will be evaluated first by the medicine resident, who will then present the case to the gynecology attending prior to implementing a plan of care.

Medicine residents will be given core reading material prior to their rotation, and will be expected to complete this during their rotation. Gynecology attendings will supplement patients seen with standardized cases to offer residents a greater breath of gynecologic disease. When applicable, medicine residents will be required to attend Gynecology Grand Rounds.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Gynecology experience is gained at the outpatient office(s) of the attending gynecologist. Occasionally, the attending may ask the resident to round on an inpatient gynecology case admitted either at Mercy Hospital or Moses Taylor Hospital.

b. Types of Clinical Encounters: Mostly outpatient but occasionally inpatient at Mercy and Moses Taylor Hospitals. Medicine residents will not be provided a unique schedule; however, they will be able to choose patients from the schedules of the gynecology attending that best meet their educational needs.

c. Disease Mix: Residents will be exposed to the full spectrum of gynecologic disease. While medicine residents may not be expected to participate in the care of return obstetric appointments, they will benefit from examining first-visit obstetric patients, who require a full history and physical examination, internal examination, PAP smear and pelvic examination, and breast examination.

d. Patient Characteristics: Care is provided for adolescent to geriatric age patients. The racial and ethnic distribution closely matches that of the Scranton and surrounding areas. When English is not the primary spoken language, interpreters are available to assist in the patient care setting, either through direct interview or via a remote language line service.
e. **Services:** All care will be under the direct supervision of an attending gynecologist.

f. **Procedures:** Medicine residents are expected to observe and perform internal examinations, PAP smears, and breast examinations under the supervision of an attending gynecologist. In addition, residents should be able to collect specimens for gonorrhea, Chlamydia, bacterial vaginosis, candidiasis, and trichomonas., and evaluate these as appropriate.

g. **Pathological Materials:** Wet mounts, Pap smears.

### IV. Principal Ancillary Educational Materials / Educational Resources

a. **Reading List:**


b. **Educational Resources:** In addition to the reading list provided, residents will have available to them library resources at both Mercy and Moses Taylor Hospitals along with internet-based resources to review medicine and office gynecology topics.

### V. Methods of Evaluation

a. **Resident Performance:** Attending evaluations will be completed on each resident upon completion of the non-operative orthopedic rotation. Residents will receive a summarized evaluation at the end of the rotation with both verbal and written comments.

b. **Faculty Performance:** Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. **Program Performance:** Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

### VI. Rotation Specific Progressive Learning Goals and Competency Objectives

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
</table>

**OFFICE GYNECOLOGY ROTATION EXPECTATIONS**

PGY-1, PGY-2, PGY-3
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Patient Care**               | **Interviewing**  
  • Resident will obtain focused or complete H&P for GYN patients and complete H&P for new OB patients.  
  • Residents should present cases with appropriate details of chief complaint.  
  • Resident will use interpretation service when patient cannot communicate in spoken English.                                               |
| **Physical Examination**       | • Resident will perform focused or detailed physical examination, as appropriate.  
  This includes, but is not limited to, internal examination, PAP smear, breast examination, routine examination.                                                                                     |
| **Medical Knowledge**          | • Resident will understand the epidemiology, evaluation and treatment of common gynecologic diseases encountered by the general internist.                                                                       |
| **Procedural Skills**          | • Resident will develop experience and competence in the performance of internal examinations.  
  • Resident will develop competence in the collection and evaluation of PAP smears and wet mounts.  
  • Resident will develop competence in performing complete breast examination.                                                                                                                   |
| **Practice-Based Learning and Improvement** | • Resident will prioritize diagnostic and treatment decisions based on severity of illness.  
  • Resident will develop clinical judgment regarding therapeutic decisions.  
  • Resident will attend OB-GYN Grand Rounds, as appropriate  
  • Resident will participate as part of the team in providing care.  
  • Resident will seek and accept feedback.                                                                                                                                                    |
| **Systems-Based Practice**     | • Resident can effectively initiate the appropriate clinical pathways.  
  • Resident can appropriately use further consultants in the care of the patient.  
  • Resident will be prepared to integrate information into a multidisciplinary approach to gynecologic care for medical patients.                                                                   |
| **Interpersonal and Communication Skills** | • Resident communicates effectively with patients and family members.  
  • Resident is respectful to the patient.  
  • Resident is concerned about patient comfort.  
  • Resident involves patient in discussions about further care.                                                                                                                                 |
| **Professionalism**            | • Resident completes all work prior to leaving the gynecology office.  
  • Resident offers assistance to other team members, as necessary.  
  • Resident completes assigned required reading.  
  • Resident recognizes and takes steps/actions to correct perceived deficiencies.  
  • Resident treats staff and other team members with respect.                                                                                                                                    |
Informal Discussion / Self Directed Learning Topics:

Checklist

Vaginitis / STDs
Cervical Cancer Screening
Breast Cancer Screening
Medications During Pregnancy
Oral Contraceptive Use
Other
I. Educational Purpose and Goals

The otorhinolaryngology elective is intended to allow internal medicine residents opportunities to develop history and physical examination skills, competence in the use of technology, diagnostic testing, and medication prescription, and exposure to basic ENT care under the supervision of a board-certified otorhinolaryngologist.

At the completion of this clinical experience, the learner will:

• Be able to perform an initial evaluation of a patient with ENT complaints, including appropriate history, physical examination, and testing.
• Understand basic management principles in patients with common ENT complaints such as epistaxis, otitis externa, otitis media, acute pharyngitis, acute sinusitis, and chronic sinusitis.
• Be able to identify and develop an understanding of common ENT urgencies and emergencies, and conditions requiring appropriate referral to a specialist, such as nasal polyposis, posterior epistaxis, orbital cellulitis, osteitis of the sinus bones, and invasive sinusitis.

II. Principal Teaching Methods

Residents are expected to participate in direct patient care under the supervision of a board-certified otorhinolaryngology attending physician. Residents will spend two weeks in the outpatient offices of the otorhinolaryngology attending. The supervising attending may vary on a day-to-day or a weekly basis. Whenever possible, patients will be evaluated first by the medicine resident, who will then present the case to the attending prior to implementing a plan of care. The decision regarding which patients are most suitable for medicine residents is left to the discretion of the attending, to allow the resident to become familiar with aspects of otorhinolaryngologic care that can be diagnosed and managed by general internists.

Residents are expected to obtain a focused and pertinent history prior to performing a physical examination. After discussion with the attending physician, a physical examination, including otoscopy, rhinoscopy and / or laryngoscopy is expected to be performed, as appropriate, under supervision. They are then expected to develop a differential diagnosis, as well as an appropriate plan of care, including further studies, testing, and medication, as appropriate.

Residents are expected to begin reading the core reading material prior to the start of their rotation, and are expected to complete it during their rotation. Otorhinolaryngology attendings also may supplement cases seen with discussions of common problems not encountered during that session.

Residents will report for all scheduled sessions and conferences, as indicated on their schedule, unless exempt.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Otorhinolaryngology experience is gained at the outpatient offices of the attending otorhinolaryngology surgeon attending.

b. Types of Clinical Encounters: Otorhinolaryngology training for internal medicine residents is mainly in the outpatient setting and allows the residents to become familiar with aspects of otorhinolaryngologic care that can be diagnosed and managed by general internists.

c. Disease Mix: Residents will be exposed to the full spectrum of ENT disease presenting for care at the attending otorhinolaryngologists private outpatient office. Medicine residents will not be
provided a unique schedule; however, they will be able to interview and examine patients from
the daily schedules at the attending physicians’ discretion to best meet their educational needs.

d. **Patient Characteristics:** Care is provided at the attending physician’s office for patients ranging
from adolescence to geriatric ages and including the racial and ethnic distribution of the area.
When English is not the primary spoken language, interpreters should be available to assist in
the patient care setting, either through direct interview or via a remote language line service.

e. **Services:** All care will be under the direct supervision of an attending otorhinolaryngologist.

f. **Procedures:** Residents are expected to observe, perform, and interpret routine ENT tests and
examinations.

g. **Pathological Materials:** None

**IV. Principal Ancillary Educational Materials / Educational Resources**

a. **Reading List:**
   i. ENT section of Harrison’s Principles of Internal Medicine
   ii. ENT topics from Uptodate
   iii. ENT topics from MKSAP

b. **Educational Resources:** In addition to the reading list provided, residents will have available to
them library resources at both Mercy and Moses Taylor Hospitals along with internet-based
resources to review medicine and otorhinolaryngology topics.

**V. Methods of Evaluation**

a. **Resident Performance:** Attending evaluations will be completed on each resident upon
completion of the non-operative orthopedic rotation. Residents will receive a summarized
evaluation at the end of the rotation with both verbal and written comments.

b. **Faculty Performance:** Upon completion of each rotation, residents complete a confidential web-
based electronic faculty evaluation.

c. **Program Performance:** Residents complete a semi-annual program evaluation form
commenting on the faculty, facilities, and service experience. These evaluations are returned to
the residency administration for review. The Program Director uses the feedback for
improvement of the rotations and learning experiences.

**VI. Rotation Specific Progressive Learning Goals and Competency Objectives**

**OTOLARYNGOLOGY ROTATION EXPECTATIONS**
PGY-1, PGY-2, PGY-3

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<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
</table>
| Patient Care Interviewing         | • Resident will obtain focused or a complete H&P, as appropriate, for all ENT patients.  
• Residents should present cases with appropriate details of chief complaint.  
• Resident will use interpretation service when patient cannot communicate in spoken English. |
| Physical Examination              | • Resident will perform focused or detailed physical examination, as appropriate. This includes, but is not limited to, otoscopy, rhinoscopy, laryngoscopy and routine examination. |
| Medical Knowledge                 | • Resident will understand the epidemiology, evaluation, and treatment of common otolaryngologic diseases encountered by the general internist. |
| Procedural Skills                 | • Resident will develop experience and competence in the performance of otoscopy, including cerumen disimpaction, rhinoscopy and laryngoscopy. |
| Practice-Based Learning and       | • Resident will prioritize diagnostic and treatment decisions based on the severity of illness.  
• Resident will develop clinical judgment regarding therapeutic decisions.  
• Resident will attend ENT conferences, as appropriate.  
• Resident will participate as part of the team in providing care.  
• Resident will seek and accept feedback. |
| Systems-Based Practice            | • Resident can effectively initiate the appropriate clinical pathways.  
• Resident can appropriately use further consultants in the care of the patient.  
• Resident will be prepared to integrate information into a multidisciplinary approach to otolaryngologic care for medical patients. |
| Interpersonal and Communication   | • Resident communicates effectively with patients and his / her family members.  
• Resident is respectful to the patient.  
• Resident is concerned about patient comfort.  
• Resident involves patient in discussions about further care. |
| Professionalism                   | • Resident completes all work prior to leaving the ENT office.  
• Resident offers assistance to other team members, as necessary.  
• Resident completes assigned required reading.  
• Resident recognizes and takes steps to correct perceived deficiencies.  
• Resident treats staff and other team members with respect. |
OTORHINOLARYNGOLOGY ROTATION SELF DIRECTED LEARNING CHECKLIST

Name: ____________________________  Rotation Dates: ____________

Informal Discussion / Self Directed Learning Topics:

Checklist

Otitis Externa ____________
Otitis Media ____________
Cerumen Impaction ____________
Tinnitus ____________
Epistaxis ____________
Sinusitis ____________
Hoarseness ____________
Hearing Loss ____________
Other ____________

Clinical Exposure:

Otoscopy ____________
Rhinoscopy ____________
Indirect Laryngoscopy ____________
PALLIATIVE CARE CURRICULUM

I. Educational Purpose and Goals

The palliative care elective is intended to allow WCGME residents an opportunity to understand the basic approach to palliative medicine and hospice care. Under the supervision of a board-certified palliative medicine physician, residents will develop history and physical examination skills, competence in the care of patients with terminal or life-threatening disease.

II. Principal Teaching Methods

Residents are expected to participate in direct patient care under the supervision of a board-certified palliative medicine attending. Whenever possible, patients will be evaluated first by the resident, who will then present the case to the attending physician prior to implementing a plan of care. Patients are seen in the acute care, hospice inpatient and home hospice setting.

Residents are expected to begin reading the core reading material mentioned hereunder prior to their rotation and are expected to complete it during their rotation. This material is also available on the website http://www.palliativecare-nepa.com.

Residents will also take a pre-test measuring their knowledge base in pain and symptom management as well as the general principles in palliative care. A post-test is also given measuring these same domains.

The resident will be supervised communicating end-of-life care issues with patient and caregivers.

III. Educational Content / Structure of the Rotation

a. Learning Venues: As noted above, this rotation will utilize the acute care, inpatient hospice and home hospice settings.

b. Types of Clinical Encounters: The service is a consultative service. Therefore, residents will be seeing patients as a palliative medicine consultant.

c. Disease Mix: Resident will be exposed to patients with a wide range of pathology. Special emphasis is placed on the care of patients with:
   - Advanced cancer
   - End stage cardiac or pulmonary disease
   - Advanced dementia

d. Services: All care will be under the direct supervision of a palliative medicine attending.

IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List: In addition to the selected readings that are provided by the palliative medicine attending, the resident is also encouraged to read any textbooks or review books pertinent to the area of palliative care. Residents will have available to them library and internet based resources to review palliative medicine, especially areas of their selection and interest.
Key rotation articles are provided to the resident at the beginning of the rotation. In addition, these same articles are available on the website http://www.palliativecare-nepa.com.

V. Methods of Evaluation

a. Resident Performance: Attending evaluations will be completed on each resident upon completion of the palliative medicine rotation. Residents will receive a summarized evaluation at the end of the rotation with both verbal and written comments.

b. Faculty Performance: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives
# PALLIATIVE MEDICINE ROTATION EXPECTATIONS
**PGY-2, PGY-3**

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Interviewing</td>
<td>• Resident will obtain focused or detailed history for patients with end-of-life (EOL) care issues.</td>
</tr>
<tr>
<td></td>
<td>• Residents should present cases with appropriate details to the attending.</td>
</tr>
<tr>
<td></td>
<td>• Resident will negotiate a plan of care with patients and their caregivers.</td>
</tr>
<tr>
<td>Patient Care Physical Exam</td>
<td>• Resident will perform focused or detailed physical examination, as appropriate. This includes routine examination and any pertinent procedures.</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>• Resident will understand the basic principles of symptom management at the EOL.</td>
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<tr>
<td></td>
<td>• Residents will understand the basic principles of effective communication with patients and families (e.g. “breaking bad news”).</td>
</tr>
<tr>
<td></td>
<td>• Residents will understand the fundamentals of hospice care.</td>
</tr>
<tr>
<td>Procedural Skills</td>
<td>• Not applicable.</td>
</tr>
<tr>
<td>Practice-Based Learning</td>
<td>• Resident will prioritize diagnostic and therapeutic decisions based on the severity of illness.</td>
</tr>
<tr>
<td>and Improvement</td>
<td>• Resident will participate as part of the palliative medicine team in providing care.</td>
</tr>
<tr>
<td></td>
<td>• Resident will seek and accept feedback.</td>
</tr>
<tr>
<td>Systems-Based Practice</td>
<td>• Resident can effectively initiate the appropriate clinical pathways.</td>
</tr>
<tr>
<td></td>
<td>• Resident can appropriately use further consultants in the care of the patient.</td>
</tr>
<tr>
<td>Interpersonal and</td>
<td>• Resident communicates effectively with patients and family members.</td>
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<td>Communication Skills</td>
<td>• Resident is respectful to the patient.</td>
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<tr>
<td></td>
<td>• Resident involves patient in discussions about further care.</td>
</tr>
<tr>
<td>Professionalism</td>
<td>• Resident completes all work prior to leaving the practice site.</td>
</tr>
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<td>• Resident offers assistance to other team members, as necessary.</td>
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<td>• Resident completes assigned required reading.</td>
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<td>• Resident recognizes and takes steps to correct perceived deficiencies.</td>
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<tr>
<td></td>
<td>• Resident treats staff and other team members with respect.</td>
</tr>
</tbody>
</table>
### PALLIATIVE MEDICINE ROTATION SELF DIRECTED LEARNING CHECKLIST

Name: ______________________________

Rotation Dates: ______________

Informal Discussion / Self Directed Learning Topics:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Checklist</th>
</tr>
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<tbody>
<tr>
<td>Pain Management</td>
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<tr>
<td>Other symptom management at EOL</td>
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<tr>
<td>Feeding and hydration</td>
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<td>Communication</td>
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<td>EOL care in the U.S.</td>
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<td>Medicare Hospice Benefit</td>
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<td>Psychological Issues @ EOL</td>
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<td>Spiritual Issues @ EOL</td>
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<tr>
<td>Other</td>
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</tbody>
</table>
I. Educational Purpose and Goals

The psychiatry elective is intended to allow internal medicine residents opportunities to develop interviewing skills, competence in medication prescription, and exposure and experience with aspects of psychiatry that can be diagnosed and managed by the general internist.

At the completion of this clinical experience, the learner will:

- Be able to diagnose and manage common psychiatric illness in the primary care setting, including but not limited to depression, anxiety, and personality disorders.
- Be able to safely and appropriately prescribe antidepressants and anxiolytics to patients in need, and manage their most common side effects.
- Be able to appropriately refer patients to mental health services.

II. Principal Teaching Methods

Residents are expected to participate in direct patient care under the supervision of a board-certified psychiatry attending physician. Residents will spend two to four weeks in the outpatient offices of the psychiatry attending. The supervising attending may vary on a day-to-day or a weekly basis. Whenever possible, patients will be evaluated first by the medicine resident, who will then present the case to the attending prior to implementing a plan of care. The decision regarding which patients are most suitable for medicine residents is left to the discretion of the attending, to allow the resident to become familiar with aspects of psychiatric care that can be diagnosed and managed by general internists.

Residents are expected to obtain a focused and pertinent history (including a depression / bipolar / anxiety screening and/or screening for drug and alcohol use, as appropriate) prior to performing a physical examination. They are then expected to develop a differential diagnosis, as well as an appropriate plan of care, including further studies, testing, and medication, as appropriate.

Residents are expected to begin reading the core reading material prior to the start of their rotation, and are expected to complete it during their rotation. Psychiatry attendings also may supplement cases seen with discussions of common problems not encountered during that session.

Residents will report for all scheduled sessions and conferences, as indicated on their schedule, unless exempt.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Psychiatry experience is mostly gained at the outpatient offices of the psychiatry attending in the Scranton Counseling Center in downtown Scranton. Inpatient exposure is rare and attending dependent but may occur in the Senior Medical and Mental Health unit in Moses Taylor Hospital.

b. Types of Clinical Encounters: Psychiatry training for internal medicine residents is mainly in the outpatient setting and allows the residents to become familiar with aspects of psychiatric care that can be diagnosed and managed by general internists. Rare inpatient exposure, as mentioned above, may happen.

c. Disease Mix: Residents will be exposed to the full spectrum of psychiatric disease presenting for care at the Scranton Counseling Center. Scranton Counseling Center is a private, non-profit organization providing comprehensive behavioral healthcare services to people of all
ages. Services include psychological testing, psychiatric evaluation, individual / family / marital / grief counseling, expressive therapies, early intervention, 24 hour crisis intervention, emergency services, residential programs, partial hospitalization, stress management, suicide intervention, employee assistance programs and community consultation and education. Staff includes psychiatrists, psychologists, social workers, art and music therapists and other mental health / mental retardation specialists.

d. **Patient Characteristics:** Care is provided at the Scranton Counseling Center for patients of adolescence to geriatric ages. The racial and ethnic distribution closely matches that of the surrounding areas. When English is not the primary spoken language, interpreters are available to assist in the patient care setting, either through direct interview or via a remote language line service.

e. **Services:** All care will be under the direct supervision of an attending psychiatrist.

f. **Procedures:** Residents are expected to perform appropriate standardized clinical interviews, including but not limited to depression / bipolar / anxiety screening and screening for drug and alcohol abuse.

g. **Pathological Materials:** None.

**IV. Principal Ancillary Educational Materials / Educational Resources**

a. **Reading List:**
   1. Psychiatry section of Harrison’s Principles of Internal Medicine
   2. Psychiatry topics from Uptodate
   3. Psychiatry topics of MKSAP
   4. Remick RA. Diagnosis and Management of Depression in Primary Care: A Clinical Update and Review. CMAJ 2002; 167(11): 1253-60

b. **Educational Resources:** In addition to the reading list provided, residents will have available to them library resources at both Mercy and Moses Taylor Hospitals along with internet-based resources to review medicine and psychiatry topics.

**V. Methods of Evaluation**

a. **Resident Performance:** Attending evaluations will be completed on each resident upon completion of the non-operative orthopedic rotation. Residents will receive a summarized evaluation at the end of the rotation with both verbal and written comments.

b. **Faculty Performance:** Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. **Program Performance:** Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

**VI. Rotation Specific Progressive Learning Goals and Competency Objectives**
## PSYCHIATRY ROTATION EXPECTATIONS
**PGY-1, PGY-2, PGY-3**

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Care Interviewing</strong></td>
<td>• Resident will obtain a complete psychiatric history for patients presenting for psychiatric care.</td>
</tr>
<tr>
<td></td>
<td>• Residents should present cases with appropriate details of chief complaint.</td>
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<tr>
<td></td>
<td>• Resident will use interpretation service when patient cannot communicate in spoken English.</td>
</tr>
<tr>
<td><strong>Patient Care Physical Examination</strong></td>
<td>• Resident will perform a focused or detailed physical examination, as appropriate to the case.</td>
</tr>
<tr>
<td><strong>Medical Knowledge</strong></td>
<td>• Resident will understand the epidemiology, evaluation, and treatment of common psychiatric illnesses encountered by the general internist.</td>
</tr>
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<td></td>
<td>• Residents will understand the impact of psychiatric illness upon medical care.</td>
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<td>• Residents will understand the work-up for organic causes of psychiatric disease.</td>
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<tr>
<td><strong>Procedural Skills</strong></td>
<td>• Resident will develop experience and competence in the performance of depression / bipolar / anxiety screening, drug and alcohol screening, and other common psychiatric tools.</td>
</tr>
<tr>
<td><strong>Practice-Based Learning and Improvement</strong></td>
<td>• Resident will prioritize diagnostic and treatment decisions based on the severity of illness.</td>
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<td>• Resident will develop clinical judgment regarding therapeutic decisions.</td>
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<td></td>
<td>• Resident will participate as part of the team in providing care.</td>
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<td></td>
<td>• Resident will seek and accept feedback.</td>
</tr>
<tr>
<td><strong>Systems-Based Practice</strong></td>
<td>• Resident can effectively initiate the appropriate clinical pathways.</td>
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<tr>
<td></td>
<td>• Resident can appropriately use further consultants in the care of the patient.</td>
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<tr>
<td></td>
<td>• Resident will be prepared to integrate information into a multidisciplinary approach to psychiatric care for medical patients.</td>
</tr>
<tr>
<td><strong>Interpersonal and Communication Skills</strong></td>
<td>• Resident communicates effectively with patients and his / her family members.</td>
</tr>
<tr>
<td></td>
<td>• Resident is respectful to the patient.</td>
</tr>
<tr>
<td></td>
<td>• Resident is concerned about patient comfort.</td>
</tr>
<tr>
<td></td>
<td>• Resident involves patient in discussions about further care.</td>
</tr>
<tr>
<td><strong>Professionalism</strong></td>
<td>• Resident completes all work prior to leaving the clinic.</td>
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<tr>
<td></td>
<td>• Resident offers assistance to other team members, as necessary.</td>
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<tr>
<td></td>
<td>• Resident completes assigned required reading.</td>
</tr>
<tr>
<td></td>
<td>• Resident recognizes and takes steps to correct perceived deficiencies.</td>
</tr>
<tr>
<td></td>
<td>• Resident treats staff and other team members with respect.</td>
</tr>
</tbody>
</table>
PSYCHIATRY ROTATION SELF DIRECTED LEARNING CHECKLIST

Name: ________________________________  Rotation Dates: _____________

Informal Discussion / Self Directed Learning Topics:

Checklist

Major Depression  _____________
Bipolar Disorder  _____________
Anxiety Disorders  _____________
Personality Disorders  _____________
Other  _____________
PULMONARY MEDICINE CURRICULUM

I. Educational Purpose and Goals

The pulmonary medicine rotation at WCGME is a required rotation for all residents. This rotation is preferably to be completed in the second or third year of residency training. The rotation is designed to provide residents with an understanding of the pathophysiology basis of pulmonary disease. Emphasis is placed on active resident participation in the diagnosis and management of patients with pulmonary disease based upon an understanding of the pathophysiologic changes that occur in the disease process. The resident will learn to function as a consultant recommending care for pulmonary diseases as presenting in the adult population.

II. Principal Teaching Methods

Residents learn management and pathophysiology of pulmonary disease through consultative care provided directly to patients under the close supervision of board-certified pulmonologists. Also, didactic sessions in respiratory medicine are held throughout the year.

Residents will work one-on-one and be supervised at all times by board-certified Pulmonologists.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Inpatient (including ICU) training occurs at Mercy and Moses Taylor Hospitals, and usually includes observation of certain number of bronchoscopies. Outpatient pulmonary medicine is taught in the private clinics of the supervising pulmonologist.

b. Types of Clinical Encounters: Mainly inpatient but also outpatient encounters in the private offices of the faculty pulmonologists. Residents will write all pulmonary medicine progress notes on the inpatients which they follow along with the faculty pulmonologist. No clinical activity will occur without being supervised.

c. Disease Mix: Residents are exposed to the full spectrum of pulmonary disease diagnosis and management.

d. Patient Characteristics: Patient care is provided from adolescent to geriatric age patients. Patients of both sexes and all ethnic backgrounds are seen on the pulmonary disease rotation. When English is not the primary language, interpreters are available for translation service in all patient care areas.

e. Services: While assigned to the pulmonary disease rotation, residents will be under the direct supervision and guidance of a pulmonary attending. No clinical activity will occur without being supervised.

f. Procedures: Residents are expected to develop competency in the interpretation of chest X-rays and pulmonary function tests (PFTs). When possible residents will complete procedures including thoracentesis.

g. Pathological Materials: As available during the rotation.

IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List:

1. Uptodate – Pulmonary Medicine topics
2. Harrison’s Principles of Internal Medicine – Disorders of the Respiratory System
3. Pulmonary Medicine booklet of MKSAP
4. Evidence-based medicine searches of relevant pulmonary medicine topics

b. **Educational Resources:** In addition to the reading list provided, residents will have available to them library resources at both Mercy and Moses Taylor Hospitals along with internet-based resources to review pulmonary medicine topics.

V. Methods of Evaluation

a. **Resident Performance:** Attending evaluations will be completed on each resident upon completion of the pulmonary medicine rotation. Residents will receive a summarized evaluation at the end of the rotation with both verbal and written comments.

b. **Faculty Performance:** Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. **Program Performance:** Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. **Rotation Specific Progressive Learning Goals and Competency Objectives**
<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
</table>
| Patient Care Interviewing         | • Resident will obtain a detailed HPI emphasizing chronology of presentation and containing good descriptions of symptoms.  
• Resident’s presentation will include appropriate pertinent positives and negatives.  
• Resident will use appropriate additional sources of data if patient cannot give a history.                                                                                                                                                                                                                     |
| Patient Care Physical Examination | • Resident will tailor the physical examination to the patient’s complaint.  
• Resident will be able to identify and characterize pulmonary auscultatory findings.                                                                                                                                                                                                                                                                        |
| Medical Knowledge                 | • Resident understands the epidemiology, pathophysiology, and pharmacology of common respiratory illnesses including hemoptysis, hypoxemia, asthma, bronchitis, COPD, infectious disease, malignancy, interstitial lung disease, pulmonary hypertension, cystic fibrosis, and bronchiectasis.  
• Resident will become familiar with pulmonic manifestations of systemic disease.  
• Resident will become familiar with the impact of pulmonic disease on other major organ systems.                                                                                                                                                     |
| Procedural Skills                 | • Resident will develop competency in arterial blood gas analysis and basic chest x-ray interpretation.  
• Resident will demonstrate developing competency in the completion of thoracentesis, in the interpretation of pulmonary function testing, in the interpretation of advanced radiographic imaging of the chest, and when appropriate, ventilator management.                                                                                                             |
| Practice-Based Learning and Improvement | • Resident prioritizes diagnostic and therapeutic decisions based on patient’s severity of illness.  
• Resident will develop clinical judgment in the strategies used to match treatment protocols with pulmonic disease.  
• Resident will utilize core reading material to facilitate learning.                                                                                                                                                                                                                                     |
| Systems-Based Practice            | • Resident can effectively initiate the appropriate clinical pathways.  
• Resident can effectively initiate the appropriate use of consultant in the care of patients suffering from pulmonic disease.  
• Resident serves as a consultant to other services with extensive faculty oversight.  
• Resident develops a multidisciplinary approach to pulmonary care.                                                                                                                                                                                                                                      |
| Interpersonal and Communication Skills | • Resident communicates regularly with patient and his / her family.  
• Resident is respectful to the patient.  
• Resident is concerned about the patient’s comfort.  
• Resident communicates effectively with other members of the health care team.                                                                                                                                                                                                                             |
| Professionalism                   | • Resident completes the history and physical / consultation within 24 hours of contact, and writes a daily progress note as appropriate.  
• Resident will follow through with scholarly assignments promptly.  
• Resident completes medical records on time.  
• Resident recognizes and takes steps to correct his / her deficiencies.  
• Resident treats team members, including nurses and other health care providers, with respect.  
• Resident acknowledges personal reaction to morbidity and mortality associated with pulmonary disorders.  
• Resident adheres to all ACGME mandated duty hour restrictions.                                                                                                                                                                                                                                       |
**PGY-2**

Competency at each year includes continued demonstration of the preceding year’s competency goals.

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
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<tbody>
<tr>
<td>Patient Care Interviewing</td>
<td>• Resident will obtain a detailed HPI emphasizing chronology of presentation and containing good descriptions of symptoms.</td>
</tr>
<tr>
<td></td>
<td>• Resident will present without notes.</td>
</tr>
<tr>
<td></td>
<td>• Resident’s presentation will include appropriate pertinent positives and negatives.</td>
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<tr>
<td></td>
<td>• Resident will use appropriate additional sources of data if patient cannot give a history.</td>
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<tr>
<td></td>
<td>• Resident teaches junior residents / medical students the fundamentals of time sensitive interviewing technique.</td>
</tr>
<tr>
<td>Patient Care Physical Examination</td>
<td>• Resident will tailor the physical examination to the patient’s complaint.</td>
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<tr>
<td></td>
<td>• Resident will be able to identify and characterize pulmonary auscultatory findings.</td>
</tr>
<tr>
<td></td>
<td>• Resident teaches junior residents / medical students the fundamentals of time sensitive physical examination.</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>• Resident understands the epidemiology, pathophysiology, and pharmacology of common respiratory illnesses including hemoptysis, hypoxemia, asthma, bronchitis, COPD, infectious disease, malignancy, interstitial lung disease, pulmonary hypertension, cystic fibrosis, and bronchiectasis.</td>
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<tr>
<td></td>
<td>• Resident will become familiar with pulmonic manifestations of systemic disease.</td>
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<tr>
<td></td>
<td>• Resident will become familiar with the impact of pulmonic disease on other major organ systems.</td>
</tr>
<tr>
<td>Procedural Skills</td>
<td>• Resident will demonstrate competency in arterial blood gas analysis, chest x-ray interpretation, interpretation of pulmonary function testing, and ventilator management.</td>
</tr>
<tr>
<td></td>
<td>• Resident will demonstrate developing competency in thoracentesis and in the interpretation of advanced radiographic imaging of the chest.</td>
</tr>
<tr>
<td>Practice-Based Learning and</td>
<td>• Resident prioritizes diagnostic and therapeutic decisions based on patient’s severity of illness.</td>
</tr>
<tr>
<td>Improvement</td>
<td>• Resident will develop clinical judgment in the strategies used to match treatment protocols with pulmonic disease.</td>
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<td></td>
<td>• Resident will use major textbooks, review articles, and current literature to facilitate patient care.</td>
</tr>
<tr>
<td>Systems-Based Practice</td>
<td>• Resident can effectively initiate the appropriate clinical pathways.</td>
</tr>
<tr>
<td></td>
<td>• Resident can effectively initiate the appropriate use of consultant in the care of patients suffering from pulmonic disease.</td>
</tr>
<tr>
<td></td>
<td>• Resident serves as a consultant to other services with moderate faculty input.</td>
</tr>
<tr>
<td></td>
<td>• Resident develops a multidisciplinary approach to pulmonary care.</td>
</tr>
<tr>
<td>Interpersonal and Communication</td>
<td>• Resident communicates regularly with patient and his / her family.</td>
</tr>
<tr>
<td>Skills</td>
<td>• Resident addresses patient care issues such as end of life decisions with moderate faculty input.</td>
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<td></td>
<td>• Resident provides feedback to junior team members.</td>
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<td></td>
<td>• Resident functions as an effective team leader.</td>
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<tr>
<td>Professionalism</td>
<td>• Resident has history and physical / consultation on chart within 24 hours of admission or consultation, and writes a daily progress note.</td>
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<td></td>
<td>• Resident will follow through with scholarly assignments promptly.</td>
</tr>
<tr>
<td></td>
<td>• Resident completes medical records on time.</td>
</tr>
<tr>
<td></td>
<td>• Resident recognizes and takes steps to correct his / her deficiencies.</td>
</tr>
<tr>
<td></td>
<td>• Resident treats team members, including nurses and other non-physician health care providers, with respect.</td>
</tr>
<tr>
<td></td>
<td>• Resident counsels junior team members on issues of professionalism including personal reactions to the morbidity and mortality associated with the care of pulmonic disease.</td>
</tr>
<tr>
<td></td>
<td>• Resident adheres to all ACGME mandated duty hour restrictions.</td>
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</tbody>
</table>
### PGY-3

Competency at each year includes continued demonstration of the preceding year’s competency goals.

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
</table>
| **Patient Care Interviewing**          | • Resident will obtain a detailed HPI, present without notes and will include appropriate pertinent positives and negatives.  
• Resident will use appropriate additional sources of data if pt. cannot give a history.  
• Resident teaches junior residents / medical students the fundamentals of time sensitive interviewing technique. |
| **Patient Care Physical Examination**  | • Resident will tailor the physical examination to the patient’s complaint.  
• Resident will be able to identify and characterize pulmonary auscultatory findings.  
• Resident teaches junior residents / medical students the fundamentals of time sensitive physical examination. |
| **Medical Knowledge**                  | • Resident understands the epidemiology, pathophysiology, and pharmacology of common respiratory illness including hemoptysis, hypoxemia, asthma, bronchitis, COPD, infectious disease, malignancy, interstitial lung disease, pulmonary hypertension, cystic fibrosis, and bronchiectasis.  
• Resident will become familiar with pulmonic manifestations of systemic disease.  
• Resident will become familiar with the impact of pulmonic disease on other major organ systems. |
| **Procedural Skills**                  | • Resident will demonstrate competency in arterial blood gas analysis, chest x-ray interpretation, interpretation of pulmonary function testing, and ventilator management.  
• Resident will demonstrate developing competency in thoracentesis and in the interpretation of advanced radiographic imaging of the chest. |
| **Practice-Based Learning and Improvement** | • Resident prioritizes diagnostic and therapeutic decisions based on patient’s severity of illness.  
• Resident will develop clinical judgment in the strategies used to match treatment protocols with pulmonic disease.  
• Resident integrates current evidence-based literature into patient care and teaching responsibilities.  
• Resident actively seeks and accepts feedback. |
| **Systems-Based Practice**             | • Resident can effectively initiate the appropriate clinical pathways.  
• Resident can effectively initiate the appropriate use of consultant in the care of patients suffering from pulmonic disease.  
• Resident develops a multidisciplinary approach to pulmonary care.  
• Resident serves as a consultant to other services with minimal faculty input.  
• Resident critically evaluates all consultant evaluations including conflicting recommendation to develop an effective patient care plan. |
| **Interpersonal and Communication Skills** | • Resident communicates regularly with patient and his / her family.  
• Resident is respectful to the patient.  
• Resident is concerned about the patient’s comfort.  
• Resident is able to deal with challenging patients and families.  
• Resident effectively coordinates team to optimize patient care. |
| **Professionalism**                    | • Resident has the history and physical / consultation completed within 24 hours of contact, and writes a daily progress note.  
• Resident will follow through with scholarly assignments promptly.  
• Resident completes medical records on time.  
• Resident recognizes and takes steps to correct his / her deficiencies.  
• Resident treats team members, including nurses and other health care providers, with respect.  
• Resident identifies ethical issues and employs available resources to solve them.  
• Resident counsels junior team members on issues of professionalism including personal reactions to the morbidity and mortality associated with the care of pulmonary disease.  
• Resident sets a tone of respect and collegiality for the team.  
• Resident adheres to all ACGME mandated duty hour restrictions. |
RADIOLOGY CURRICULUM

I. Educational Purpose and Goals

Internists must have the opportunity to enhance and improve their understanding of the radiological aspect of medicine. The purpose of this rotation is to familiarize the resident to both the common radiological investigational modalities as well as the advanced imaging in this field. The emphasis is also on training the residents to correctly and logically approach common radiological presentations and generate radiological differential diagnoses. They are expected to learn the appropriate indications and basic interpretation of various radiological tests.

II. Principal Teaching Methods

a. Residents will observe in the Radiology Department of Mercy Hospital over a 2-week period. They may remain under the same radiology attending or may rotate under different attendings.

b. Residents will learn to analyze plain film Conventional Radiology (CR) images, Ultrasonograms (US), Computed Tomography (CT) scans and Magnetic Resonance Imaging (MRI) images. The tests shall be supervised and interpreted by the attending radiologist with the observing resident.

c. Residents will also be exposed to a wide variety of radiographic images and taught nuances of radiology.

d. Residents are expected to begin reading the core reading material prior to the start of their rotation and are expected to complete it during the rotation.

III. Educational Content / Structure of the Rotation

a. Learning Venues: The main learning venue is the Radiology Department of Mercy Hospital, Scranton.

b. Types of Clinical Encounters: Most of the teaching is “film based” but occasional patient interaction may occur when a patient comes to the Radiology Department for a special test.

c. Disease Mix: The disease mix includes all patients, including inpatient and outpatient, who are undergoing radiological testing.

d. Patient Characteristics: Radiology cases will include predominantly inpatient imaging from Mercy Hospital but may also include outpatient imaging read by radiologists. The demographic and ethnic mix approximates that of the Scranton and surrounding areas.

e. Services: While assigned to the radiology rotation, residents will be under the direct supervision and guidance of a certified radiologist. No clinical activity will occur without being supervised.

f. Procedures: The radiological tests and procedures available for observation and interpretation are listed below; however emphasis will be placed on interpreting Chest X-Rays and CT scans.

   i. Chest X-Rays
   ii. Abdominal X-Rays
   iii. Computed Tomography
   iv. Magnetic Resonance Imaging
   v. Ultrasonography
   vi. Mammography
vii. Nuclear Imaging  
viii. Interventional Radiology Procedures

g. Pathological Materials: None.

IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List: Library facilities are available at Mercy Hospital with onsite medical librarians. Web-based searchable medical databases are available, and standard medical journals are available in both print and electronic formats.

List of suggested textbooks for reading:

All resident can access the Up-to-Date database and text using their own personal subscription.

Selected topics and material provided by the instructor.

b. Educational Resources: In addition to the reading list provided, residents will have available to them library resources at both Mercy and Moses Taylor Hospitals along with internet-based resources to review pulmonary medicine topics.

V. Methods of Evaluation

a. Resident Performance: Attending evaluations will be completed on each resident upon completion of the pulmonary medicine rotation. Residents will receive a summarized evaluation at the end of the rotation with both verbal and written comments.

b. Faculty Performance: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives

a. Patient Care: By the end of the rotation, the resident must be able to:
  i. Demonstrate a logical approach in the analysis of basic diagnostic radiological findings on plain film conventional radiology exams and have a basic knowledge of interpretation of more advanced diagnostic imaging modalities.
  ii. Form a differential diagnosis based on radiological findings.
  iii. Demonstrate an ability in using radiological technology to support decisions, procedures, prevention and patient-focused care.

b. Medical Knowledge: By completion of the rotation, the resident must be able to:
i. Identify indications for appropriate individual radiological investigations.

ii. Residents will develop satisfactory skill and competence in basic interpretation of plain film CR exams and some exposure to interpretation of more advanced imaging procedures such as CT and MRI scans.

c. Interpersonal and Communication Skills

i. Residents will productively and cooperatively participate in multidisciplinary treatment planning.

ii. Residents will actively work with the radiology support staff and demonstrate the ability to work well in a team setting.

iii. The resident will create and sustain a therapeutic and ethically sound relationship with patients and their families.

iv. The resident will demonstrate the ability to communicate effectively and demonstrate caring, compassionate, and respectful behavior in all patient encounters.

d. Professionalism

i. Residents will demonstrate respect, compassion and integrity.

ii. Resident will be committed to excellence and continuous professional development.

e. Practice-Based Learning and Improvement

i. The resident will be able to locate, critically appraise, and assimilate evidence from scientific studies and apply it to patients' health problems.

ii. Residents will learn to use information technology to manage information, access on-line medical resources, and support self-education, patient care decisions and patient education.

iii. The residents will be able to apply the indications of appropriate radiology testing learnt in this rotation to their clinical practice.

f. Systems-Based Practice

i. Residents will be able to practice cost-effective health care and resource allocation while advocating for quality.

ii. They will be able to recognize costs of outpatient radiology testing and be able to use the most cost-effective therapy on an individual basis.

REHABILITATION MEDICINE CURRICULUM

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I. Educational Purpose and Goals

The rehabilitation medicine sessions are intended to allow internal medicine residents opportunities to develop history and physical examination skills, competence in the use of technology, diagnostic testing, and medication prescription, and exposure to basic neurorehabilitation under the supervision of a board-certified physiatrist. In addition, the resident will be given exposure to the variety of rehabilitation options available for patients, including but not limited to neurorehabilitation, cardiac rehabilitation, and pulmonary rehabilitation.

At the completion of this clinical experience, the learner will:

- Be able to appropriately diagnose and begin treatment of common physiatric problems encountered in the primary care office.
- Be able to perform a complete neurologic evaluation of the rehabilitation patient, including examination of mental status, cranial nerve function, motor and sensory function, cerebellar function and gait.
- Be able appropriately prescribe rehabilitation treatment for patients, including pharmacologic treatments, physical and occupational therapy, and other necessary services.

II. Principal Teaching Methods

Residents are expected to participate in direct patient care under the supervision of a rehabilitation medicine attending physician. Whenever possible, patients will be evaluated first by the medicine resident, who will then present the case to the rehabilitation medicine attending prior to implementing a plan of care.

Medicine residents will be given core reading material prior to their rotation, and will be expected to complete this during their rotation.

Rehabilitation medicine attendings may supplement patients seen with standardized cases to offer residents a greater exposure to rehabilitation medicine.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Rehabilitation units at Mercy Hospital and Moses Taylor Hospitals.

b. Types of Clinical Encounters: Mostly inpatient at the rehabilitation units at Mercy Hospital and Moses Taylor Hospitals. Occasionally residents might accompany the attending to his outpatient rehabilitation center for ambulatory exposure. Medicine residents will not be provided a unique schedule; however, they will be able to choose patients from the schedules of the individual clinics that best meet their educational needs. Patients seen will be tracked to ensure medicine residents are participating in the care of an appropriate number of patients.

c. Disease Mix: The disease mix includes all patients, including inpatient and outpatient, who are undergoing rehabilitation.

d. Patient Characteristics: Care is provided for patients from adolescence to geriatric ages. The racial and ethnic distribution reflects the diversity within the Scranton Valley. When English is not the primary spoken language, interpretation services are available to assist in the patient care setting, either through direct interview or via a remote language line service.

e. Services: All care will be under the direct supervision of an attending physiatrist.
f. **Procedures**: Medicine residents are expected to observe and perform diagnostic testing appropriate for rehabilitation medicine.

g. **Pathological Materials**: None.

**IV. Principal Ancillary Educational Materials / Educational Resources**

a. **Reading List**:


b. **Educational Resources**: In addition to the reading list provided, residents will have available to them library resources at both Mercy and Moses Taylor Hospitals along with internet-based resources to review pulmonary medicine topics.

**V. Methods of Evaluation**

a. **Resident Performance**: Attending evaluations will be completed on each resident upon completion of the pulmonary medicine rotation. Residents will receive a summarized evaluation at the end of the rotation with both verbal and written comments.

b. **Faculty Performance**: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. **Program Performance**: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

**VI. Rotation Specific Progressive Learning Goals and Competency Objectives**
<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Interviewing</td>
<td>• Resident will obtain focused HPI and/or complete H&amp;P for rehabilitation patients, as appropriate.</td>
</tr>
<tr>
<td></td>
<td>• Residents should present cases with appropriate details of chief complaint.</td>
</tr>
<tr>
<td></td>
<td>• Resident will use interpretation service when patient cannot communicate in spoken English.</td>
</tr>
<tr>
<td>Patient Care Physical Examination</td>
<td>• Resident will perform focused or detailed physical examination, as appropriate. This includes routine examination and any pertinent maneuvers or procedures.</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>• Resident will understand the epidemiology, evaluation, and treatment of common rehabilitation issues encountered by the general internist.</td>
</tr>
<tr>
<td>Procedural Skills</td>
<td>• Resident will develop experience and competence in the performance of neurorehabilitation testing.</td>
</tr>
<tr>
<td>Practice-Based Learning and Improvement</td>
<td>• Resident will prioritize diagnostic and treatment decisions based on severity of illness.</td>
</tr>
<tr>
<td></td>
<td>• Resident will develop clinical judgment regarding therapeutic decisions.</td>
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<tr>
<td></td>
<td>• Resident will participate as part of the team in providing care.</td>
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<td>• Resident will seek and accept feedback.</td>
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<td>Systems-Based Practice</td>
<td>• Resident can effectively initiate the appropriate clinical pathways.</td>
</tr>
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<td>• Resident can appropriately use further consultants in the care of the patient.</td>
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<td>• Resident will be prepared to integrate information into a multidisciplinary approach to rehabilitation care and services for medical patients.</td>
</tr>
<tr>
<td>Interpersonal and Communication Skills</td>
<td>• Resident communicates effectively with patients and family members.</td>
</tr>
<tr>
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<td>• Resident is respectful to the patient.</td>
</tr>
<tr>
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<td>• Resident is concerned about patient comfort.</td>
</tr>
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<td></td>
<td>• Resident involves patient in discussions about further care.</td>
</tr>
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<td>Professionalism</td>
<td>• Resident completes all work prior to leaving for the day.</td>
</tr>
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<td>• Resident offers assistance to other team members, as necessary.</td>
</tr>
<tr>
<td></td>
<td>• Resident completes assigned required reading.</td>
</tr>
<tr>
<td></td>
<td>• Resident recognizes and takes steps/actions to correct perceived deficiencies.</td>
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<td>• Resident treats staff and other team members with respect.</td>
</tr>
</tbody>
</table>
# REHABILITATION MEDICINE ROTATION SELF DIRECTED LEARNING CHECKLIST

Name: ______________________________  Rotation Dates: __________

Informal Discussion / Self Directed Learning Topics:

<table>
<thead>
<tr>
<th>Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurologic Evaluation</td>
</tr>
<tr>
<td>Gait Analysis</td>
</tr>
<tr>
<td>Swallowing and Dysphagia</td>
</tr>
<tr>
<td>Occupational Therapy</td>
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<tr>
<td>Cardiac Rehabilitation</td>
</tr>
<tr>
<td>Pulmonary Rehabilitation</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

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RHEUMATOLOGY CURRICULUM

I. Educational Purpose and Goals

The rheumatology rotation allows residents to acquire history and physical examination skills, develop expertise in the use of diagnostic testing, and learn management skills working with patients presenting with rheumatic disease.

II. Principal Teaching Methods

Residents learn rheumatology by supervised direct patient care. Residents work one-on-one with a board certified faculty rheumatologist who directly supervises all resident activities.

Also, didactic sessions in rheumatology are held throughout the year.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Rheumatology experience is mostly gained at the outpatient offices of the rheumatology attending. Inpatient exposure is less common but may occur on admitted patients at Mercy and Moses Taylor Hospitals.

b. Types of Clinical Encounters: Rheumatology training for internal medicine residents is mainly in the outpatient setting and allows the residents to become familiar with aspects of rheumatologic care that can be diagnosed and managed by general internists. Inpatients are seen either as primary patients on the rheumatology service or as consults requested through other departments.

c. Disease Mix: Residents are exposed to the full spectrum of rheumatic disease. Patient care is provided in the inpatient and outpatient setting. Inpatient care is generally consulted. Outpatients are seen in the faculty rheumatologist’s private office.

d. Patient Characteristics: Patient care is provided for adolescent through geriatric age patients. Patients of both sexes and all ethnic backgrounds are seen while on the rheumatology rotation. When English is not the primary language, interpreters are available for translation service in all patient care settings.

e. Services: Residents will work directly with faculty rheumatologists in either the inpatient or the outpatient setting. No clinical activity will occur without being supervised.

f. Procedures: Residents are expected to develop expertise and confidence in arthrocentesis, intra-articular injection of medium and large joints as well as soft tissue injections while on rotation. In addition, residents will learn the indications and contra-indications of arthrocentesis. In the setting of crystal induced disease, residents will develop confidence in the preparation and interpretation of joint fluid specimens using the polarizing microscope. Interpretation of bone / joint radiographs as they apply to rheumatology will all so be stressed.

g. Pathological Materials: Pathological material will be reviewed based upon patient mix. In general, this will include joint fluid and histopathology as applies to rheumatic disease.

IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List:
i. Rheumatology topics from Uptodate
ii. Rheumatology section of Harrison's Principles of Internal Medicine
iii. Rheumatology booklet of MKSAP
iv. The primer of rheumatic disease
v. Peer reviewed current literature based upon patient mix and reading assignments

b. **Education Resources:** In addition to the reading list provided, residents will have available to them library resources at both Mercy and Moses Taylor Hospitals along with internet-based resources to review medicine and rheumatology topics.

V. **Methods of Evaluation**

a. **Resident Performance:** Attending evaluations will be completed on each resident upon completion of the rheumatology rotation. Residents will receive a summarized evaluation at the end of the rotation with both verbal and written comments.

b. **Faculty Performance:** Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. **Program Performance:** Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. **Rotation Specific Progressive Learning Goals and Competency Objectives**
<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Care Interviewing</strong></td>
<td>• Resident will obtain a detailed HPI emphasizing chronology of presentation and containing good descriptions of symptoms.</td>
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<tr>
<td></td>
<td>• Resident’s presentation will include appropriate pertinent positives and negatives.</td>
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<td></td>
<td>• Resident will use appropriate additional sources of data if patient cannot give a history.</td>
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<tr>
<td><strong>Patient Care Physical Examination</strong></td>
<td>• Resident will tailor the physical examination to the patient’s complaint.</td>
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<td></td>
<td>• Resident will be able to accurately identify and discriminate fibromyalgia from inflammatory connective tissue disease presentations.</td>
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<td>• Resident will be able to distinguish between inflammatory and non-inflammatory arthritic presentations.</td>
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<td></td>
<td>• Resident will be able to identify and characterize physical findings leading to the diagnosis of systemic lupus erythematosus, progressive systemic sclerosis, myositis, vasculitis, and rheumatoid arthritis, and the seronegative arthritides.</td>
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<td></td>
<td>• Resident will be able to identify the presence of a joint effusion.</td>
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<tr>
<td><strong>Medical Knowledge</strong></td>
<td>• Resident understands the epidemiology, pathophysiology, and pharmacology of common rheumatic disease syndromes, including polyarthritis, monoarthritis, fibromyalgia, vasculitis, systemic lupus erythematosus, scleroderma, and myositis.</td>
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<tr>
<td></td>
<td>• Resident will demonstrate developing competency in the ordering of rheumatologic serologies and in the interpretation of basic bone and joint x-rays.</td>
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<tr>
<td><strong>Procedural Skills</strong></td>
<td>• Resident will develop competency in large joint arthrocentesis (knee).</td>
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<td>• Resident will demonstrate developing competency in soft tissue and medium and large joint injection techniques.</td>
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<td>• Resident will demonstrate developing competency in crystal examination of joint fluid.</td>
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<td></td>
<td>• Resident will demonstrate developing competency in gram stain interpretation of infectious arthritis.</td>
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<tr>
<td><strong>Practice-Based Learning and Improvement</strong></td>
<td>• Resident prioritizes diagnostic and therapeutic decisions based on patient’s severity of illness.</td>
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<td>• Resident will develop clinical judgment in the strategies used to match drug treatment protocols with specific rheumatic diseases.</td>
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<td></td>
<td>• Resident will utilize core reading material to facilitate learning.</td>
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<tr>
<td><strong>Systems-Based Practice</strong></td>
<td>• Resident can effectively initiate the appropriate clinical pathways of care.</td>
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<td></td>
<td>• Resident can initiate the appropriate use of consultants in the care of patients with rheumatologic disease.</td>
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<td></td>
<td>• Resident serves as a consultant to other services with extensive faculty oversight.</td>
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<td></td>
<td>• Resident develops a multidisciplinary approach to rheumatologic care.</td>
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<tr>
<td><strong>Interpersonal and Communication Skills</strong></td>
<td>• Resident communicates regularly with patient and his / her family.</td>
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<tr>
<td></td>
<td>• Resident is respectful to the patient.</td>
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<tr>
<td></td>
<td>• Resident is concerned about the patient’s comfort.</td>
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<tr>
<td></td>
<td>• Resident communicates effectively with other members of the health care team.</td>
</tr>
<tr>
<td><strong>Professionalism</strong></td>
<td>• Resident completes the history and physical / consultation within 24 hours of contact, and writes a daily progress note as appropriate.</td>
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<td>• Resident will follow through with scholarly assignments promptly.</td>
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<td>• Resident completes medical records on time.</td>
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<td></td>
<td>• Resident recognizes and takes steps to correct his / her deficiencies.</td>
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<tr>
<td></td>
<td>• Resident treats team members, including nurses and other health care providers, with respect.</td>
</tr>
<tr>
<td></td>
<td>• Resident acknowledges personal reaction to morbidity and mortality associated with rheumatologic disease.</td>
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<tr>
<td></td>
<td>• Resident adheres to all ACGME mandated duty hour restrictions.</td>
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</tbody>
</table>
# RHEUMATOLOGY ROTATION EXPECTATIONS

## PGY-2, PGY-3

Competency at each year includes continued demonstration of the preceding year’s competency goals.

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Care</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Interviewing                    | • Resident will obtain a detailed HPI, will present without notes and his presentation will include appropriate pertinent positives and negatives.  
                                       • Resident will use appropriate additional sources of data if patient cannot give a history.  
                                       • Resident teaches junior residents / medical students the fundamentals of time sensitive interviewing technique.                                                                                           |
| Physical Examination            | • Resident will tailor the physical examination to the patient’s complaint.  
                                       • Resident will be able to accurately identify and discriminate fibromyalgia from inflammatory connective tissue disease presentations.  
                                       • Resident will be able to distinguish between inflammatory and non-inflammatory arthritic presentations.  
                                       • Resident will be able to identify and characterize physical findings allowing for the discrimination of inflammatory connective tissue diseases including systemic lupus erythematosis, progressive systemic sclerosis, myositis, vasculitis, and rheumatoid arthritis.  
                                       • Resident will be able to identify the presence of a joint effusion.  
                                       • Resident teaches junior residents / medical students the fundamentals of time sensitive physical examination.                                                                 |
| Medical Knowledge               | • Resident understands the epidemiology, pathophysiology, and pharmacology of common rheumatic disease syndromes, including polyarthritis, monoarthritis, fibromyalgia, vasculitis, systemic lupus erythematosus, scleroderma, and myositis.  
                                       • Resident will demonstrate competency in discriminating between the classic crystal induced arthropathies.  
                                       • Resident will develop experience with the ordering of rheumatologic serologies as well as an understanding of the indications for the use of these tests.                                      |
| Procedural Skills               | • Resident will demonstrate competency in large joint arthrocentesis (knee), in soft tissue and medium and large joint injection techniques, in crystal examination of joint fluid and in gram stain interpretation of infectious arthritis. |
| Practice-Based Learning and Improvement | • Resident prioritizes diagnostic and therapeutic decisions based on patient’s severity of illness.  
                                       • Resident demonstrates clinical judgment in the strategies used to match drug treatment protocols with specific rheumatic diseases.  
                                       • Resident will use major textbooks, review articles, and current literature to facilitate patient care and integrates current evidence-based literature into patient care and teaching responsibilities.  
                                       • Resident actively seeks and accepts feedback.                                                                                                       |
| Systems-Based Practice          | • Resident can effectively initiate the appropriate clinical pathways.  
                                       • Resident can initiate the appropriate use of consultants in the care of patients with rheumatologic disease.  
                                       • Resident serves as a consultant to other services with minimal faculty input.  
                                       • Resident develops a multidisciplinary approach to rheumatologic care.  
                                       • Resident critically evaluates all consultant evaluations including conflicting recommendation to develop an effective patient care plan. |
| Interpersonal and Communication Skills | • Resident communicates regularly with patient and his / her family.  
                                       • Resident is respectful to the patient.  
                                       • Resident is concerned about the patient’s comfort.  
                                       • Resident addresses patient care issues such as end of life decisions with moderate faculty input.  
                                       • Resident is able to deal with challenging patients and families.  
                                       • Resident functions as an effective team leader and provides feedback to junior team members.                                                                 |
| Professionalism                 | • Resident has history and physical / consultation on chart within 24 hours of admission or consultation, and writes a daily progress note as appropriate.                                                                 |

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• Resident will follow through with scholarly assignments promptly.
• Resident completes medical records on time.
• Resident recognizes and takes steps to correct his / her deficiencies.
• Resident treats team members, including nurses and other non-physician health care providers, with respect.
• Resident identifies ethical issues and employs available resources to solve them.
• Resident counsels junior team members on issues of professionalism including personal reactions to the morbidity and mortality associated with the care of rheumatologic disease.
• Resident adheres to all ACGME mandated duty hour restrictions.
UROLOGY CURRICULUM

I. Educational Purpose and Goals

The urology rotation allows residents to acquire history and physical examination skills, develop expertise in the use of diagnostic testing, and learn management skills working with patients presenting with urologic disease.

II. Principal Teaching Methods

Residents learn urology by supervised direct patient care. Residents work one-on-one with a board certified faculty urologist who directly supervises all resident activities.

In addition, didactic sessions in urology are held throughout the year.

III. Educational Content / Structure of the Rotation

a. Learning Venues: Urology experience is mostly gained at the outpatient offices of the urology attending. Inpatient exposure is less common but may occur on admitted patients at Mercy and Moses Taylor Hospitals.

b. Types of Clinical Encounters: Urology training for internal medicine residents is mainly in the outpatient setting and allows the residents to become familiar with aspects of urologic care that can be diagnosed and managed by general internists. Inpatients are seen either as primary patients on the urology service or as consults requested through other departments.

c. Disease Mix: Residents are exposed to the full spectrum of urologic disease. Patient care is provided in the inpatient and outpatient setting. Inpatient care is generally consulted. Outpatients are seen in the faculty urologist’s private office.

d. Patient Characteristics: Patient care is provided for adolescent through geriatric age patients. Patients of both sexes and all ethnic backgrounds are seen while on the urology rotation. When English is not the primary language, interpreters are available for translation service in all patient care settings.

e. Services: Residents will work directly with faculty urologists in either the inpatient or the outpatient setting. No clinical activity will occur without being supervised.

f. Procedures: None

g. Pathological Materials: Pathological material will be reviewed based upon patient mix.

IV. Principal Ancillary Educational Materials / Educational Resources

a. Reading List:
   i. Urology topics from Uptodate
   ii. Urology section of Harrison’s Principles of Internal Medicine
   iii. Peer reviewed current literature based upon patient mix and reading assignments

b. Education Resources: In addition to the reading list provided, residents will have available to them library resources at both Mercy and Moses Taylor Hospitals along with internet-based resources to review medicine and rheumatology topics.
V. Methods of Evaluation

a. Resident Performance: Attending evaluations will be completed on each resident upon completion of the rheumatology rotation. Residents will receive a summarized evaluation at the end of the rotation with both verbal and written comments.

b. Faculty Performance: Upon completion of each rotation, residents complete a confidential web-based electronic faculty evaluation.

c. Program Performance: Residents complete a semi-annual program evaluation form commenting on the faculty, facilities, and service experience. These evaluations are returned to the residency administration for review. The Program Director uses the feedback for improvement of the rotations and learning experiences.

VI. Rotation Specific Progressive Learning Goals and Competency Objectives

UROLOGY ROTATION EXPECTATIONS
PGY-1, PGY-2, PGY-3

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Expected Behaviors / Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Interviewing</td>
<td>• Resident will obtain a complete urologic history for patients presenting for urologic care.</td>
</tr>
<tr>
<td></td>
<td>• Residents should present cases with appropriate details of chief complaint.</td>
</tr>
<tr>
<td></td>
<td>• Resident will use interpretation service when patient cannot communicate in spoken English.</td>
</tr>
<tr>
<td>Patient Care Physical Examination</td>
<td>• Resident will perform a focused or detailed physical examination, as appropriate to the case.</td>
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<td></td>
<td>• Resident will gain confidence in performing a rectal examination, including a proper prostate examination in males.</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>• Resident will understand the epidemiology, evaluation, and treatment of common urologic illnesses encountered by the general internist.</td>
</tr>
<tr>
<td>Procedural Skills</td>
<td>• None.</td>
</tr>
<tr>
<td>Practice-Based Learning and Improvement</td>
<td>• Resident will prioritize diagnostic and treatment decisions based on the severity of illness.</td>
</tr>
<tr>
<td></td>
<td>• Resident will develop clinical judgment regarding therapeutic decisions.</td>
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<td>• Resident will participate as part of the team in providing care.</td>
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<td>• Resident will seek and accept feedback.</td>
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<tr>
<td>Systems-Based Practice</td>
<td>• Resident can effectively initiate the appropriate clinical pathways.</td>
</tr>
<tr>
<td></td>
<td>• Resident can appropriately use further consultants in the care of the patient.</td>
</tr>
<tr>
<td></td>
<td>• Resident will be prepared to integrate information into a multidisciplinary approach to urologic care for medical patients.</td>
</tr>
<tr>
<td>Interpersonal and Communication Skills</td>
<td>• Resident communicates effectively with patients and his/her family members.</td>
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<td>Professionalism</td>
<td>• Resident completes all work prior to leaving the clinic.</td>
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<td>• Resident offers assistance to other team members, as necessary.</td>
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</tr>
</tbody>
</table>
ROTATION SIGN-IN SHEET

Name: 

Year of Residency Training: 

Date: 

Rotation: 

A key component of adult based learning is pro-actively identifying key learning objectives at the onset of an educational experience.

Please identify 5 key learning objectives for your rotation block and discuss them with the attending at the beginning of your rotation.

1. 

2. 

3. 

4. 

5. 

Signature: 

Note: Each resident will be responsible to seek 2 Patient Evaluations of Residents and 2 Mini-CEXs each while on service and in the MVP Clinic.
GOALS, OBJECTIVES AND METHODS OF ASSESSMENT OF THE VARIOUS CONFERENCES

Ambulatory Care Conference

Goals: To systematically review and present to peers, as a powerpoint presentation, a topic of importance in the ambulatory practice domain.

Objectives:
- To review important ambulatory medicine topics.
- To develop confidence in synthesizing and providing powerpoint presentations to enhance self and peer education.
- To gain confidence in answering questions raised by peers and faculty.

How are residents assessed: Competency based evaluation on www.myevaluations.com plus a verbal feedback on the thoroughness of the presentation and any additional issues that should have been addressed from the supervising ambulatory medicine faculty.

Morning Reports

Goals: Morning reports are faculty facilitated resident case based presentations to promote resident discussion and review of patients admitted to the teaching service. In addition to learning effective presentation of history, examination and pertinent lab and ancillary test results, presenting residents learn to engage peers in active discussion of patient-centered management plans and to promote active participant sharing of clinical judgement and skills of decision making.

Objectives:
- To review important admissions to the teaching service.
- To develop confidence in case presentations.
- To learn to establish an effective and coherent differential diagnosis based on the history, physical examination, laboratory and radiological tests.
- To review topics of importance to inpatient medicine.
- To learn principles of ICU care (Thursday ICU morning report).

How are residents assessed: Verbal faculty feedback and competency based evaluation from the supervising faculty on www.myevaluations.com.

Grand Rounds

Goals: Case presentation of a teaching service patient followed by a thorough, detailed and systematic review of the pertinent topic in internal medicine to peers, faculty and the general medical staff.

Objectives:
- To learn to identify goals and objectives for a presentation.
- To develop confidence in making formal presentations to a large audience of physicians.
- To review a topic of importance to inpatient medicine.
- To conduct an evidence based medicine search and thorough, systematic review of an internal medicine topic which includes the critical appraisal of relevant literature, particularly with regard to diagnostic and therapeutic management.
**How are residents assessed:** A Program Evaluation form is filled by the physicians present at the conference. A summary of the evaluations received is given to the resident, which includes whether the objectives presented at the beginning of the conference were met or not, constructive comments on the organization of the presentation and the slideshow and whether practice change will likely result based on the given presentation.

**STHC Tuesday Noon Conference**

**Goals:** To have subspecialty speakers give didactic presentations on topics relevant for the internal medicine residents followed by an interactive discussion on the topic presented.

**Objectives:**
- To provide didactic lecture series on topics of medical subspecialties and other relevant topics.

**How are residents assessed:** Not applicable.

**Tumor Board**

**Goals:** To discuss clinical-pathological correlation of important and/or rare case presentations of tumors of different kinds and their optimal multidisciplinary management.

**Objectives:**
- To review case based presentations of common/rare tumors.
- To review pathology slides of the tumors, stressing their characteristic features and special staining characteristics.
- To review related radiological studies.
- To learn management guidelines for cancer patients.
- To learn the value of multidisciplinary participation in the care and management of cancer patients including the contributions of primary care, medical subspecialists, surgery, nursing, radiology services, radiation therapy, chemotherapy and rehabilitation services.
- To have an opportunity to present to the medical staff.
- To have an opportunity to experience established physicians case presentation skills and to constructively evaluate them.

**How are residents assessed:** Verbal evaluation by the supervising faculty member. In addition, a program evaluation form is filled by the physicians present at the conference. A summary of the evaluations received is given to the resident or faculty presenter. The evaluation includes whether the objectives presented at the beginning of the conference were met or not and whether practice change will result based on what is presented.

**Journal Club**

**Goals:** To critically appraise selected critical care articles using standard EBM techniques.

**Objectives:**
- To review and apply EBM search skills.
- To learn the skills for critical appraisal of specific studies.
- To learn the skills needed to present such an appraisal to an audience of peers and faculty.

**How are residents assessed:** The Journal Club is evaluated by Dr. Edward Dzielak, DO, ICU attending and Journal Club supervisor formally in our online evaluation system (www.myevaluations.com).
**Morbidity and Mortality Conference**

**Goals:** To present and review cases which resulted in suboptimal medical outcomes in a blameless environment.

**Objectives:**
- To learn the process of blameless and thoughtful reflection on suboptimal patient outcomes.
- To promote experiential learning from medical errors.
- To learn to promote a blameless environment for the disclosure of medical errors and the skills of micro-system and root cause analysis to facilitate system improvement.
- To review pathology slides, autopsy findings, and/or organ examination, if applicable.

**How are residents assessed:** Dr. Haitham Abughnia, MD, key clinical faculty member of the program guides and supervises the conference and then gives a one-on-one verbal evaluation to the residents involved. Resident documentation of related self-reflection and the M/M conference experience is encouraged in the resident portfolio.

**Resident as Teachers Conference**

**Goals:** To facilitate the transition of interns into the senior resident role emphasizing the development of skills for team leadership, supervision of patient care, peer education and performance feedback, and increased communication with the family and involved consultants.

**Objectives:**
- The development of teaching skills.
- The ability to give effective formative feedback.
- The role of mentoring and modeling professionalism.
- The necessary components of leadership including emotional intelligence and sensitivity and self awareness and self regulation.
- The enhancement of communication skills
- The development of system improvement skills

**How are residents assessed:** Feedback is given by the program faculty to the resident participants as part of the conference itself and continually in their future performance in the mentioned areas through monthly rotational competency based 360 degree evaluations.