Gen Med Block Expectations and Orientation - Vikas Parekh, MD

****Introductions/Who are You and What are your goals?**

Nuts/Bolts:

1. Schedule for rounding :
   -Time TBD post-late call – sit or walk depending on team desires– I'll read up best I can before rounds and for those patients we can do shorter presentations focused on A+P. (**please use and update the shared team list in careweb so I can see who you admitted even if your notes are not up yet)
   - non-post-late call can vary based on census but usually 8:30 am weekdays – we'll just walk unless there is something sensitive we need to talk about in conf. room (or if we need to review images,etc). Presentations outside patient's rooms can be limited to 1-liner plus updates/new data and then A+P.
   I will always page you to let you know if there is a change in plans/time and expect the same from you. It is totally OK to delay rounds, etc if urgent issues intercede patient care should always be the priority
   -Generally we can round by gravity but we should see any sick patients first and anyone who is pending a major diagnostic decision (or discharge decision) after that to ensure expedient patient care

2. Resident schedules:
   -Days off – The SMR should make a schedule of days off and post it in the conference room.
   -Clinic days/times – please let me know when they are, post on board

3. Case managers/Discharge planning – I'll typically meet and discuss service with case managers after rounds – SMR/interns are encouraged/welcome to join in but if busy or if it's time for morning report then you should work and I'll update you via page with anything major

4. Touching Base at the end of the day – I like to touch base (page me and we'll chat) at the end of the day to keep up to speed on daily events and expedite rounds/patients care – SMR can do this when present, interns when SMR off. Do this before when you're wrapping up for the day.

Patient Care:

1. Pre-round on patients to gather interval history, exam, etc before we meet and formulate a plan of care before we meet. Having said this, I realize you don't have time to do a full exam, etc on everyone, that's OK but I do expect you've seen/done relevant exam by the time we meet. For holdovers on early call, I understand you may have limited time before rounds but I expect you've at least quickly seen the patient, done a brief focused exam on relevant systems and know the basic story before we round. We can definitely look up details later on or on rounds.
2. Review active med list, labs, micro daily (rounding sheets can help but remember to look at MAR daily in Carelink (new Med View tab) to see if critical meds actually given)
3. Review all imaging (x-ray, CT, etc) with your own eyes – don't simply rely on the report
4. Team work – Remember the team extends beyond just MDs – involve nursing, PT, OT, SW, D/c planning, etc in the care of the patient and if you have ?s make a point of talking to these key members of the team.
5. My role is to provide input, teaching and supervision but I expect the SMRs to be running the show and steering the ship. Interns are the primary care provider for their patients and should be on top of their patients care and details of their care.
6. I am ALWAYS available by page, phone, etc. Please page me (#12377) at anytime. My cell phone is 734-330-4844 and my home phone is 734-930-9788. Review reasons you MUST call me (death, escalation of care, invasive procedure planned, consulting surgery emergently, med error, etc) but remember you can Always call me for any ?s or to help facilitate patient care such as nudging reluctant consultants, etc. When in doubt, err on the side of contacting me.
7. Contact PCP/primary MD (maybe a specialist) on admit and at discharge. Email is great for internal docs. For those outside our system use M-Line so you're not wasting time. While this may take extra time it will

add save a lot of effort, frustration and ensures your patient gets the care they need. *I can help with this especially on busy days – just ask me or let know me which patients you want me to help with*

8. Consultants – We will consult when appropriate to facilitate patient care or to get advice on patient care. We should always have a question for our consultants to answer for us or an issue for them to help us with. Remember, however, we are driving the show, consultant's recommendations are just that – we will discuss and decide what to recs to implement and which we do not agree with. Always feel free to ask consultants the reasoning behind their recommendations.
9. Systems Issues/Errors/etc- These will occur. We should openly discuss, figure out how best to handle and how best to address (i.e. who to inform, who to discuss systems issues with, etc).
10. Notes – comprehensive but succinct and up to date plans – avoid excessive copy/paste
11. Code Status – always address on new admits
12. Contact Info- get family/next of kin contact info and document on all new admits – families disappear by morning and then we're often stuck when ?s come up during the day.
13. Discharge Summaries- most important parts are med reconciliation and clinical course plus outstanding issues/follow-up items (such as pending labs, etc). Bulleted format by problem works well. Try to anticipate discharge in advance to allow Res. Asst to book d/c appts prior to discharge so they are in d/c summary.
14. Keep a list of follow-up items post-discharge (labs, bx, etc) and note who is following it up and when we need to follow-up.

Teaching:

We are all here to learn through the process of providing optimal care to our patients. We should all feel comfortable asking questions about anything and should feel comfortable admitting we don't know. We should then come up with a plan on how we as a team will answer our questions. On rounds I will try to capture questions and write them down so we don't forget them.

We can do formal teaching as the schedule allows – please let me know what you want to hear about and I will work to plot out a schedule.

I will also send around what I call the "post-call evidence" summary – I will endeavor to do this periodically – typically a minimum of once every 4 day call cycle – this will be my attempt to ask a few key questions about our patients and answer those questions with the evidence. My goal is get us thinking about our patients and also to help you see how/where to go to answer questions. We can discuss what I send out the next-day on rounds.

Obviously, you should make an effort to attend all program teaching activities such as MR and Noon Conferences/Intern Reports.

Feedback:

If you have questions about how you things are going just ask. I will definitely let you if things are not going well by the end of week 1. I will sit down with you at the end of the 2 weeks to give you formal feedback.

Questions???