

Orientation to General Internal Medicine and Consultation Rotations at Memorial Hermann Hospital

Effective 7/1/08

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I. Internal Medicine Office

The Department of Internal Medicine is located on the first floor of the medical school building, adjacent to the green elevators on the back hallway. The Chairman's Office and the Kirkendall Library are located in MSB 1.150. The Program Director's Office is in MSB 1.126. Dr. Farnie's assistant is Dolores Castro. Cindy Collins is the Education Coordinator and is also located in Dr. Farnie's Office. The Residency Program House Staff Office is at MSB 1.134: Susan Jones, Phyllis Martin, and Charity Harbes are the program coordinators. The Chief Medical Resident Office is at MSB 1.124.

Departmental Phone Numbers

- Chairman's Office/Department (713) 500-6500
- Dolores Castro (713) 500-6528
- Residency Program/Susan Jones (713) 500-6525
- Phyllis Martin (713) 500-6526
- Charity Harbes (713) 500-6536
- Chief Medical Residents (713) 500-6523

After hours or if you are sick or have an emergency and cannot report for work, please notify the Float Chief Resident, who can be reached at pager number 22001. This pager is active twenty-four hours a day, seven days a week.

II. Conferences

All required conferences for those rotating at Memorial Hermann Hospital are held in the Medical School Building. Weekdays (Monday through Friday) there will be a Morning Report 8:00-9:00 am and a Noon Conference 12:00-1:00 pm daily. Attendance is required for all house staff and students. Please sign in before the conference begins in order to receive credit for attendance. Required conferences for ward teams include morning report and all noon conferences. Required conferences for the MICU and CCU rotations include all noon lectures, but not Morning Report. Post-call residents are excused from Noon Conference and Morning Report, with the exception of the Post call Ward Resident presenting at Post Call Morning Report with Dr. Orlander on Tuesday and Thursday mornings. Consultation residents are required to attend Morning Report and Noon Conference, but may substitute subspecialty conferences that are sponsored by other divisions; please notify the Chief Resident by email so that you will receive credit.

If you have continuity clinic in the morning, you are excused from Morning Report that day. You are excused from noon conference if you have a morning continuity clinic and it runs long; however, you will get extra credit if you make it in time to noon conference. If you have continuity clinic at a location other than the hospital that you are currently rotating through, then you are excused from noon conference to account for travel time. Please notify the Chief Resident so that your conference attendance can be adjusted accordingly.

Please be on time and set your pagers and cell phones to silent before each conference begins. If you must answer pages, please slip out of the back of the room quietly and return promptly if the issue does not require your immediate attention. Monthly conference attendance must be > 70%. For each month that your attendance >90%, you will have a letter of commendation placed in your file. Should your attendance be less than 70% for the month, you will be required to do an eight-hour shift in the LBJ Emergency Room and you will receive a letter reflecting this fact in your file. If you do not schedule this ER shift within 30 days of the end of the month, you will be assigned to an ER shift.

Description of Conferences:

Morning Reports

- General Morning Report will be held Mondays, Wednesdays and Fridays in MSB 2.135 from 8:00-9:00 am and all House Staff and Students assigned to Memorial Hermann Hospital are required to attend. The On call Interns will present one case each for which they have prepared a complete discussion and one PowerPoint teaching slide.
- Post Call Morning Report will be held in the Kirkendall Library in MSB 1.150 on Tuesday and Thursday Mornings 8:00-9:00 am with Dr. Orlander. Only PGY-2 and PGY-3 Residents on Ward or Consultation services attend these conferences and the Post call Ward Resident will present cases to Dr. Orlander based on the Dr. Fred Morning Report Card system. (Please refer to the Chief's Corner for a document explaining this system).
- Intern/Student Morning Report will occur on Tuesday and Thursday Mornings in MSB 2.135 from 8:00-9:00 am. All Interns and Medical Students assigned to Memorial Hermann are expected to attend. Discussion will be facilitated by the Assistant Chiefs of Service and two cases will be presented by the on call Interns and Medical Students in the same fashion as General Morning Report.
- Dr. James T. Willerson, Former President of the UT Health Science Center, will conduct Morning Report on selected Saturdays in the Kirkendall Library (MSB 1.150) at 6:45 AM. The post-call ward resident will present one case for discussion. Attendance is mandatory for the post call ward team and the house staff and students of other ward teams that are in the hospital that morning.

Noon Conferences

- Didactic lectures on core curriculum topics will be presented by faculty members in the Department of Internal Medicine on Mondays, Wednesdays, Thursdays and Fridays in MSB 2.103.
- Grand Rounds will be given by guest lecturers for the Department of Internal Medicine each Tuesday in MSB 2.103.

- **Medicine-Radiology/Pathology Conferences** will occur monthly on the last Friday of the month in MSB 2.135. Ward teams and consultation services will be asked to provide interesting cases with radiologic findings for Radiology to discuss and then biopsy or peripheral blood smear specimens for Pathology to discuss. Each ward team should submit a case by the start of the 3rd week of the month. Submitting residents will be asked to give a 5 minute clinical history of the patient, complete with differential diagnosis and then the pathologic findings will be discussed by the Pathology Department.
- **Autopsy CPC** will be given on the last Thursday of the month at 12:00pm in MSB 2.135 and will be a joint conference between the Departments of Internal Medicine and Pathology. One case will be presented. The clinical piece of the case will be presented by the Upper level Medicine Resident that say the patient and will be presented in PowerPoint format. Afterwards, the pathologic specimens will be presented by one of the Pathology Residents and then there will be a multi-disciplinary discussion of the case.

III. General Orientation to Memorial Hermann Hospital

Memorial Hermann is composed of 5 Pavilions:

- **Robertson Pavilion:** Cafeteria on 1st floor; Operating Rooms, Day Surgery and Surgical Pathology on 2nd floor; other floors are Admin and call rooms.
- **Jones Pavilion:** Patient Rooms on all floors; Radiology on 2nd floor; Hemodialysis unit on the 9th floor.
- **Hermann Pavilion:** Women and Children's Hospital; 2nd floor PACU; 3rd floor with Transplant ICU and Shock Trauma ICU.
- **Cullen Pavilion:** MRI and Cullen Atrium on 1st floor; MIMU, MICU and call rooms on the 2nd floor; Internal Medicine patients on 3rd floor; Renal and Geriatric patients on the 4th floor; Private Internal Medicine patients on 5th floor.
- **Heart and Vascular Institute (HVI):** Cardiac Catheterization Labs on 2nd floor; Cardiac Imaging on 3rd floor; CCU on 4th floor, CIMU on 5th floor; CVICU on 8th floor

The House Staff Association Office is located on the 1st floor of Cullen Pavilion. This office manages call room keys, scrub cards, and parking.

- There are several eateries in and around the hospital: The Cafeteria (Cafe Hermann) is on the 1st floor Robertson Pavilion. There is also Brioche Doree (breakfast and lunch) at the top of the escalators and Au Bon Pain in the Memorial Hermann Professional Building on the 2nd floor at the end of the sky bridge. On the ground floor of the UTPB is the Rising Roll (lunch).

- A general ATM machine is adjacent to the general elevator bank on the 1st floor of the Jones Pavilion.

IV. Internal Medicine Ward Service

General Information

All Residents and Interns on the Ward services are required to be in the hospital at 6:45am on each day during the month that is not their day off. Each Resident and Intern is granted 4 days off for the month, which is averaged at 1 day off per week.

The general internal medicine in-patient service at Hermann consists of four teams A-D that admit and care for patients in the hospital until discharge. Each team consists of one resident and two interns and 3-5 third-year medical students, with the possible addition of fourth-year medical students that are Acting Interns.

Each team will take overnight call in the hospital every 4th night. Medical students will take overnight call with the team. Each new patient will be seen by medical students, interns and the upper level resident. Medical students and Interns will be required to each write a full admission history and physical exam on each new patient that they admit. Additionally, Interns are required to dictate their admission H&P in the MHH system within 24 hours of admission. Supervising Residents must write an admission note on every new admission, which may be a brief addendum that focuses on the assessment and plan, provided that a full intern history & physical is on the chart.

On Call Responsibilities

The on call Resident begins to receive new admissions at 7:00 am and ends at 2:00 am the following morning or when the cap is reached. All Internal Medicine admissions should be handled exclusively through the Internal Medicine admission pager (#24032) in order to avoid confusion over which resident is on call at any given time. The person who carries the admission pager must collect information about all admissions when paged. Do not ask the caller to page another resident. If for any reason you are paged directly on your personal pager for an admission, please accept the admission and politely direct the caller to the admission pager for subsequent admissions. **In your professional judgment, if you believe the patient would receive more appropriate care on a different service, promptly notify your attending. Please, do not argue with the emergency room.**

You may begin seeing a patient in the ER while they are waiting for transport to their assigned bed. In the event the ER "retracts" a patient after you have already spent time evaluating the patient, you still count that patient toward your total cap. If you feel that an admission is inappropriate for your service or for the assigned level of care, discuss the matter immediately with your attending, who can discuss the matter directly with the emergency room attending. In the event that patient care is compromised from

inappropriate triage and/or assignment to your service, promptly notify the Chief Resident on call.

Each morning at 2:00 am, ideally, the resident on call should pass off the admission pager to the Float Resident. Each morning at 6:30 am, the Float Resident, in turn, should pass off the admission pager to the next resident on call.

Note: Your attending physician must approve direct admissions from an outside hospital. Patients younger than 18 years are admitted to the Pediatrics service. Generally, a pregnant patient that is less than 20 gestational weeks will be admitted to the Internal Medicine service if she has a primary medicine problem. Patients 20 weeks and beyond with a primary medicine problem will go to the Maternal Fetal Medicine service and they may obtain a Medicine Consultation if assistance is needed. There may be exceptions to this general policy, which may require a discussion between the respective Attendings to determine the best service for the patient.

The “cap”

The team “cap” for the on call day includes new admissions from the emergency room, direct admissions from a UT Clinic or outside hospital, MICU transfers and patients admitted by the Float Resident overnight. The cap is defined as a total of 12 patients, of which no more than 10 can be new patients from the Emergency Room. The team may receive 2 or more In-house transfers from the MICU, but the total patients received must still not exceed 12, (i.e. it is theoretically possible for the team to receive 8 MICU transfers and 4 ER patients). This cap applies to the Resident on the team.

The cap for each Intern is 5 new patients and up to 2 in-house transfers per call night. The cap for Medical Students is 3 new patients per call night.

In-House Transfers

The MICU is allowed to transfer patients twenty-four hours a day. If the MICU notifies you of a transfer before 2:00 am, you must accept the patient. If your team is capped, or after 2:00 am, the Float Resident will accept the patient and assume care until the next day’s on call team is officially on duty at 7:00 am.

Post Call Rounds

On the morning following the night on call, post call teaching rounds will be conducted by the Attending physician on the service with the entire team, starting at 6:00am. The 3 West Cullen conference room may be used for post call rounds. All patients will be seen by the team and the Attending. By 1:00pm, the Post call team will check out to either the Post Call Cover Resident (if the post call day is Monday-Friday) or the Float Intern if it is Saturday, Sunday or a Holiday and then the post call team will be required to leave the hospital.

Bounce backs

A patient, who is under the care of an Internal Medicine Ward team from the 3rd of the month until the 2nd of the following month and requires readmission to a medicine service during that time, will be assigned to that same Internal Medicine Ward team that originally discharged the patient. Patients bounce back according to the Resident schedule. All patients from the Emergency Room, UT clinic, In-House transfers from the MICU or CCU, or transfers from outside hospitals will be admitted to the on call medicine team. If the patient was discharged by one of the Ward Residents (Medicine Team A-D, Cardiology, Renal Wards or Geriatrics) and the patient needs readmission to the hospital, the on call Medicine team will write a full admission H&P on the patient and after staffing the patient with their Attending, the patient may be transferred back to the team that previously cared for the patient. Residents should be notified at 7:00am of bounce backs, but care of the patient cannot be transferred until the admitting team has staffed the patient with their Attending.

Example: Resident A admitted and discharged Ms. Smith on December 5th. Ms. Smith comes back to the hospital December 12th and is admitted to Resident B on a different Ward team. Resident B is responsible for writing a full H&P and then staffing with their Attending and then may call Resident A at 7:00am on Resident B's post call morning and transfer care of the patient back to Resident A.

Daily Rounds

Daily Teaching Rounds are conducted by the Attending physician, seven days a week throughout the month. Residents, Interns and Medical Students are expected to be present (unless it is their day off), on time, prepared and to participate in rounds. Interns are required to write daily progress notes on each of their patients, unless it is their day off. If the Intern is off, it is expected that the Resident will write the progress notes on their patients.

Daily "pre-rounds" are required, regardless of the size of the service. Pre-rounds are conducted by the Resident and it is an opportunity for the Resident, Interns and Medical Students to review the patients and ensure the plan of care of each patient is clear. The upper level resident must see and examine every patient on the service daily prior to attending rounds. Although the upper level resident is not required to write a daily progress note, he/she must examine the patient and supervise the interns and students. As interns and students are still inexperienced, their history and physical examination skills may be incomplete. Ultimately, the upper level resident is accountable for all patients on the service.

Interdisciplinary Rounds

Walking rounds are performed daily (Monday-Friday) with the Nursing Manager, Case Manager and Social Worker on the 3 Cullen Medicine Floor. Meet on 3 E Cullen at nurse's station with (1) team member from each team (may be a Resident, Intern or

Student):

Team A 1:05-1:15pm
Team B 1:15-1:25pm
Team C 1:25-1:35pm
Team D 1:35-1:45pm
Renal Wards 1:45-1:55pm

V. MHH Case Managers/Social Workers

	3 Cullen	4 Cullen	5 Cullen
Clinical Manager pager	Phyllis Bertash 22982	Trina Allison-Moss 29617	Destiny Williams 18578
Case Manager pager	Katherine Koger 18954 Rooms C301-355 Aileen Dejele 20196 C356-366	Aileen Dejele 20196	Renita Buckner 24551
Social Work pager	Debbie Brod 29610 Leila Oreuber 19513 C312-318, 330-347	Debbie Brod 29610	Leila Oreuber 19513
Director:	Virginia Earley 22642	Virginia Earley 22642	Virginia Earley 22642

VI. Renal Ward Service

The Renal Ward Service (also known as the Nephrology In-patient Service) functions similarly to the Internal Medicine Ward Services. The team is composed a Resident, two Interns, A Renal Fellow and an Attending Nephrologist. The Renal Ward Service functions 7 days per week and the same procedures for admitting and discharging patients as the Ward services except that all of the patients will have renal impairment. The service still conducts daily pre-rounds (which also include the Renal Fellow) and

daily teaching rounds with the Attending. The differences between this and General Medicine Ward services are that this service only admits Monday-Friday and does not take overnight call. At the end of each day, the Resident or Interns are responsible for checking out the Renal Wards patients to the Float Intern.

As on the Internal Medicine Ward Services, the upper level renal ward resident should write an admission note on every new admission. Again, this may be a brief addendum that focuses on the assessment and plan, provided that a full intern note is on the chart. Prior to daily attending rounds, the upper level resident must see and examine every patient.

The nephrology in-patient service admits weekdays from 7:00 am through 4:00 pm and weekends from 7:00am through noon. If you are aware that a patient will arrive soon (via the ER or from clinic) and it is 4:00 pm, you should wait to evaluate the patient.

Admission Criteria for Renal Ward Service

- Creatinine greater than or equal to 2.5
- Patients with ESRD and a UT Nephrologist
- Patients with ESRD and are under the care of by a private nephrologist who does not have admitting privileges at Hermann (same caveats apply), unless that private physician has an arrangement with another private nephrologists who does have admitting privileges (for example, Dr. Cherem is in Dr. Esquenazi's group and takes care of their patients).

Caveats:

- If a patient was directly admitted to the MICU or CCU and is set to be transferred out, the ICU Nephrology Consult Attending will ultimately decide to which team that patient will be transferred, *irrespective* of the current creatinine level.
- Patients NOT admitted to UT Renal Wards - Patients with ESRD and are under the care of private nephrologists who have, or whose practice group has, admitting privileges at Hermann. For example, Dr. Noor Rahman.
- If a private nephrologist who has, or whose practice group has, admitting privileges at Hermann refuses to admit one of his/her own patients, and then promptly notify the Renal Fellow.

VII. Hospitalist/Medicine Consultation Teams

Team Structure

The hospitalist team at Memorial Hermann is new for 2008-2009. The purpose is to give upper-level residents an opportunity to get exposure to being a hospitalist and to better disperse patients across medicine services. It is composed of two teams of 1 attending and 2 upper-level residents [Team A (Resident 1 and 3) and Team B (Resident 2 and 4)].

The service will be responsible for taking new medicine admissions with a cap of 5, direct admissions from surgical subspecialty services (e.g., orthopedics) with a cap of 1, as well as all general medicine consults. The cap for all admissions per call is 6, with an unlimited amount of medicine consults. In the rare event that more than one surgical subspecialty patient is admitted in a 24 hour period, the patient should be seen by the hospitalist resident on call and passed to the oncoming hospitalist resident the following morning. The total team cap is 12 inpatients (patients admitted to the hospitalist service) with no limit on the number of medicine consults that can be followed. There will no longer be a separate medicine consult service.

Call will be on an alternating basis between the 2 teams, with each resident being on overnight call every 4th night:

Day 1: Team A, Resident 1
Day 2: Team B, Resident 2
Day 3: Team A, Resident 3
Day 4: Team B, Resident 4
Day 5: Team A, Resident 1

Admissions

The hospitalist resident will start taking admissions after the medicine ward team has admitted its 7th patient, and will do so on an alternating basis until the medicine team caps. Once the medicine ward service has admitted its 7th patient, the admission pager will be handed to the hospitalist resident on call who will be responsible for triaging subsequent admissions to the appropriate service.

For example: The ward team takes its 7th patient, and the ward resident on call gives the admission pager to the hospitalist resident on call. This hospitalist resident takes the 8th admission, gives the medicine team the 9th admission, takes the 10th admission, gives the medicine team the 11th admission, and so on until the medicine team has reached its 10th new admission (pt #13) or 2:00am, whichever comes first. The hospitalist team will then continue to take medicine admissions until they cap or until 6:00am, whichever comes first. Once the medicine ward team and hospitalist team have capped, the float will be responsible for all subsequent admissions.

The hospitalist resident on call will be responsible for all medicine consults during the 24 hour period that they are on call. All Medicine Consults will still be triaged by the Medicine Consult attending, utilizing the (713) 608-0071 pager, as previously arranged. The hospitalist service is responsible for continuing care of all admissions/consults they see. The float will still be responsible for admits to the geriatrics and renal services, and seeing consults for the various medicine subspecialties (i.e. cardiology and endocrinology).

The internal medicine team can also take 2 MICU transfers in addition to its 10 new patient admissions [please see the Internal Medicine (General Medicine) Ward section for

details]. If these transfers are called while the hospitalist resident is holding the admission pager, they should be given to the medicine ward team up until 2:00am. All MICU transfers occurring after the medicine ward cap or 2:00am are to be taken by the float medicine resident and passed to the admitting ward team in the morning. The hospitalist team will not be assuming care of MICU transfers.

Post-Call Day

If the hospitalist team has not capped and is still carrying the admission pager, it should be handed off to the medicine ward resident on call that day at 6:45am. The second hospitalist resident on the post-call team will arrive that morning at a reasonable time to see his/her patients and help the post-call hospitalist resident with any unresolved issues if necessary. The post-call hospitalist resident will be responsible for writing notes on all of his/her patients (previous admissions in addition to admissions from overnight). The team should decide on a reasonable time to round that will allow the necessary work to be completed beforehand (e.g., 9am). The post-call resident is expected to leave by 1:00pm, and will check out to the other resident on his team (e.g., Team A resident 1 will check out to Team A Resident 3) who will serve as post-call cross cover for all of the patients on the service. At 4:45pm, the cross-cover hospitalist will check out to the medicine float intern and go home. The second resident on the team (e.g., Team A Resident 3) will then be on call the following day, and is expected to arrive by 6:45am to resume care of the hospitalist team's patients when the float intern goes home.

Days Off

A member of the team is only allowed to take a day off when the other resident is on call; otherwise, they are post call or on call themselves. They are not allowed to take a day off when the other resident on their team has clinic because they will have to cover admissions during that period.

VIII. Post-call Cover Resident

The post-call cover (PCC) resident is an upper-level resident who fulfills the duties of the resident & intern after rounds are completed on the post-call day. The PCC resident picks up the PCC pager in the float intern's room the morning of duty. The PCC is expected to be on rounds with the team to become familiar with the patients. When the team members are prepared to go home for the day, the team resident and/or interns will check-out their patients to the PCC, who will care for the patients until 4:45 pm, at which time the PCC will check-out the patients to the Float Intern and drop off the PCC pager in the Float Intern's room for the next day's PCC resident.

The designated PCC should touch base with the team resident the day before to determine when and where the team will round. *Note to the ward team: if the PCC fails to do an acceptable job, promptly notify the Chief Resident so that this unfortunate situation can be addressed.*

As proposed by the Residency Education Council, we will institute an EBM component to the post-call cross cover. In the past, we have “pulled” different residents every day from their rotation and interrupted the consult services. Starting January 2009, we will have one resident from different rotations who will serve as the post-call cross **cover for the week**. Their responsibilities are as follows:

1. Must be present for post-call rounds from the start....ie, if the team rounds at 0600, you must be there at 0600.
2. Must present an article, via email, to everyone on the team on a particular topic or clinical question that was discussed on rounds.
3. Must do an EBM presentation on Friday mornings limited to 10 minutes regarding the different clinical questions that occurred during the week.
Therefore, you will not be rounding with the team from 0800 to 0810 on Fridays.

You are excused from Morning report while you are post call cross cover but must be at noon conference.

You will still get credit for the consult month since you will be doing at least two weeks on that rotation (three weeks if you don't have vacation).

You will be evaluated by the attending in which you serve as post-call cross cover most often. (ie. Two post-call days)

IX. Medical Intensive Care Unit

Note: When you are on this rotation, you do NOT attend your continuity clinic. Please make sure that the clinic schedulers know before the start of the month that you will be in the CCU and not in continuity clinic for the month.

The Medical Intensive Care Unit (MICU) rotation is the primary critical care experience for all residents. The MICU usually has 4 Resident-Intern teams similar to the CCU. Call is every 4th night when there are 4 Residents, but changes to every 3rd night if there are only 3 Upper level Residents in the MICU. This rotation has 3rd year Medical Students as well, but they do not take call with the residents. There is a Pulmonary Fellow assigned to the MICU for the month and the Fellows take home call nightly.

The Fellow is to be called to discuss all admissions and is expected to come in for all patients (exceptions: stable ESRD or hypertensive patients). All of the Resident-Intern pairs work as one contiguous team and the on call team will take care of all the patients in the unit. The post-call team is expected to see all the unit patients each morning and write progress notes on all patients. Rounds typically start at 7:30 am, except on those days of Critical Care Morning Report and Pulmonary Grand Rounds (Fridays), when rounds will start at 9 am. All members of the team are expected to attend rounds daily, unless you are off. If you are not post-call, you can typically get to the unit by 7:20 am each day. Each resident is to have 4 days off during the month. Noon conference attendance is required everyday, and the same rules apply in regards to receiving an ER shift if conference attendance is less than 70%. Excuse yourself from rounds at 11:45 am if you are not post-call. If a patient is acutely decompensating, and the fellow needs your

assistance, you are excused, but you need to let the chief residents know so you aren't marked absent.

The "short call" team includes everyone not on call, and this team should stay in the unit until at least **2:00 pm**. Their role is to assist the on-call team in any way, primarily with old patients, including procedures, transfer notes and orders during rounds. When all of the work is completed, this team can check out to the on call team and the ICU fellow prior to leaving.

Please take time to write detailed transfer notes, and gather the chart and other data prior to calling report on a patient. Make sure you know who to transfer the patient to, whether it is a particular medicine team, a private physician, or other service.

Do not make ventilator changes without the respiratory therapist or the ICU fellow. Otherwise, simply write your vent orders and alert the RT.

X. Coronary Care Unit

Note: When you are on this rotation, you do NOT attend your continuity clinic. Please make sure that the clinic schedulers know before the start of the month that you will be in the CCU and not in continuity clinic for the month.

The Coronary Care Unit (CCU) is located in the new Heart and Vascular Institute at Memorial Hermann (HVI). The CCU is located on the 4th floor of the HVI building and ICU-level patients with cardiac disease are housed there. The CCU service is composed of 4 Resident-Intern teams that function as a unit and take overnight call every 4th night. The CCU service is a hybrid of an ICU month and a General Medicine Ward month. The CCU team will receive only admissions with cardiac problems. Patients that are deemed by the ER in need of a Cardiology service may either be admitted to the CCU (if they are in need of ICU care) or the CIMU. The CIMU (Cardiac Intermediate Monitoring Unit) is a Telemetry capable floor on the 5th floor of the HVI building where patients are admitted if they need a Cardiology service but do not need ICU Nursing care. There is an in-house Cardiology Fellow that is on call each night, referred to as the CCU Fellow. The CCU Fellow will need to be called to assist with each patient admitted to the CCU and any CIMU admissions with difficult issues. The CCU teams operate on a short call, long call system.

The CCU residents and interns are referred to as the **Orange Team**. The typical CCU schedule would be that you are on call Day #1, post call Day #2, Day #3 is a regular work day and is the post post call day, Day #4 you are short call and is the pre-call day and Day #5 you are on call again. You are to be given 4 days off for the month with an average of one off day per week. Generally, the Interns take off the pre-call day and the Residents take off the post post call day. Short call is 1 day prior to long call. Short call is from 6:00 am to 12:00pm or 4 admissions, whichever one comes first. There is no short call on the weekends. Long call begins after short call is capped or at noon, whichever comes first. The resident cap is 10 patients. Please note that the intern

admission cap is 5, meaning five patients for whom they perform a history and physical. Once the intern cap is reached, all other patients that the resident admits must still be followed by the intern, but the Resident will be responsible for writing the H&P. Thus, the interns must know all patients on the service. Generally speaking, the Resident will admit patients to the CCU and the Intern will admit the patients to the CIMU. However, the Resident must discuss all admissions with the Intern and must write an admission note on every new admit. Again, this may be a brief addendum that focuses on the assessment and plan, provided that a full intern note is on the chart.

At the end of each day, before leaving the hospital, all non-call CCU Interns must check out all CIMU patients to the on call CCU Intern and all non-call CCU Residents must check out all of their CCU patients to the on call CCU Resident for cross-coverage purposes. There is no float in the CCU.

Rounds typically begin at 8:00 am in the CCU. All CCU Residents and Interns are exempt from Morning Reports but are expected to attend Noon Conferences daily.

The house staff will not work up patients who are admitted for elective procedures, such as pacemaker and cardiac catheterization. The interventional cardiology or electrophysiology fellow must admit and care for these patients. The fellow may inform the residents about these patients for float type coverage overnight. If a procedure-oriented admission is complicated and will require more than a forty-eight hour stay, then the interventional fellow must notify the on call team staff that this will be a full admission, which will count towards the team cap. If a floor patient from another hospital service is transferred to the CCU, that patient must be transferred back to the original primary team after all cardiology issues are resolved. There is no continuity clinic during this month.

The White Team is composed of a cardiology fellow, nurse practitioners and physician's assistants. They follow the patients of the private attendings, please refer to the list entitled "Cardiology Active Attendings" on the Chief's corner for the list of attendings. The White Team admits the private attendings' patients Monday through Sunday during the day. In the evening, the Orange Team on call will admit those patients of the listed private attendings and pass them off to the White Team the next day. The Orange Team resident on call must also be aware of all patients in the CCU for cross coverage overnight.

XI. Consultation Residents

At Memorial Hermann each month, residents are assigned to the following consultation services: Cardiology, Endocrinology, Gastroenterology, Geriatrics, Hepatology, Infectious Diseases, Pulmonary, Renal and Rheumatology. There is a single pager for each consult service. The resident or intern must leave the hospital no later than 7 pm. If the attending or consult fellow does not abide by this rule, promptly notify the Chief Resident. You are responsible for taking new consults from 7 am through 4 pm during

the week and from 7 am through noon on weekends. The Float Resident will notify you in the morning of any consults that were seen overnight.

XII. Geriatrics and Palliative Care Consult Service

Three residents per month (on average) will be assigned to the Geriatrics Service. Usually, two residents will be apportioned to MHH and one to LBJ. The two residents will be distributed according to the preference of the service, but will generally be divided among the Geriatrics Consultation and the Palliative Care Consultation Service.

Consult service:

The geriatrics team will provide consultative services on patients with dementia, delirium, dizziness, falls, failure to thrive, palliative care, or abuse/neglect. Also, consults may be taken for pre-operative clearance and peri-operative management of patients on the Physical Medicine & Rehabilitation service and General Surgery or Orthopedic Surgery services.

Consult pager: (713) 506-0069.

Weekend consult pager: (713) 404-0101.

ACE Unit/Inpatient service:

The Geriatrics team will accept direct admissions from the ER to their inpatient service 7:00- 4:00 pm Monday- Friday. The Medicine Team On Call will take admits from 4:00-5:30pm until the Float comes in and the Float will begin taking admits at 5:30pm. The Geriatrics Inpatient Service will be maintained by the Attending (Dr. Nasiya Ahmed) and a Nurse Practitioner. Criteria for admission are: Any patient over the age of 70 and not going to ICU or CCU.

All patients admitted to the Geriatrics Service MUST have a bed assignment on the ACE (Acute Care of the Elderly) unit, which is 4 East Cullen. The Geriatrics primary service will not take care of patients outside of the ACE unit.

After 5:30 pm on Monday-Thursday, Geriatrics admissions will be taken from the ER by the Float Resident and they will pass off to the Geriatrics team the next morning. The Float Resident will call Dr. Nasiya Ahmed or Dr. Carmel Dyer for urgent Geriatric questions overnight. The Geriatrics service does not admit from Friday 5:00pm to Sunday 12:00pm. After 12:00 pm on Sunday, the Float Resident will accept patients on behalf of the Geriatrics service. Weekend admissions (Friday 5:00pm- Sunday 12:00pm) will be admitted and followed by the Medicine Ward services that are on call and will be treated as any other Medicine admit.

Weekend on-call pager: (713) 404-0101

Direct Pager Numbers:

713-605-8989- pin 17245- Dr. Ahmed

713-605-8989- pin 18635, Dr. Varas

713-605-8989- pin 18645- Pearce (NP)

713-605-8989- pin, 19592- Villarreal (NP)

Outpatient services:

Drs. Dyer and Ahmed have ambulatory clinic at UT West Loop Clinic. Their clinic also has the capability to do home visits in certain situations. Please call 713-572-8122 for appointments.

Ambulatory, consultative, and inpatient geriatrics services are also available at LBJ Hospital. The LBJ Consult Pager is 281-952-3674.

XIII. Routine Patient Care

Please keep your pager on at all times, except when you are post call or on vacation. The post-call cover resident must address all questions concerning the post-call team's patients after noon. The post-call cover schedule will be given to page operators and to the nursing units. This schedule is available on Amion.com.

All orders written and progress notes must be signed legibly with a physician's name with the physician's pager number and hospital ID number. Please co-sign your medical students' orders and notes as well as your verbal orders within 24 hours of giving the order. If you need to make corrections on your handwritten notes, use a single line to cross through the error, then initial and date the correction.

For billing purposes, please specify an admitting attending physician on your admission orders, diagnostic imaging tests, and consultations. Please confirm with the unit clerk that the attending of record on the Electronic Medical Records (EMR) is correct.

We utilize a sticker system to specify the team, Attending and the Residents on the teams to facilitate easier paging for the nursing and other hospital staff. Please utilize stickers both on admission orders and on the front of the chart. The Chief Residents will distribute pre-printed labels to the upper level residents to all ward teams, the CCU teams, and the Float Resident at Orientation at the beginning of each month.

In general, the Internal Medicine patients occupy the 3rd floor of the Cullen Pavilion and Renal and Geriatric patients occupy the 4th floor of the Cullen Pavilion. The 5th floor of the Cullen Pavilion will be reserved for Private General Medicine patients. Cardiac monitoring is available on the 3rd, 4th and 5th floors of Cullen Pavilion.

XIV. Direct Admissions

The UT Professional Building Medicine clinics and subspecialty clinics may directly admit patients to the hospital when they have evaluated the patient and deem them needing admission.

- They must call Admissions and obtain a bed assignment for the patient.
- They must write Admission Orders to obtain a bed.
- They must call the on call Medicine Resident to checkout the patient.

XV. Evaluations

At the beginning of each month, the Attending physicians are encouraged to sit down with their Residents and Students and discuss goals and objectives for the month, particulars of the rotation and delineate expectations.

At mid month, the Residents and Students should get brief feedback about their performance from the Attending. We would also encourage you (interns in particular) to request a mid-month evaluation if not mentioned by the Attending in order to address any concerns about your performance and rectify any deficiency before the rotation concludes.

Near the end of the month, residents and interns must meet with their attending to discuss their performance evaluation. At the end of the rotation, you must complete the GMEIS on-line evaluation of both the rotation and the attending physician. The GMEIS system will send you email reminders at the end of each month to complete your evaluations as well as online Duty Hours forms.

XVI. Educational Materials and Resources

The Kirkendall Library contains the most recent copies of journals and textbooks. After hours, you may enter through the keypad on the doors. To gain entrance, press 1 and 4 simultaneously, and then press 2. The Jesse Jones Medical Center Library is located adjacent to the Medical School, and you have a free membership with your ID badge. We encourage you to register for remote online access to the Jesse Jones Library so that you may have instant access to online journals and databases. You can locate the Library Website at <http://www.library.tmc.edu/>.

XVII. Meal Tickets

Phyllis Martin in the House Staff Office (MSB 1.134) distributes meal tickets for your call days. Please note that in order to receive meal tickets, you must be up to date on your dictations.

XVIII. Parking

Parking at Memorial Hermann is at the UT Professional Building Garage located at 6411 Fannin Street (directly across from Memorial Hermann Hospital) at the intersection of Ross Sterling Street and Fannin Street.

Note: You have to set up parking with the GME office (713) 500-5150 at the beginning of the academic year. Parking arrangements are not handled by the Residency Program office.

XIX. Dictations

The hospital requires that you must dictate all Admission H&P's, Consultation notes and Discharge Summaries. Dictations should be done on the day of admission, consultation or discharge. Your dictations must be complete when you leave the service at the end of the month. The Hermann Dictation system can be accessed by dialing (713) 704-7811 outside the hospital and 4-7811 inside the hospital. You will be required to enter your hospital ID number and the patients 12 digit account number.

Here are a few suggestions that have helped achieve this goal:

The house staff that actually discharges the patient is responsible for completing the discharge summary dictation. Upper level residents, if you discharge patients on your intern's day off then you must personally complete the discharge dictations.

A useful outline to follow for Admit notes, Consult notes and Discharge summaries is:

- Admitting date
- Discharge date
- Admitting diagnosis
- Discharge diagnosis
- Attending physician
- Service name
- Consulting Services
- Diagnostic tests/Dates/Results
- Hospital course (only pertinent findings, not a full H&P)
- Condition
- Activity level
- Diet instructions
- Discharge medications (in detail)—must match Medication Reconciliation List
- Follow up arrangements

XX. Call Rooms

There is a card system for entry into the call rooms - one card opens all the doors. These cards are available to the residents in the Physician Staff Services Office, which is located on the 1st floor of the Cullen Pavilion. Please defer any questions or problems

with these cards to this office. Please, DO NOT use any call room that is not assigned to you.

- Cullen 238: Hospitalist Residents
- Cullen 244: MICU Intern
- Cullen 246: MICU Resident
- HVI 2nd floor 2312.1 - CCU Resident
- HVI 2nd floor 2312.2 - CCU Intern
- Robertson 539: Ward resident/Intern
- Robertson 631: Ward resident/Intern
- Robertson 675: Float Resident
- Robertson 676: Float Intern

XXI. Float Intern

Two interns are assigned to the Float Intern position each month and they should decide on their schedule before the beginning of the month. Each intern will have at least 15 shifts, depending on the number of days in the month. Let the chiefs know if you are leaving town during the month.

The Float Intern provides cross coverage for the Ward teams, Renal Wards and Geriatrics In-patients. Each day, a member of all inpatient teams (including the post-call cover resident on weekdays) will provide both a written and verbal checkout of their respective patients. Checkout must consist of providing the Float Intern with a list of your patients, preferably using the Online Checkout Sheet <https://secure1.mhhs.org/checkout/>. Checkout that is given over the phone or by simply pushing a checkout sheet under the door to the Float's call room is **unacceptable** and will **not be tolerated**.

Hours are now 4:45pm until 6:30am on weekdays. Weekend and **holiday** shifts start at 12:00pm and end at 7:00 am. The official UT holidays can be found at <http://publicaffairs.uth.tmc.edu/calendar/>.

This means that when the medicine team checks out at least one intern must stay until 4:45pm to check out. Similarly, one intern must be there in the morning at 6:30 to receive face-to-face checkout from the float.

You will see below based on the resident schedule – but the float intern backup will be the Ward Resident on-call until the Float Resident arrives.

We are NOW REQUIRING that the Float Intern Check-out their patients with the Float Resident twice during the night (we suggest 10:00pm and 4:00am) – you must also use the attached form to document checkouts on all patients called about. This form **MUST** be turned into the CMRs the morning post-call (i.e. slip under the door). Compliance with filling out this form and turning it in will be considered when you are being evaluating for the month.

IMPORTANT: Your schedule calendar must look like the following regardless if you are an intern or a resident. I.e. you cannot work more than 5 days in a row and must alternate Friday-Saturday-Sunday days

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	1	1	1	1	1	2
1	2	2	2	2	2	1
2	1	1	1	1	1	2
1	2	2	2	2	2	1
2	1	1	1	1	1	

Float Interns start at 4:45pm and ends at 7:00am on Monday-Friday. HOW TO TRANSFER A PATIENT TO THE MICU

1. Inform the Medicine Float Resident that a patient on the floor needs to go to the MICU and he / she will help you with the transfer.
2. Call the MICU team on call and inform them of the patient needs to be transferred. They will inform the MICU Charge Nurse that they need to prepare a bed for your patient. Once they officially accept the patient, give them check out on the patient.
3. Inform the Charge Nurse on your floor that the patient needs to go to the MICU.
4. Write Transfer Orders and a Transfer Note while waiting for the bed.
5. Accompany the patient to the MICU if you have time and follow up with the MICU team later regarding the patient's status.
6. Inform the Primary Team that their patient went to the MICU the next morning.
7. Special Situations:
 - a. There are no beds in the MICU
 1. The Floor Charge Nurse and OA on call will try to find another Intensive Care Bed for the patient to be transferred to (i.e. CCU, TSICU (Transplant ICU), STICU (Shock Trauma ICU), etc. . .) until an MICU bed opens up.
 2. You need to call and give checkout to the accepting critical care team, then follow steps 4-6.
 3. Caveat – The TSICU does not have a designated critical care team 24 hours a day 7 days a week, so you have to call for a Pulmonary Consult to manage the patient in the TSICU. The Float Resident should help you with this.

ADDITIONAL TIPS:

- **The Float Resident is your first backup.** The MICU & on-call residents may be able to help you if they aren't busy, and there is always the CCU resident or fellow. The **on-call UT General Medicine Attending** is your official backup attending.
- Don't forget that the Float Chief Resident pager is 22001 and can also be paged through amion.com under the "Ward Attending" tab.
- You are welcome to call the primary team if you need help with management of their patient, especially if they have instructed you to page them with questions or if it's early in the evening. However, keep this to a minimum so as to give them a break (remember what it's like when you are on wards!)
- Get here on time – There will be lots of people watching the clock and waiting on you at **your call room**.
- **Sign all your verbal orders** before you leave the hospital!
- If a patient dies, you need to call the team, and write a death note and fill out paperwork the nurses give you. The team can dictate the death summary the next day. You should also call the team if a patient unexpectedly deteriorates and needs to be transferred to the unit.
- Figure out the cafeteria hours so you don't get stuck without food! Don't forget your meal cards.
- Don't settle for bad checkout! House staff are required to checkout in person, no exceptions. Notify the Chiefs if there are any repeat offenders that are giving back checkout!
- If you implement a new management plan for a patient (other than the usual Ambien, Tylenol, etc.) **write a short note so the team knows what you are thinking.** If you are called to evaluate an unstable patient, **write a note.** Go see patients with new fever, pain, chest pain, shortness of breath, or hypotension and **write a short note.** Page the team the next morning for any significant events. When in doubt, go see the patient and **write a note.** If a patient is unstable, notify the ICU resident early on. If you cannot quickly stabilize the patient, then initiate transfer to the ICU under the supervision of your backup resident.
- Don't give patients big boluses of insulin when the nurses call you at 9pm with a high blood sugar!
- Watch out for renal and hepatic function when writing meds!
- Get an idea what the team wants you to do if an event happens. For example, if a patient is here for an infection, what do they want you to do if they spike a fever?
- If the team wants you to follow up on labs (i.e. q 8 H/H's) ask what time they expect the next lab to be done and what they want you to do if the Hemoglobin drops! If the answer is to transfuse, make sure they have consented their patient.
- Politely defer family discussions until the primary team is available the next day, unless it is an emergency. In that case, call your backup for help.

- Good resources: The Washington Manual Internship Survival Guide and Survival Guide for Interns by Hammond.
- If something fishy is going on, like a nurse can't figure out what team a patient belongs to, and they've been calling around, go to the chart and help figure it out. There have been lots of patients sent to the floor without a doctor or checkout. You can help avoid having a patient on the floor several days without ever being seen by a doctor – it happens!
- Remember to coordinate your clinic days this month with the clinic coordinators at LBJ or Hermann, and adjust your float schedule accordingly.
- Keep the Chiefs in the loop for any issues we can help you with, or instructions we need to clarify, so we can resolve it quickly.
- The code team for the hospital is made up of the CCU fellow, resident, and intern on call. If you are called that a patient you are covering is coding, assist the code team by calling the primary team and the family of the patient. Ask the code team resident if there is anything else you can do to help out.
- If the Medicine Consult Service has been following a patient, you may be called about new or acute medicine issues overnight. Take down the information about the patient, and call the Medicine Float Resident to handle the issue further.
- You are required to do all 4 continuity clinics this month. If you need to, you can contact your clinic coordinator to reschedule some of your clinic days but they must all be in 4 separate weeks (for example, you can't have 2 clinics in the same week).

XXII. Float Resident

Similar to the Float Intern, the Float Resident rotation consist of two upper-level residents that share night shifts for the month.

Hours are now from 5:30pm until 6:45 am on weekdays. Noon-6:30am on weekends and Holidays. One on-call resident must be in-house by 6:45 am to receive checkout from the Float.

In addition, the new rules apply to Hermann and the services that checkout to the float:

- 1) Renal Admits – One member of the Renal Ward Team must stay and take admits to Renal until the Float Resident Arrives
- 2) Cardiology Consults – Emergent consults will be handled by the CCU Fellow. The Cardiology Team will handle other issues until the Float Resident Arrives
- 3) Geriatrics – “Geriatric Admits” will be admitted to the medicine team until the float arrives at 5:30pm

Cap: The Float Resident's cap is 10 total patients. The cap on new admissions from the ER to the Inpatient Medicine Services is 4. The remaining cap would then be any combination of 6 - this can include Nephrology Admits, Geriatrics Admits, and any

consults (Cardiology, Endocrinology or Renal). Please triage these patients accordingly and attend to the sickest patients first. You may begin seeing a patient in the ER while they are waiting for transport to their assigned bed. In the event the ER "retracts" a patient after you have already spent time evaluating the patient, you still count that patient toward your total cap if you have written admit orders and an H&P. If you are inundated with cases, do not hesitate to call the CCU fellow on call to help see cardiology consults.

The Float Resident serves three functions:

1. Taking admissions for:
 - a. Internal Medicine Ward Teams: When the Ward team that is on-call has capped AND the Hospitalist Team has capped, you may accept up to 4 patients total for the following day's medicine team on call.
 - b. Renal Wards: You accept admissions for the Renal Ward service. All admits should be discussed with the Renal Fellow on call.
 - c. Geriatrics: After 12:00 pm on Sunday and after 5:30 pm on Monday-Thursday, Geriatrics admissions will be taken from the ER by the Float Resident and they will pass off to the Geriatrics team the next morning. Criteria for geriatrics admissions are any patient over the age of 70 and not going to the ICU or CCU. The Float Resident should call Dr. Nasiya Ahmed or Dr. Carmel Dyer for urgent Geriatric questions overnight. The Geriatrics service does not admit from Friday 5:00pm to Sunday 12:00pm. Weekend admissions (Friday 5:00pm- Sunday 12:00pm) will be admitted and followed by the Medicine Ward services that are on call and will be treated as any other Medicine admit.
2. Providing urgent Cardiology consultations after 5:30pm on weekdays and after 12:00pm on weekends and holidays. All urgent cardiology consults should be discussed with the cardiology fellow on call. The Float Resident is responsible for notifying the Cardiology consult team of new Cardiology consults at 7:00am the following morning.
3. To provide primary backup for the Float Intern on duty. This is especially important when the Float Intern is called to see an unstable patient and needs help. Please help the Float Intern with all transfers of unstable patients to the MICU.

If urgent/emergent consults in other internal medicine subspecialty services (*e.g.*, endocrinology, rheumatology) are required, the Float should contact the fellow on call for that service. Non-emergent consults can be referred to the appropriate consult service the next day.

You are required to do all 4 continuity clinics this month. If you need to, you can contact your clinic coordinator to reschedule some of your clinic days but they must all be in 4 separate weeks (for example, you can't have 2 clinics in the same week).

IMPORTANT: Your schedule calendar must look like the following regardless if you are an intern or a resident. I.e. you cannot work more than 5 days in a row and must alternate Friday-Saturday-Sunday days

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	1	1	1	1	1	2
1	2	2	2	2	2	1
2	1	1	1	1	1	2
1	2	2	2	2	2	1
2	1	1	1	1	1	

Backup Attending: Your backup attending is the On-Call Medicine Ward Team Attending.

XXIII. Ready Reserve

Ready Reserve exists to provide coverage in the event that a resident has to miss a day or work for personal reasons (*e.g.*, illness, death in family). Please contact the Float Chief Resident promptly so that ready reserve coverage can be arranged. This coverage will have to be given back to the resident providing it on 1:1 basis. The Residency Program will not provide coverage for voluntary absences (*e.g.*, weddings, birthdays, interviews, USMLE); instead, you should plan ahead and utilize your days off or arrange your own coverage with other house staff. Please promptly notify the Float Chief Resident as well as the page operator if you have modified the call schedule.

Everyone on Ambulatory will be on Ready Reserve. This system is designed as a backup plan to cover clinical assignments due to illness or family emergencies. During this month, you are subject to being pulled to temporarily cover other clinical assignments. You should not leave town without permission from the Chief Residents. Ready reserve house staff must keep their pagers on at all times. If you fail to return a page from the Float Chief Resident, you risk being penalized by accruing an additional ready reserve duty. Your ready reserve month will be listed in your schedule on Amion.com. If you foresee a problem with your designated month, notify in advance the Chief Resident in charge of the schedules.

XXIV. Paging

When using the paging system (713) 605-8989, we strongly recommend specifying a full ten-digit phone number. You may also add an asterisk (*) followed by your five-digit pager number in case the person is not able to promptly return your page. Please, do not assume that the person who you page is at the same facility as you are and will recognize a four or five digit call back extension. If you are certain that the other party is also at Hermann, for example, you may page to an extension that begins with 4 x x x x but not 5 x x x x. For example, if you page Dr. Farnie to extension 53375 and he is at his office in the medical school, he will not be able to return your call. However, if you

page him to extension 44008, then he will recognize that extension as 704-4008, and be able to return your call.

The Telecommunications Office is located on the first floor of the Robertson Pavilion in the hallway adjacent to the service elevators for that pavilion. It is located on the left side through the double doors. At this office you may obtain replacement pagers and batteries. The phone number for the page operator is (713) 704-4284, or if you are inside Hermann Hospital, 44284.

XXV. Continuity Clinic

The UT General Medicine Clinic is located on the sixth floor of the UT Professional Building (UTPB). Some house staff will have their continuity clinics here. The general number for the clinic is 832-325-7100. Others will have continuity clinic at LBJ Hospital in the General Medicine Clinic on the first floor with Dr. Gardiner, Dr. Mehta or Dr. Bhattacharjee. The main number to the LBJ Medicine clinic is 713-566-4921. Please verify your clinic day assignments prior to each month. You are responsible for contacting your clinic scheduler Sheri Janowski at 832-325-7462 for UTPB clinics or Donna McKee at 713-566-5079 or 713-566-4921 at LBJ to inform of clinic cancellations for post-call days and MICU/CCU/ER/vacation months. Clinics missed post call need to be rescheduled for some other time that week. Please note that you are the clinic patients' primary care physician, and the clinic must be notified in advance if you will be absent. There is no scheduled clinic for the following rotations: MICU, CCU and ER.

XXVI. Days Off

House staff can take 4 days off per month, free from educational, administrative, and clinical responsibilities, averaged over a 4 week period to 1 day per week. Please arrange for days off early in the month, and coordinate with your fellow teammates. **Upper level residents on call months (except at St Luke's) CANNOT take the 1st or the 2nd of the month as a day off.** You CANNOT take these last two days of the month off because there are brand new interns on service, new attending, and a new fellow when applicable. The overlap of interns and residents from month to month is intended to facilitate a smooth handoff and taking these days off would defeat this purpose.

XXVII. Medical Students

Students will be assigned to each ward team and they will take overnight call with the team and this will be your primary opportunity to perform bedside teaching. You are expected to let the students evaluate patients before the interns and residents see them and formulate a plan (when possible). You are expected to involve them in patient care

and return education for clinical service. They will have the opportunity to evaluate you at the end of each month. A few ground rules:

- Students must take overnight call
- No more than 3 new admissions per student per night
- No more than 5 “active” patients per student
- Their month ends on Saturday, not the last Friday of the month
- They are excused from all duties Thursday prior to their exam and have no call on the Wednesday before their exam
- They must have on average 1 day off per week and are excused on Labor Day, Memorial Day, Thanksgiving (Thurs and Fri) and July 4th.

All student notes must be co-signed by a resident on service. A full resident note should accompany every student note each day. Acting interns should follow patients with the upper level resident on that service. A full resident note should accompany every acting intern note.

XXVIII. Moonlighting

Moonlighting is a privilege, not a right. Your primary responsibility lies with the rotation to which you have been assigned. Moonlighting is not permitted on call months. Moonlighting privileges are granted solely at the discretion of the Program Director, Dr. Farnie. You are only able to moonlight after you have obtained your individual Texas Medical License and completed paperwork with the GME office. Moonlighting shifts will count towards your 80 work week total.

XXIX. Psychiatric Response Team

To contact the Psych Response Team, write a consult order in the chart and include the clinical question. The unit clerk will put it in the ClinWeb system, and the information goes straight to the team’s pager. You can also page them at 713-448-8100.

XXX. Hepatology Consult Rotation

The Hepatology service will typically consist of 1-2 interns per month. This service is a purely consults service and has no in-patients. You will round with a Hepatology Attending and Fellow daily.

XXXI. Death Pronouncements

When you are called to see a patient who has died, you must first make sure that this is not a code situation. Once the patient has died, you must contact the patient’s family and the Attending physician on the primary team. Additionally, you must write a note in the chart with the following information:

1. Called to see patient regarding (cyanotic: no respiration, pulse, etc.)

2. Physical exam: pulse 0 and BP 0
 - HEENT: Pupils fixed and dilated
 - Chest: No spontaneous respirations
 - CV: No heart sounds
 - Neuro: Unresponsive to deep pain

3. Patient pronounced dead at: (give time, date).
 - (Specific family member) notified via (phone or in person).
 - Dr. (Attending) notified.
 - (Family refused or agreed to) (full or limited) autopsy.
 - Patient (is or is not) candidate for organ donation.

If you are called to pronounce a private **Medicine** patient, make sure the private attending is notified. You are expected to do the exam, and write a Death Pronouncement note. All further paperwork and contacting the family is to done by the private Medicine attending. Document in the note that you contacted the attending, **and document that the attending agrees to contact the family.**
YOU MUST INFORM THE CHIEFS OF EACH PRIVATE PATIENT YOU ARE CALLED TO PRONOUNCE.

Last revised 1/14/2009