1. You are guaranteed 1 day off per week; work hour rules will be enforced.

2. Education/Medical training:
   a. Provide **specific and timely feedback** to your junior residents and students.
   b. Read thoroughly and **cosign medical students notes daily**.
   c. Teaching as we go. Be present (even if not presenting your patient)

3. Rounding:
   a. Goal: 1-2 hours/day. The senior resident will pick up to FIVE patients that everyone will round on together; the remainder of the patients will be seen either with the senior resident or independently. Medical students are encouraged to round with me one-on-one for more hands-on and educational experiences.
   b. Begin with most critically ill and those with greatest time-constraints on disposition (ex. transfer to nursing home). Immunocompromised patients trump all others if possible.
   c. Be prepared to show radiographs (laptop/desktop) and bring EKGs, rhythms strips, etc. when rounding.
   d. If possible (...and it is...), round with nursing staff

4. Medical documentation and patient care:
   a. **MEDICATION RECONCILIATION** (contact healthcare facilities/family as needed to confirm): Spell out generic (+/-brand) name, dose, route, frequency, indication/diagnosis, AND number each medication. (Ex. **1. Acetaminophen (Tylenol) 325 mg tablet; take 1-2 tabs by mouth every 4 hours as needed for back pain**) -- Must be present in BOTH H&P and Discharge summary
   b. **CULTURES**: Check and annotate pending cultures **daily (may need to call microbiology)**; ensure inclusion on discharge summary if cultures are still pending.
   c. Please include in all progress notes:
      i. DVT ppx (unless contraindicated; please provide reason)
      ii. Diet
      iii. Lines/catheters (site, date placed, when to remove)
      iv. Code status
      v. Disposition (...what are the next steps and what is holding up disposition...)
         1. Example: “Anticipate discharge to LTAC in 1-2 days for IV ABx pending TEE.”
   d. Never use a TJC unauthorized abbreviation

5. Admissions:
   a. Gather data and physically interview/evaluate patient prior to rounding with attending. If team is especially busy, we may round together (“discovery rounds”) to save time.
   b. Consult case management, physical/occupational therapy early (to make discharge more efficient)
   c. **Document smoking (type, quantity duration) and alcohol (AUDIT-C) on all patients (Don’t use “Denies”); if positive, document counseling (must be in discharge summary).**

6. Discharges (recommend starting Discharge Summary day of admission):
   a. **MY FORMAT**: Brief (2-3 sentence each) HPI, general hospital course, and problem focused discharge with bullet-point “to do” list for each problem.
   b. **PCM FOLLOW-UP**: Document PCM DC summary transmittal, reinforce discharge instructions, and return-to-care precautions for ALL discharge summaries
   c. **MEDICATIONS**: Order new medications and refill all other medications as indicated
   d. **FOLLOW-UP**: Annotate labs/rads/studies to follow-up in PCM transmittal and summary (see above)

For free online medical education, visit [www.thecurbsiders.com/podcast](http://www.thecurbsiders.com/podcast). If you are interested in helping to write a script (interview, round-table, interesting case), contact thecurbsiders@gmail.com. Also, I recommend [http://www.humandx.org](http://www.humandx.org) for additional cases to review.

(The views expressed on “The Curbsiders” podcast are solely those of its authors and do not reflect the official policy or position of any official entity.)
e. Document smoking cessation counseling if history of smoking

7. Orders:
   a. Discontinue any unnecessary daily labs and remove lines/catheters when no longer indicated.
   b. **Avoid continuous IVFs orders;** state rate (cc/hr) and total volume. Clinically reassess volume status. May assess how a patient will respond to 500cc of fluid by elevating legs prior to giving fluids.
   c. Elderly patients (in general) doses: “start low and go slow”
   d. Adjust doses for renal impairment and ensure hold parameters up front for BP & HR altering meds

8. Text/Page me for any of the following:
   a. Transfers to/from MICU, decompensation, inpatient deaths, change of code status, DNR/DNI admissions, active duty admission, prior to D/C from ER, any concerns with patient/family

9. Professionalism:
   a. Careful to avoid HIPAA violations.
   b. Communicate professionally with the nurses/techs and team.
   c. Please let me know of any personal issues/concerns that may arise, suggestions/ideas, etc. We are a team!

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**Diagnostic Reasoning Yellow Card**

- Presenting fewer than three possible diagnoses for the primary problem
- Suggesting an evaluation without a differential diagnosis
- Failing to present an argument against your favored diagnosis (or failing to identify the data you disregarded to make your diagnosis work)
- Excluding a diagnosis based on the absence of a sign or symptom
- Failing to obey the law of parsimony
- Diagnosing the zebra rather than the horse in a zebra suit
- Ignoring pretest probability when interpreting a surprising test result

Adam Cifu, MD

- You will receive a yellow-card if you fail to follow the instructions detailed out in the yellow card. If you receive three yellow-cards, something absolutely terrible might happen to you. I’m not quite sure what that is as of yet. (You probably don’t want to find out.)