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OSTEOPATHIC RESIDENCY IN INTERNAL MEDICINE
AT LAKELAND HEALTHCARE
Introduction

Lakeland HealthCare is a not-for-profit community healthcare system serving the southwest Michigan counties of Berrien, Cass and Van Buren. Lakeland’s three acute care hospitals, Lakeland Regional Medical Center in Saint Joseph, Lakeland Community Hospital in Niles, and Lakeland Community Hospital in Watervliet, consist of 383 total beds. In addition to these hospitals, the system includes a long term acute care hospital, walk-in clinics, long-term continuing care, home care, laboratory, radiology, rehabilitation and other services throughout the region. Lakeland also offers health, safety, wellness and prevention events/classes and programs throughout the year. Lakeland HealthCare is also a member and active participant in the Statewide Campus System of Michigan State University College of Osteopathic Medicine, the osteopathic training consortium which has become a model for postgraduate training throughout the country.

Lakeland’s Internal Medicine Residency offers a broad-based training experience in all aspects of patient care. Residents train in the area’s outpatient community, as well as, Lakeland’s acute care hospitals in Saint Joseph and Niles. This academic medical center experience provides solid preparation for those residents who may be planning fellowship training. The hospital provides for ambulatory continuity care for internal medicine residents, supervised by board certified internal medicine physicians. At Lakeland’s two primary inpatient sites and the ambulatory setting, residents experience a complete range of medicine pathology and psychosocial issues and also learn the “business of medicine,” becoming familiar with admission criteria, capitated fees, HMO’s PPO’s, PHO’s, HCFA and HIPAA regulations, and current pharmacology. Residents supplement their medical training with continuous interaction with case managers to gain a full understanding of these concepts and how they are essential to successful health care practice.

These clinical experiences are complemented by a structured didactic program at both hospitals through the entire post-graduate training experience. In addition, the Statewide Campus System (SCS) offers a wide range of seminars and workshops for residents in internal medicine, in addition to faculty development opportunities for program faculty. These SCS programs occur at least one full day each month during training. Also, residents receive yearly educational stipends that can be used to attend professional meetings. These stipends permit residents to attend up to five additional days of educational activity at local, regional, and national professional meetings.
Lakeland HealthCare
Mission, Vision, and Values

Lakeland HealthCare Mission Statement
• To be the leader in safe, high quality, patient-centered, compassionate, health-related services

Osteopathic Medical Education Mission Statement
• To provide osteopathic training programs that will prepare quality physicians who provide excellent health care and healing.

Vision
• Quality osteopathic medical education programs that support our mission statement of excellence in the science and art of health care and healing
• Flexible, responsive, and innovative osteopathic Medical Education programs that anticipate the evolution of the health care environment

Values and Behaviors
• Integrity
• Respect and support for all people and life in all of its phases
• High performance and accountability
• Scholarship and collegiality
• Learning and continuous improvement
• A social conscience
INTERNAL MEDICINE PROGRAM INFORMATION
**Internal Medicine Program Description**

Total AOA Approved Positions in Internal Medicine: 18  
Program Director: Mark Smalley, DO  
Director of Medical Education: Mark Smalley, DO

**Lakeland HealthCare**

Size (beds) 397  
Medical Staff 232MD/37DO  
ER Visits 67,221  
Admissions 15,471  
Surgeries 12,708  
Deliveries 1,925

At Lakeland Regional Medical Center, all residency programs are linked through the AOA Resident Match. However, physicians who have completed an internship at another program may apply for residency level positions if they become available and at the discretion of the Director of Medical Education.

**Institutional Responsibilities and Requirements**

- The institution will comply with the requirements of the AOA for accreditation for resident training  
- The institution will meet all requirements as indicated by the Basic Standards for Residency Training in Internal Medicine  
- The medical library must meet AOA requirements and be available for trainee utilization. Resources must be available 24 hours a day and include books, journals, and electronic literature.  
- The institution will furnish salary and benefits as indicated in the “Lakeland Resident Training Agreement”  
- The institution will furnish trainee sleeping quarters  
- Trainee on-call schedules will be in accordance with work hour policies of the AOA  
- Senior residents in the internal medicine program are supported by the Medical Education Department to attend the ACOI convention and scientific seminar

**Program Director Requirement and Responsibilities**

The Program Director shall be licensed to practice medicine in the State of Michigan, certified by the AOBiM, be a member in good standing with the AOA and ACOI, be in practice for a minimum of three years as an internal medicine or a medical subspecialty, and will follow the guidelines and obligations as defined by these organizations. The Program Director has sole responsibility and authority for the education, content and conduct of the residency, and will fully implement the Basic Standards for
Residency Training in Internal Medicine. The Program Director shall report to the Director of Medical Education. Additional responsibilities include:

- Attend the Statewide Campus System Internal Medicine meetings and an ACOI residency director’s workshop every year.
- Attend the annual ACOI Congress on Medical Education for Resident Trainers, or provide a designee.
- Approve and arrange supervision of the resident’s required scholarly activity.
- Provide an annual report to the ACOI Committee on Education and Evaluation via ACOI documentation
- Provide a list of residents’ entry into the program on an annual basis via ACOI documentation
- Verify that each resident demonstrates competency in meeting or exceeding the minimum standards for quality patient care utilizing the competency-based evaluation
- Report to the ACOI Committee on Education and Evaluation deficiencies in the residency
- Assume coordination of inspections as required by the AOA
- Meet with and review the performance of each resident quarterly
- Provide the resident with an annual review to verify requirements have been met for progression to the next year of training
- Document that residents needing remediation as a result of evaluations is given in a timely manner, and document follow-up evaluations of these residents.
- Evaluate faculty performance on an annual basis

Program Faculty

Those individuals within the Department of Internal Medicine designated as faculty shall be licensed to practice medicine in the State of Michigan, be board eligible or board certified in Internal Medicine. Members of the faculty may also be selected from those individuals who are board eligible or board certified in other related fields of medicine (e.g., pathology, radiology, or psychiatry). Appointment and reappointment shall be an ongoing process based on input from the Program Director and formal resident evaluation of the teaching services and faculty.

Faculty shall provide trainees with suitable patient exposure (scope, volume, variety). Faculty shall provide trainees with progressive responsibilities, which shall be determined by:

- Chronology of the trainee
- Proficiency of the trainee
- Direction of future medical interest of the trainee
- Review of performance following each rotation
- Annual Resident In-Service testing as provided by the ACOI

The faculty shall conform to the requirements of the AOA to provide optimum exposure as outlined within the Basic Standards of Residency Training in Internal Medicine.

Faculty shall provide an evaluation of each trainee’s performance at the end of each rotation. The evaluation shall be reviewed with the trainee in a timely manner, signed by the trainee, and submitted to the Department of Medical Education to be placed in the trainee’s permanent file.

Faculty members will participate in an annual evaluation of program goals and curriculum.
Criteria for Faculty Appointment

Faculty appointment is not an automatic privilege of medical staff appointment. Faculty appointment is based on interest in participating in the program along with physician qualifications for the desired position. Faculty applicants are evaluated by the DME and sent for final approval by the Vice President for Medical Affairs. Faculty status may be reviewed at any time by the Medical Education Committee, which may develop a remediation plan or terminate the appointment if the Committee determines that established standards of supervision and instruction are not being met. Faculty appointments shall be reported to the OPTI (SCS of MSUCOM).

Faculty Categories

The faculty dedicated to resident teaching include inpatient and outpatient primary care and specialties such as, Cardiology, Neurology, General Surgery, Critical Care, Endocrinology, Gastroenterology, Rheumatology, Nephrology, Orthopedic Surgery, Pulmonology, and Geriatrics.

Resident Eligibility and Selection

- All applicants must be graduates of Colleges of Osteopathic Medicine before beginning residency and in compliance with all OPTI requirements
- All applicants must complete application to the residency program using ERAS
- All applicants must pass COMLEX I and II in order to be ranked
- All applicants must pass COMLEX II PE in order to be appointed
- The Program Director will determine qualifications of applicants using the completed application, letters of recommendation, educational background, publications, academic record, class rank, board scores, and interpersonal, humanistic, and professional qualities as determined by these tools and the personal interview

Resident Requirements/Responsibilities

Residents will conform to the requirements delineated for them by the Director of Medical Education, the Program Director, and the Graduate Medical Education Committee. Residents will participate in this process utilizing the following methods:

- Residents must obtain a Michigan Educational Limited Osteopathic License and NPI Number before beginning their residency
- Discussions with the faculty, Program Director, DME, and the Department and the Graduate Medical Education Committee about progress in meeting the objectives of the training program (scheduled formally at regular intervals)
- Submit a resident annual report online to the ACOI by July 31 of each calendar year
- The resident will attend all required didactic meetings, including SCS Internal Medicine education programs, Journal Club, Morning Report, lectures, and others as assigned
• The resident will attend those committee meetings to which s/he has been assigned by the Program Director or DME (these may include Quality Assurance, Utilization Review, Quality Council, Mortality/Morbidity, Osteopathic Utilization, Tumor Conference)
• Attend a minimum of 70% of all assigned meetings as directed by the program director
• The Chief Internal Medicine Resident will be a member of the Graduate Medical Education Committee
• Participate as instructors in the education programs for medical students.
• The resident will take the annual ACOI In-Service Exam
• The resident shall seek and maintain candidate membership in the ACOI and the AOA. The program will pay for AOA dues yearly during the residency
• Each resident must pass COMLEX III in order to advance to OGME-3
• Each resident will meet annually with the Program Director to discuss the results of the ACOI In-Service Exam
• Each resident must complete a Service Evaluation at the end of each month’s rotation and submit it to the Medical Education Department
• Each resident must participate in an annual evaluation of the program goals and curriculum
• Each resident must maintain a log of each procedure performed
• Each resident must maintain ambulatory continuity logs
• The resident must follow the schedule set forth by the Program Director and complete all assignments in a timely fashion
• Each resident must attend a minimum of one ACOI Annual Convention or another ACOI continuing education program during OGME-2 or OGME-3.
• The resident will comply with research requirements as assigned by the Program Director and according to the Basic Standards Scholarly Activity requirement
• All residents must maintain ACLS certification beginning on the first day of the residency
• Each resident must function in an ethical and professional manner
Residents at each level are expected to treat all other members of the health care team with respect and with recognition of the value of the contribution of others involved in the care of patients and their families. The highest level of professionalism is expected at all times. Ego and personality conflicts are not conducive to good patient care. Long hours and the stress of practice can precipitate conflict. The resident should be aware of the situations where this is likely to happen and try to compensate by not escalating the situation.

The resident is expected to develop a personal program of self-directed learning. Besides the general reading in the specialty, residents should do directed reading daily with regard to problems that they encounter in patient care. The resident is responsible for reading prior to performing or assisting in procedures that the resident has not yet had the opportunity to see. Residents are expected to attend all conferences at the services and program level. The conference program is designed to provide a didactic forum to augment the resident’s reading and clinical experience.

Residents shall follow hospital policies and procedures and support the mission, vision, and values of the facility. Residents shall maintain a professional appearance and safety of the patient.

The position of a resident entails provision of care commensurate with the resident’s level of advancement and competence, under the general supervision of an appropriately privileged member of the faculty. This includes, but is not limited to:

- participating in safe, effective and compassionate care;
- developing an understanding of ethical, socioeconomic and medical/legal issues that affect graduate medical education, as well as an understanding of how to apply cost-containment measures in the provision of patient care;
- participating in the education activities of the residency program and, as appropriate, participating in institutional orientation programs, education programs, continuous quality improvement teams and other activities involving the clinical staff;
- participating in institutional committees and councils to which the resident is appointed or invited;
- performing these duties in accordance with the established practices, procedures and policies of the institution and those of its programs, clinical departments and other institutions to which the resident is assigned, including, among others, state licensure requirements and occupational health and safety requirements.

**Graduated Levels of Responsibility**

Graduate medical education is based on the principle of progressively increasing levels of responsibility, in caring for patients, under the supervision of the faculty. To maintain a high-quality educational and patient care environment, the competence of the resident is evaluated on a regular basis. Factors considered in these evaluations include the resident’s clinical experience, judgment, professionalism, cognitive knowledge, and technical skills. The residency program maintains a confidential record of these individual evaluations.

The faculty are responsible for evaluating the progress of each resident in acquiring the skills necessary for the resident to progress to the next level of training. These levels are defined as postgraduate years (PGY) and refer to the clinical years of training that the resident is pursuing.
At each level of training, there is a set of competencies that the resident is expected to master. As these are learned, greater independence is granted the resident in the routine care of the patient at the discretion of the faculty who, at all times, remain responsible for all aspects of the care of the patient.

Examples of expected competencies and responsibilities for each level follow:

**PGY 1** - Individuals in the PGY 1 year are closely supervised by senior level residents or faculty. Examples of tasks that are expected of PGY 1 physicians include: perform a history and physical, start intravenous lines, draw blood, order medication and diagnostic tests, collect and analyze test results and communicate those to the other members of the team and faculty, obtain informed consent, place urinary catheters and nasogastric tubes, and perform other invasive procedures under the supervision of the faculty or senior residents at the discretion of the responsible faculty member. The resident is expected to exhibit a dedication to the principles of professional preparation that emphasizes primacy of the patient as the focus for care. The first-year resident must develop and implement a plan for study, reading and research of selected topics that promotes personal and professional growth, and be able to demonstrate successful use of the literature in dealing with patients. The resident should be able to communicate with patients and families about the disease process and the plan of care as outlined by the attending. At all levels, the resident is expected to demonstrate an understanding of the socioeconomic, cultural, and managerial factors inherent in providing cost effective care.

**PGY 2** - Individuals in the second postgraduate year are expected to perform independently the duties learned in the first year and may supervise the routine activities of the first year residents. The PGY 2 may perform some procedures without direct (on-site) supervision such as insertion of central lines, arterial lines, paracentesis, and, thoracentesis. Second-year residents may manage critically ill patients including ventilator management, resuscitation from shock, and anti-arrhythmic therapy. Residents at this level can perform more complex procedures (such as bone marrow biopsy, pulmonary catheter placement, and flexible sigmoidoscopy) under the direct supervision of faculty or senior level residents. The PGY 2 should be able to demonstrate continued sophistication in the acquisition of knowledge and skills in his/her selected specialty and further ability to function independently in evaluating patient problems and developing a plan for patient care. The resident at the second-year level may respond to consults and learn the elements of an appropriate response to consultation in conjunction with the faculty member. The resident should take a leadership role in teaching the PGY 1 and medical students the practical aspects of patient care and be able to explain complex diagnostic and therapeutic procedures to the patient and family. The resident should be adept at the interpersonal skills needed to handle difficult situations. The PGY 2 should be able to incorporate ethical concepts into patient care and discuss these with the patient, family, and other members of the health care team.

**PGY 3** - In the third year, the resident should be capable of managing patients with virtually any routine or complicated condition and of supervising the PGY 1 and PGY 2 in their daily activities. The resident is responsible for coordinating the care of multiple patients on the team assigned. The PGY 3 can perform progressively more complex procedures under the direct (on-site) supervision of the faculty. It is expected that the PGY 3 resident be adept in the use of the literature and routinely demonstrate the ability to research selected topics and present these to
the team. At the completion of the third year, the resident should be ready to assume
independent practice in the specialty of Internal Medicine.

**Fellows** - In the fellowship years, the resident should be capable of managing patients with
virtually any routine or complicated condition and of supervising the PGY 1-3 residents in their
daily activities. At the completion of the fellowship, the resident should be ready to assume
independent practice in the subspecialty of Internal Medicine.

**Duty Hours**

Resident work duty hours shall be in compliance with the Basic Standards of the AOA. Refer to the
Lakeland House Staff Manual for detailed information regarding duty hours.

**Outside Professional Medical Activities (Moonlighting)**

Internal medicine residents may participate in moonlighting activities as defined in the Lakeland House
Staff Manual. In addition to the House Staff Manual requirements, the internal medicine resident must
be in good standing within the residency program and all residency requirements, logs, evaluations, and
medical records must be up-to-date. Moonlighting is prohibited during the OGME-1 year.

Refer to the Lakeland House Staff Manual for detailed information regarding moonlighting policies.

**Orientation**

During orientation residents are introduced to aspects of the health system that are integral to
providing safe, quality care. Topics covered include: risk management, time outs, safety call outs,
charting/documentation, codes, infection control, pharmacy, transcription and electronic health
records, human resources and benefits, order sets, and care management. Additional orientation will
occur during the first month of internal medicine. Residents will be oriented to the ambulatory clinic, as
well as, services available for the delivery of effective patient care.

**Financial Arrangements**

Resident salary and benefits are outlined in the Resident Training Agreement. Benefits include
health/dental/vision insurance, life and short-term disability insurance, professional liability insurance,
technological device stipend, educational stipend, meal allowance (in hospital only), State of Michigan
licensing fees, and lab coats.

**Medical Library and Electronic Resources for the Residency**

**Lakeland Health Sciences Library**

**Hours of Operation**

The Lakeland Health Sciences Library is staffed from 7:00 am-3:00 pm, Monday-Friday. The Library is
closed on weekends and holidays with 24 hour access available to trainees and faculty using a badge
entry system. In addition, there is a library in the Medical Education Department for use by residents
and medical students. This library is also accessible 24 hours.
Scope of Services

The Library’s online services are also available in the medical education library and resident office. The Library Services Department provides knowledge-based information, audiovisual and computer services needed by customers, both internal and external. The primary focus is to support the patient care, education, research and administrative needs of the medical staff, leadership, house staff, medical students and employees. The Library staff evaluates, selects and organizes information resources for optimal use. A summary of our services is outlined below.

- Provide materials in a variety of formats for on-site use and loan.
- Reference assistance – literature searching
- Interlibrary loan and document delivery
- Updating services
- Computer learning lab facilities
- Assistance in the use of the Internet and the office suite of computer resources
- Personal book ordering

Computer Software—Internet

- 9 computers in the Medical Education Library and 6 computers located in the hospital library all equipped with writeable cd rom drives and dvd drives
- Software available includes: Microsoft’s, Excel, PowerPoint and Word
- Books are available via StatRef- Medical Books and full text is available on-line

Journals

- Print journal subscriptions are available on-site
- 500+ electronic journals are available through the Lakeland Regional Health System intranet: [http://clineguide.ovid.com](http://clineguide.ovid.com)
- Additionally, the Library staff has access to all of the Michigan State University electronic resources through the use of their proxy server.
- Lakeland HealthCare has established a Virtual Library, where not only are you able to access the most up to date journals and books and have them emailed to the resident within minutes, but, more importantly at Lakeland the resident will be able to access all resources from Michigan State University’s virtual library. This system allows a more convenient approach to viewing and procuring an article from a pertinent journal.

Databases

- **Clin-eguide**: Evidence based [http://clineguide.ovid.com](http://clineguide.ovid.com)
- **Up-To-Date** [www.lakelandhealth.org](http://www.lakelandhealth.org)
- **Stat-Ref**: Medical Books [www.statref.com](http://www.statref.com)
- **Pub Med**: Searching Tool [www.pubmed.gov](http://www.pubmed.gov)
- **Ovid SP**: Nursing Database [http://ovidsp.ovid.com/ovidweb](http://ovidsp.ovid.com/ovidweb)

**Ordering Articles**: Most articles can be ordered and delivered within 1 to 2 days. Order requests via Lakeland librarian, Michael Dill - mdill@lakelandregional.org
Medical Education Department Library

- 24 hour access
- Medical Literature
- Printer and copy machine access

Michigan State University Medical Library – Complete Online Access

Department Contact Information

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INTERNAL MEDICINE TRAINING AND CURRICULUM
CLINICAL TRAINING PROGRAM

Core Competencies

All rotation and didactic training incorporates the core competencies established by the AOA – Osteopathic Philosophy and Osteopathic Manipulative Medicine; medical knowledge; patient care; interpersonal and communication skills; professionalism; practice-based learning and improvement; and systems-based practice. A full description of the Institutional Core Competency Plan for Lakeland Healthcare can be found in the Lakeland House Staff Manual.

General Training Objectives in Internal Medicine

1. To assist physicians in achieving competency in the seven core competencies established by the AOA
2. To prepare physicians for Board Certification in internal medicine or for further subspecialty or fellowship training
3. To acquaint the resident with the subspecialties of internal medicine in order to obtain a broader understanding of the scope of patient care
4. To introduce the resident to ambulatory continuity medicine
5. To create in residents a proficiency level of excellence in general internal medicine
6. To develop a working knowledge of pathophysiology of disease processes and to apply the principles of evidence-based medicine in treating patients
7. To encourage an organized approach toward the diagnosis of disease by developing:
   - expertise in physical diagnosis
   - correlation of physical diagnosis and clinical course with laboratory and radiographic findings
   - knowledge of indications and contraindications for various diagnosis procedures
   - applying the principles of evidence-based medicine in formulating treatment plans for patients
   - effectively utilizes systematic approaches and technology in the provision of patient care
8. To integrate osteopathic principles and practice into the diagnosis and treatment of medical illness
9. To develop an awareness of health care economics and cost-effective practice
10. To demonstrate respect, compassion, integrity, and honesty as well as a commitment to continuing personal and professional growth
11. To achieve a high level of interpersonal skill with patients, families, and colleagues involved in the provision of health care
12. To demonstrate ethical and moral behavior as well as respect for the dignity of patients and colleagues
13. To stimulate participation in the educational process of students and residents
14. To develop a methodological approach to reading, interpreting, and applying the medical literature
15. To understand, practice, and teach disease prevention and health promotion concepts
Individual Program Tracks

Traditional Internal Medicine

Lakeland Regional Medical Center offers the Traditional Internal Medicine curriculum which emphasizes inpatient care and may be used to prepare for practice as an internist or for subspecialty residency or fellowship training.

Primary Care Internal Medicine Program

The primary care internal medicine program emphasizes ambulatory continuity medicine with 20% of the resident’s total time spent in the ambulatory continuity clinic. Throughout the residency, an increasing amount of time is spent in ambulatory (non-hospital) rotations. This program is designed for residents desiring to enter a primary care office-based practice.

Trainees who begin this program with the Internal Medicine Track Internship will complete their training program in three years. Residents who complete another internship before beginning the program must complete three years of residency training in addition to the internship unless any completed year can be assessed as adequate for this program’s first year.

Internal Medicine Rotational Curriculum

<table>
<thead>
<tr>
<th>First Year</th>
<th>Blocks</th>
<th>Second Year</th>
<th>Blocks</th>
<th>Third Year</th>
<th>Blocks</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
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<td>General Medicine</td>
<td>5</td>
<td>General Medicine</td>
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</tr>
<tr>
<td>ICU</td>
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<td>ICU</td>
<td>1</td>
<td>ICU</td>
<td>1</td>
</tr>
<tr>
<td>Block Nights</td>
<td>2</td>
<td>Block Nights</td>
<td>1</td>
<td>Block Nights</td>
<td>1</td>
</tr>
<tr>
<td>Cardiology</td>
<td>1</td>
<td>Pulmonology</td>
<td>1</td>
<td>Behavioral Med</td>
<td>1</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>1</td>
<td>Gastroenterology</td>
<td>1</td>
<td>Rheumatology</td>
<td>1</td>
</tr>
<tr>
<td>General Surgery</td>
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<td>Nephrology</td>
<td>1</td>
<td>Heme/Onc</td>
<td>1</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>1</td>
<td>Neurology</td>
<td>1</td>
<td>Endocrinology</td>
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</tr>
<tr>
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<td>Electives</td>
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</tr>
<tr>
<td>Geriatrics</td>
<td>1</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

*Continuity Clinic ½ day per week for 36 weeks, at least, per year

Months of selectives/electives are approved by the program director. Each can only be for one 4 week block, except for general medicine which may be for an additional two blocks. Acceptable choices are as follows: any internal medicine subspecialty, additional general internal medicine, ICU, geriatrics, palliative medicine, radiology, anesthesia, neurology, psychiatry, osteopathic manipulative medicine, dermatology, pediatrics, family medicine, or any non-medical surgical ambulatory specialty such as orthopedics, ENT, urology or ophthalmology.
Internal medicine block nights are used as one of the first year general medicine months, but only if the rotation includes a minimum of five hours of structured education per week, to include, morning report or medicine lectures, and one book or journal club per month.

All medicine admissions must be reviewed and documented with an attending physician. Documentation of these activities must be available at the time of the on-site survey.

**Inpatient Clinical Training**

**General Medicine/Hospitalist Service**

Lakeland HealthCare operates a teaching service called the **Hospitalist Service**, whereby resident load is selected from approximately 100 inpatients. Lakeland’s Hospitalist Service is under the medical management of a team of employed hospitalists who also provide supervision and training on the service. The service utilizes a multi-disciplinary approach to patient care. Team members, in addition to faculty internists, include pharmacists, licensed social workers, and case managers. This integrated approach to patient care provides the resident with a well-rounded educational experience. The senior resident on the service serves as the “Junior Attending” and assigns and supervises cases with junior house staff. Duties of trainees on this service include, but are not limited to: admitting patients, performing history and physicals, responding to and running codes, fielding questions from nursing and patient families, addressing changes in patient status, completing discharge summaries, and keeping the attending informed of all changes. Training is designed to provide an opportunity for development in all of the core competencies. The training format allows the resident the progressive opportunity to gain autonomy in patient management as well as develop, under supervision, patient management skills. Daily didactic chart rounds, rounds, and other educational programs are also part of the experience. OMT, quality assurance, and utilization are also a vital part of patient care. The faculty stresses leadership development in clinical teaching and decision making.

**Goals, Objectives, and Responsibilities for Medical Students, Residents, and Attendings**

During this rotation, the medical student will develop skills to assess and manage the care of the hospitalized patient while learning to work as a member of a medical team. The resident will increase the skills required to facilitate and optimally manage the care of the hospitalized patient while developing and honing medical team leadership and management skills. The resident will develop and refine advanced teaching, feedback, self-reflective, and supervisory skills to maintain and advance the academic learning environment in the clinical training setting. The Attending represents a significant commitment of faculty time and energy focused upon facilitating trainees’ achievement of appropriate competencies and skills for his/her level of training. This facilitator capacity involves providing feedback, mentoring, modeling, advising and teaching — group and individual, oral, written, and bedside.

**Medical Students**

**Medical Student Goals:**

1. Provide highly skilled, compassionate, comprehensive patient care
2. Model professional integrity and conduct
3. Develop and utilize organizational skills
4. Develop and apply prioritization skills
5. Learn the approach to the hospitalized patient
6. Develop communication skills with patients and the medical team
7. Gain exposure to the multifaceted aspects of patient care

Medical Student Objectives (By the end of the rotation the medical student should be more competent in):

1. Develop history taking skills
2. Develop physical exam skills
3. Evolve a differential diagnosis
4. Develop a care plan
5. Develop documentation skills
6. Conduct an appropriate literature search
7. Present to attending physicians and all members of the medical team in a concise and complete manner
8. Understand and describe hospital utilization
9. Develop reading assignments for self that are related to patient care

Medical Student Responsibilities:

1. Attend all Internal Medicine conferences, including journal clubs
2. Appropriate daily exam and documentation of assigned patients
3. Be able to communicate appropriate history and physical findings of assigned patients during rounds
4. Be able to communicate all laboratory and diagnostic tests to supervisory house staff and attending physicians
5. Required attendance on the as noted on the student calendar.

Residents

OGME-1 Goals:

1. Provide highly skilled, compassionate, comprehensive patient care
2. Help establish a safe, supportive and structured learning atmosphere
3. Model professional integrity and conduct
4. Develop and practice teaching skills
5. Develop and utilize organizational skills
6. Develop and apply prioritization skills

OGME-1 Objectives (By the end of the rotation the Resident should be more competent in):

1. Assess a patient’s social, psychological, spiritual, economic, cultural realities
2. Negotiate a patient-specific care plan
3. Expand and prioritizing differential diagnosis
4. Utilize and work with non-physician members of the health care team
5. Provide time efficient and cost efficient care
6. Teach medical students to design and implement a negotiated and appropriate care plan
7. Develop a post-hospital medicine regimen and care plan
8. Arrange necessary post-hospital care and follow up
9. Manage multiple disciplinary consults and recommendations in the best interest of the patient

OGME-1 Responsibilities:

1. Help the medical student achieve their goals and objectives and ensure performance of the responsibilities
2. Provide overall performance feedback to medical students (weekly at minimum)
3. Conference attendance (e.g., morning IM meeting, noon lecture, etc.)
4. Supervise medical students in procedures and patient care
5. Responsible for all progress notes
6. Respond to codes
7. Provide in-house coverage for patients on HOSPITALIST from 0700 until 1900, unless changed by attending or resident, and must check ER admissions at 1630 prior to the scheduled 1900 change of service.
8. Observe and provide feedback on patient-medical student encounters (H&P)
9. Residents attend all other IM meetings, journal clubs, reading clubs, and related lectures
10. Required to give at least two presentations per month
11. Night resident must leave in accordance with duty requirements
12. Weekend coverage: each resident will alternate every other weekend to write progress notes for continuity and do admissions.

OGME-2, OGME-3 Goals:

1. Provide highly skilled, compassionate, comprehensive patient care
2. Help establish a safe, supportive patient care and learning environment
3. Facilitate the academic and clinical growth of self and team members
4. Appraise and evaluate the skills, abilities, and knowledge of learners and self

OGME-2, OGME-3 Objectives (By the end of the rotation the resident should be):

1. Better able to self-assess his/her own knowledge and competency gaps
2. More adept at assessing the learning needs of others
3. Recognize, address, and discuss errors and mistakes
4. Better able to complete an expanded and prioritized differential diagnosis
5. More comfortable and proficient at bedside teaching
6. Able to propose a focused clinical question and find an answer
7. More skilled at literature searches
8. Able to display more knowledge of the medical literature
9. More knowledgeable and capable regarding inpatient billing
OGME-2, OGME-3 Responsibilities:

1. Provide in house coverage for patients on the Hospitalist Service from 0700 until 1900 in a supervisory role with residents and medical students on service
2. Delegate patient admissions and floor work to Residents and medical students
3. Supervise residents and medical students with all patient care issues
4. Attend IM conferences such as IM morning report, noon lecture, and journal club, Harrison’s Club, Yale Clinic, OMT clinic, etc.
5. Provide documented rotational feedback for Residents and medical students
6. Respond to codes
7. Facilitate all residents and medical students in achieving their goals and objectives and performing their responsibilities
8. Ensure communication between the Hospitalist Service team and attending physicians
9. Resident is responsible for the assignment of presentations for either - morning report, noon lecture, or IM conferences

Procedures Performed by Residents

The resident must have training and experience in central venous line placement, arterial puncture for arterial blood gases, osteopathic manipulative treatment and endotracheal intubation to include, at minimum: indications; contraindications; complications; limitations and evidence of competent performance.

The resident must have training and experience in arthrocentesis, peripheral blood smears, exercise stress tests, ambulatory ECG monitors, lumbar puncture, spirometry, sputum gram stain, urine microscopy, vaginal wet mounts, thoracentesis and arthrocentesis to include, at minimum: indications, contraindications, complications, limitations and interpretation.

A. All procedures must be supervised and authorized by your attending or a credentialed resident.
B. No one shall be allowed to participate in a procedure without demonstrated knowledge of the indication, contraindications, potential complications of, and mechanics of the procedure.
C. The senior house staff on the service will get first right of refusal for the procedure.

Residents must log the following procedures before requesting related credentialing:

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>MINIMUM NUMBER OF SUPERVISED PROCEDURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arterial line</td>
<td>5</td>
</tr>
<tr>
<td>Central venous catheter, subclavian</td>
<td>5</td>
</tr>
<tr>
<td>Central venous catheter, internal jugular</td>
<td>5</td>
</tr>
<tr>
<td>Central venous catheter, femoral</td>
<td>5</td>
</tr>
<tr>
<td>Chest tube insertion</td>
<td>5</td>
</tr>
<tr>
<td>Endotracheal intubation</td>
<td>5</td>
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<tr>
<td>Lumbar puncture</td>
<td>5</td>
</tr>
<tr>
<td>Moderate sedation</td>
<td>5</td>
</tr>
<tr>
<td>Swan-Ganz catheterization</td>
<td>5</td>
</tr>
<tr>
<td>Thoracentesis, diagnostic</td>
<td>5</td>
</tr>
</tbody>
</table>
Ambulatory Continuity Training

Goals and Objectives

Ambulatory management of common and complex problems is a significant dimension of current medical care. As a goal of their ambulatory training experience, residents are expected to demonstrate competence in case management based on the principles of evidence based medicine. Faculty and other clinic staff will provide many opportunities for residents to acquire skills in the financial responsibilities of operating an ambulatory clinic site.

The trainee in internal medicine will attend to, on average, 4 patients per half-day session in the clinic. However, new trainees will see few patients, and the number of patient encounters will increase significantly as trainee skill, knowledge, and autonomy increase. Depending on their program, residents will spend either 10% or 20% of their time at the ambulatory continuity clinic.

As residents develop their patient panels, they will care for a growing number of patients. This training site provides their primary opportunity to develop knowledge, skills, and competency in the management of out-patient care. They will be supervised and held responsible for:

- Eliciting a chief complaint
- Developing a differential diagnosis
- Formulating a treatment plan using evidence based medicine
- Complete, accurate, timely and legible documentation of patient visits
- Utilization of the concepts of managed care

Resident Requirements

1. Regular, assigned attendance based on program:
   a. Traditional Track: 10% of resident time—one half-day per week
   b. Primary Care Track: 20% of resident time—two half-days per week
2. With the assistance of the faculty, develop a panel of a reasonable number of patients who identify the resident physician as their primary provider over the three year period of the training program.
3. Participate in formal evaluation of their ambulatory clinic performance with their faculty supervisor at least semi-annually
4. Participate in all staff meetings of the site, if appropriate
5. Participate in graduated scheduling of patients per training year with goals as follows:
   a. First Year: 30 min/visit
   b. Second Year: 20 min/visit
   c. Third Year: 15 min/visit
6. Maintain ambulatory patient logs including patient identifiers, initial diagnosis, and treatment
7. Maintain ambulatory patient procedure logs including those required by the ACOI
8. Arrive on time. If the resident is going to be late or unable to attend, the resident is personally responsible for notifying the Faculty Supervisor. All requests for time off from ambulatory continuity clinic assignments must be approved in writing in advance following the policies of the medical education department, usually 30 days. Refer to the current House Staff Manual for a written description of this policy. Forms for time off are available in the medical education office.
9. Residents will review lab, radiology, messages, consults, etc., in a timely manner. Both the resident and the assigned faculty attending must sign these items.

10. Residents must abide by all of the Basic Standards for Residency Training in Internal Medicine provided by the AOA and ACOI

11. Residents must abide by all institutional policies and procedures

Faculty Requirements

Program faculty at the ambulatory clinic site must be board certified or eligible in internal medicine. Faculty will supervise program trainees, reviewing key portions of the history and physical, discussing treatment plans and need for follow up. Medical faculty countersign patient medical records completed by the resident. Faculty will evaluate appropriate scope, volume, and variety of patient exposure, and may assign residents to particular patients based on these training needs assessments.

DIDACTIC PROGRAM IN INTERNAL MEDICINE

Core Competencies

All rotation and didactic training incorporates the core competencies established by the AOA – Osteopathic Philosophy and Osteopathic Manipulative Medicine; medical knowledge; patient care; interpersonal and communication skills; professionalism; practice-based learning and improvement; and systems-based practice. A full description of the Institutional Core Competency Plan for Lakeland HealthCare can be found in the Lakeland House Staff Manual.

The program provides a wide range of academic programs to supplement the diverse clinical training experiences of trainees. These programs include but are not limited to:

Journal Club

The monthly Journal Club format developed for the residency is designed to meet the research requirement of the ACOI. This format includes curricular components including methods for analyzing, interpreting, and presenting original data published in medical journals. Faculty for Journal Club can include the Program Director and Internal Medicine clinical faculty who act as facilitators who provide valuable input regarding research design and statistics. Medical literature assessment skills will be guided by the modules offered by the SCS of MSUCOM. The Journal Club participants utilize a detailed evaluation form to evaluate presentations, with individual verbal feedback from faculty. The evaluation assesses presentation content, critique and delivery. Attendance at Journal Club is required of all residents in the program.

Internal Medicine Board Review

The SCS of MSUCOM offers a comprehensive board review course annually. Senior residents are invited and encouraged to attend. During the board review course, all residents are released from their clinical duties. During monthly day-long SCS internal medicine didactic sessions, board review material is continually reinforced.
**Morning Report**

Department morning reports are held weekdays, Monday, Tuesday, and Thursday. These educational conferences are staffed by faculty and the format varies from case presentation to topical formal presentation. Attendance is required for all trainees on in-house medicine services and outside rotations if within acceptable traveling distance.

**Morbidity/Mortality Review**

The Morbidity/Mortality Committee meets monthly to review charts. Certain cases are selected as appropriate for an educational discussion. Residents will be required to present cases if assigned by the committee. Faculty members from various disciplines are encouraged to attend.

**Cancer Conference**

The Medical Department sponsors a Tumor Conference routinely. Residents may be assigned to present a selected case from inpatient pathology and initiate discussion. Faculty from several disciplines, in addition to internal medicine, attend and contribute to the discussion. Trainees are required to attend when asked to present a case they participated in.

**Osteopathic Manipulative Medicine**

All program trainees are required to complete osteopathic structural exams as a minimum of each patient admission. Faculty encourage residents to integrate the practice of osteopathic manipulative medicine into all aspects of patient care, both inpatient and ambulatory. Training modules from MSUCOM will be utilized as well for further instruction. Osteopathic practice and utilization must be documented on ambulatory clinical logs whenever utilized. A series of presentations on OMM/OPP are provided routinely.

**Statewide Campus System (SCS) of Michigan State University College of Osteopathic Medicine, the Michigan OPTI**

The SCS provides a wide range of didactic programs to the 30 osteopathic teaching hospital programs participating in its educational consortium. A monthly day-long didactic program in internal medicine designed by program directors of participating hospitals is included in these sessions. SCS programs combine the financial and academic resources of participating hospitals to present local, regional, and nationally known presenters at these internal medicine sessions. Formats include lectures, workshops, and board review courses. The program provides a certificate from MSUCOM to each resident upon completion of the training program at his/her base hospital.

**Didactics**

**Monthly Didactics**

A. EKG Conference - Wednesday at 11am  
B. OMM – Tuesday 7am  
C. Journal Club – Tuesday 7am  
D. M&M Conference – Wednesday 7am
Weekly Didactics

A. Yale Clinic – Monday noon
B. Faculty Lecture – Wednesday 7am
C. Morning Report – Weekdays 7am
D. Resident Lecture – Wednesday noon
E. Grand Rounds – Thursday noon
F. Harrison’s Club – Friday 6:30am
G. System Lecture – Friday noon

Didactics for Out-Rotations

Trainees on rotation at Lakeland Regional Medical Center or any other training site are required to participate fully in the didactic programs offered at that institution.

Didactic Program Resident Responsibilities and Requirements

Residents will conform to the requirements delineated for them by the Director of Medical Education, the Program Director, and the Hospital’s Graduate Medical Education Committee. Residents will participate in this process utilizing the following methods:

- Discussions with the faculty, Program Director, DME, and the Department and Hospital Graduate Medical Education Committees about progress in meeting the objectives of the training program (scheduled formally at regular intervals)
- The Chief Medical Resident will be a member of the Hospital’s Graduate Medical Education Committee
- Each resident must complete a “Rotation Evaluation” at the end of each month’s rotation and submit it to the Medical Education Department
- Each resident must pass Part III of the Boards before progressing to the third year of the residency.
- Each resident must meet annually with the Program Director to discuss the results of the ACOI Annual Resident Exam
- The resident will attend those committee meetings to which she/he has been assigned by the Program Director or DME (these may include Quality Assurance, Utilization Review, Quality Council, Mortality/Morbidity, Osteopathic Utilization, Tumor Conference)
- The resident shall seek and maintain candidate membership in the ACOI. The program will pay for AOA dues yearly during the residency
- The resident will comply with the ACOI research requirements as assigned by the Program Director
- The resident will take the annual ACOI Resident Exam
- The resident will attend all required didactic meetings, including SCS Internal Medicine education programs, Journal Club, Morning Report, Noon Lecture, and others as assigned
- The resident will satisfactorily complete, by the end of the second year, the ACOI Resident Clinical Evaluation (an observed new patient consultation and work up) as assigned by the Program Director
- Residents must obtain a Michigan Full Osteopathic License and DEA Number before beginning their residency. The “Controlled Substance Registration Certificate” (DEA Number) is issued by
the United States Department of Justice, Drug Enforcement Administration. To qualify Part III of the Boards must be successfully completed and the resident must be fully licensed. The fee for the “Controlled Substance Registration Certificate” (DEA Number) is not covered by the program
• The resident must complete the ACOI Resident Annual Report within 30 days of completion of each contract year

Didactic Program Attendance Policy

1. 100% attendance at all lectures while on rotations at LRMC or local out-patient rotations
2. 100% attendance (unless on call at LRMC) at:
   a. Journal Club
3. 100% attendance at all dedicated Internal Medicine didactic sessions while on rotations at LRMC or local outpatient rotations:
   a. Board Review
   b. Harrison’s club
   c. Morning Report
4. ICU rotations are not exempt from the above requirements
5. 70% attendance at SCS conferences
6. Any absence must be discussed with the Program Director
7. Attendance records will be kept in the Medical Education office

Research Requirement

The ACOI provides a number of ways in which the program and its residents may meet research requirements. Currently the program does not require original research projects, but strongly encourages resident research projects. The program does require that all residents participate fully in the Department’s Journal Club activities, described above. In this way, each resident will meet the minimum ACOI research requirement as included in numbers 5, 6, and 7, below.

Lakeland will allow residents to complete research papers if they wish.

The program shall provide adequate exposure to medical research/review skills and methods of presentation, including information relating to changes in the health care delivery system. Options for meeting the above requirements shall be determined by the program director and may include, but are not limited to, any of the following:

1. Original research studies (basic science, clinical studies, health services research) and writing, once per training program
2. Retrospective studies (medical records analysis), once per training program
3. Entry into the ACOI annual resident medical writing/research competition, one per training program
4. Presentation of a scientific poster/abstract at the ACOI annual meeting, once per training program
5. Resident education program on research types and methodology, ongoing throughout the program (e.g., Journal Club designed to deliver this model of education)
6. Resident education program on biostatistics, ongoing throughout the training program (e.g., Journal Club designed to deliver this model of education)
7. Formal written critique by the program director or designee of resident presentation of Journal Club articles/literature review (i.e., credibility of material, data, statistics, and study design), twice annually
8. Educational program for residents in health services research, policies, administration (i.e., access of population groups to health care, compliance issues, public policies, managed care, etc.), ongoing throughout the program
9. Educational program on “How to read and understand the medical literature,” ongoing throughout the training program
10. Formal written critique by the program director or designee of medical resident lecture presentation of researched topic, twice annually
EVALUATIONS
The residency has developed a systematic program of evaluation which includes ongoing informal and formal evaluation of program design and content, trainee performance, and faculty evaluation. *New Innovations Residency Management Software* shall be used for most of the evaluation process. Evaluation information is used by the Program Director, Medical Education Committee, and the Medical Education Department in a process of continuous quality improvement.

**Program Evaluation**

A variety of formal evaluation methods are used in addition to monthly meetings of the hospital’s Graduate Medical Education Committee. Internal Medicine Track OGME Residents evaluate the program annually using the ACOI Resident Annual Report. In addition, the Medical Education Committee conducts a survey of all trainees regarding their level of satisfaction with all aspects of the training environment. Open ended questions at the end of the survey allow residents to comment freely on areas of concern as well as strengths of the program. Each program trainee completes a formal service evaluation at the end of each month of training. This evaluation asks trainees to rate several areas of the program as well as faculty performance on their service. The DME or ADME reviews and signs these evaluations as they are delivered to the Medical Education Department. Residents also complete an evaluation of their ambulatory continuity training site experience. These evaluations are also reviewed by the DME and the Program Director. Program services receiving unsatisfactory evaluations from trainees will be reviewed by the Graduate Medical Education Committee.

All evaluations are compiled by the Medical Education Department which generates twice yearly, confidential and anonymous reports of “Service” ratings for distribution to the program faculty, Program Director, and the Graduate Medical Education Committee.

**Work Hours Evaluation**

Each trainee enters all hours worked into the *New Innovations* on a daily basis. Hours include all hours worked - clinical time, required educational sessions, call duty hours, and moonlighting. The Medical Education Department retains these records and submits them for review to the Graduate Medical Education Committee at its monthly meeting.

The Program Director and the DME maintain an open-door policy for all program trainees to address personal or programmatic areas of concern.

**Resident Evaluation**

Faculty and the Program Director closely monitor trainee performance throughout the training program. This evaluation is both informal and formal. At the completion of each month’s rotation, the supervising faculty evaluates the trainee through New Innovations using their competency-based evaluation with access provided by the Medical Education Department. This evaluation is verified by the trainee at a meeting with the faculty supervisor and submitted to the Medical Education Department for review and signature by the DME or ADME. Any indication of a problem in the trainee’s progress toward meeting the goals of the program is addressed immediately by the DME and the Program Director.

The Program Director submits an evaluation of overall resident performance on a quarterly basis.
The ambulatory continuity clinic supervisor also submits a formal evaluation of the trainee’s performance at the continuity site on a semiannual basis.

**Faculty Evaluation**

Program residents complete an evaluation of program faculty on their service at the end of each month’s rotation using New Innovations. Up to three faculty on each service may be evaluated by the trainee using a competency-based format. Additionally, the evaluation asks trainees to rate other areas. The faculty evaluation asks trainees to rate faculty on several areas relating to quality of training on the service. Encouragement is offered for additional written comments. These evaluations are summarized on a semi-annual basis and reviewed by the DME. A confidential and anonymous summary report is prepared by the Medical Education Department for distribution to the Program Director for review and action if required.

In the event that a faculty member or service does not meet minimum quality standards of performance established by the Medical Education Committee, the Committee may review the faculty status of the faculty member in question and establish a remediation plan. Failure to meet the objectives of the remediation plan may result in loss of faculty status.

**eLogs**

The American Osteopathic Association (AOA) has mandated that "The training site and intern shall keep a detailed record (log) of activities on each assigned rotation. The minimum information required in these logs is specified on the forms provided by the AOA’s Division of Postdoctoral Training." (American Osteopathic Association, Accreditation Document for Osteopathic Postdoctoral training institutions and the Basic Document for Postdoctoral Training Programs. 2006. Pg.61)

The *New Innovations* log program is designed to help each training site meet AOA record keeping requirements. The program is specifically designed to electronically record patient encounters, as well as educational and reading requirements.

The *New Innovations* program allows residents to use any computer device with internet access to log all of their patient encounters, reading and educational requirements, hours worked and service evaluations. *New Innovations* provides house staff and administrators access to real-time, web-based reports.
INTERNAL MEDICINE RESIDENT ROTATIONS AND CURRICULA
ALLERGY/IMMUNOLOGY

GOALS

The goal of this rotation is to enable residents to gain an understanding of the elements of allergy/immunology that will augment their internal medicine practice and give insight into patients’ experiences in this area of medicine.

Residents must recognize the importance of the emotional issues, concerns and anxieties in this branch of medicine, both for the patient and the patient’s primary care.

The resident should show an understanding of the importance of the patient care team in the management of these patients. The resident should develop competent management and competent referral skills.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include physical assessment, appropriate medical interviews, and daily management of medical problems encountered.

B. The resident should be able to understand:
   - The role of somatic dysfunction and the relationship of osteopathic principles and treatment on the immune system
   - Immune responses and hypersensitivity reactions
     - The biology of the immune response
     - T lymphocytes
     - B lymphocytes
     - T and B cell functioning
     - Cytokines
   - Immunology of IgE
   - Mast cells and basophil/mediator release
   - Complement
   - Classification of immune damage
     - Type I, anaphylactic/immediate, late phase and dual reactions
     - Type II, cytotoxic reaction
     - Type III, Arthus reaction
     - Type IV, delayed
     - Type V, antireceptor
   - Immunodeficiency – primary and secondary
   - Asthma
     - Definition
     - Impact on cost and quality of life for the patient and society
     - Major pathologic factors in airway obstruction (early and late phases)
       - Inflammatory mucosal edema
       - Bronchoconstriction (smooth muscle)
       - Sputum secretions (mucous plugs)
     - Triggers of symptoms
     - Triggers of inflammation
Diagnosis and differential diagnosis
- History and physical examination
- Pulmonary function tests
- Allergy evaluation
Pathophyslogic mechanisms
- Genetic factors (IgE)
- Autonomic dysfunction (adrenergic and cholinergic)
- Bronchial hyperactivity (chemical mediator release)
Monitoring peak/flow
Preventive treatment
Medical treatment
Treatment of status asthmaticus
- Management of asthma with concurrent conditions (pregnancy, hypertension, heart disease, surgery)
Factors in compliance
- Education
- Avoidance of environmental triggers
- Early intervention

Rhinitis
- Symptoms, signs, pathophysiology, quality of life
- Triggers
- Diagnosis
- Management
- Associated conditions

Adverse reactions to foods, drugs and biological

Dermatitis
- Etiology/pathophysiology
- Distribution and clinical characteristics
- Patch testing
- Management

Anaphylaxis
- Precipitating factors
- Signs and symptoms
- Diagnosis
- Treatment
- Prevention

Urticaria and angioedema
- Classification
- Wheal and flare response
- Immunologic mechanisms
- Non-immunologic mechanisms
- Diagnosis
- Management

C. The resident will focus on the following skills through interaction with patients and patient care teams:
- OMM in the management of allergic/immunologic diseases
- Skin testing
- In vitro testing
Pulmonary function tests
  Common tests
    Peak expiratory flow rate (PEFR)
    Spirometry (FEV), (FVC), and (FEV1/FVC ratio)
  Diagram of lung capacities/flow volume loop
  Typical findings in various conditions
  Exercise challenge testing

**ADDITIONAL INFORMATION**

Training in allergy/immunology will be accomplished over the course of the longitudinal experience in the ambulatory clinic. A block rotation is available as an elective.

Completion of the specific related section in *Med Challenger* is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning.

Pertinent topics are part of the Master Lecture Schedule.
BEHAVIORAL MEDICINE

GOALS

The goal of this rotation is to enable residents to recognize the inter-relationships among the biologic, psychologic and social factors in all patients. During every practice day, physicians must incorporate knowledge of human behavior, and mental disorders into the care of their patients.

Residents must recognize the importance of the relationship that exists between the patient and his or her family.

The resident must have a sensitivity to, and knowledge of, the emotional aspects of organic illness.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include diagnostic assessment psychotherapeutic approaches and psychopharmacologic management techniques.

B. The resident should acquire the following knowledge:

C. The resident will focus on the following skills through interaction with patients and patient care teams:

Basic Knowledge:
- Normal and abnormal psychosocial growth and development across the life cycle, and variants
- Recognition of interrelationships among biologic, psychologic and social factors in all patients
- Reciprocal effects of acute and chronic illnesses on patients and their primary care
- Factors that influence adherence to a treatment plan
- Primary care functions and common interactional patterns in coping with stress
- Awareness of one’s own attitudes and values, which influence effectiveness and satisfaction as a physician
- Stressors on physicians and approaches to effective coping
- Ethical issues in medical practice, including informed consent, patient autonomy, confidentiality and issues that pertain to quality of life
- Understand the body/mind/spirit relationship and be aware of opportunities to integrate OMT to treatment of behavioral issues

Mental Health Disorders:
- Disorders principally diagnosed in infancy, childhood or adolescence including mental retardation, learning disorders, motor skills disorders, communication disorders, pervasive developmental disorders, ADD and disruptive behavior disorders, feeding and eating disorders of infancy or early childhood, tic disorders and elimination disorder
- Delirium, dementia, amnestic and other cognitive disorders
- Substance-related disorders including abuse of alcohol, amphetamines, caffeine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opioids and PCP
- Schizophrenia and other psychotic disorders
- Mood disorders including major depression, dysthymic and bipolar disorders
• Anxiety disorders including panic, phobias, O/C disorder, post-traumatic stress disorder, acute stress disorder, generalized anxiety disorder
• Somatoform disorders including somatization, conversion, pain, and hypochondriasis
• Factitious disorders
• Dissociative disorders
• Sexual and gender identity disorders
• Eating disorders
• Sleep disorders
• Impulse control disorders
• Adjustment disorders
• Personality disorders including paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, Obsessive-compulsive
• Problems related to abuse or neglect
• Additional conditions including non-compliance, malingering, borderline intellectual functioning, age-related cognitive decline, bereavement, academic problems, occupational problems, identity problems, religious or spiritual problems, acculturation problems, and phase-of-life problems

D. The resident should acquire the following skills:
Evaluation Skills
• Interviewing skills, which enhance data collection in short periods of time and optimize the doctor/patient relationship
• Performance of mental status examination
• Indications for special procedures in psychiatric disorder diagnosis, including psychological testing, laboratory testing and brain-imaging testing
• Capacity to elicit and recognize the common sign and symptoms of the disorders listed previously
• Consultation procedures

Therapeutic Skills
• Management of emotional aspects of non-psychiatric disorders
• Skills in enhancing compliance with medical treatment regimens
• Initial management of psychiatric emergencies: the suicidal patient, the acutely psychotic patient
• Proper use of psychopharmacologic agents
• Primary care support therapy
• Behavior modification techniques
• Utilization of community resources
• Crisis counseling skills

ADDITIONAL INFORMATION

Training in human behavior and mental health will be accomplished in both the inpatient and outpatient settings on a longitudinal basis. This combination should include experience in diagnostic assessment, psychotherapeutic approaches and psychopharmacologic management techniques.

Completion of the specific related section in Med Challenger is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning. Pertinent topics are part of the Master Lecture Schedule.
CARDIOLOGY

GOALS

The goal of this rotation is to ground residents in the basics of this branch of medicine as cardiovascular disease is one of the major health threats in this country. The resident should be able to demonstrate proficiency in the evaluation through the cardiovascular physical exam and management of common cardiovascular disorders.

Residents must recognize the importance of the emotional issues, concerns and anxieties in this branch of medicine, both for the patient and the patient’s primary care.

The resident should show an understanding of the importance of the patient care team in the management of these patients. The resident should develop competent management and competent referral skills.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include physical assessment, appropriate medical interviews, and daily management of medical problems encountered.

B. The resident should develop attitudes that:
   • Show an awareness of the importance of the physician/patient partnership to promote cardiovascular health
   • Stress a compassionate approach to patients with cardiac disease, especially those with chronic disease
   • Recognize the impact of cardiac disease on the patient and the patient’s primary care with regards to economic and psychosocial issues
   • Help support the patient and primary care through consultation, evaluation, treatment and rehabilitation

C. The resident should develop a knowledge of:
   • Normal cardiovascular anatomy and physiology
   • Changes in cardiovascular physiology with age and pregnancy
   • Risk factors for coronary artery disease
   • Cardiovascular history
   • Cardiac-centered physical examination
   • Non-invasive examinations
   • Invasive examinations
   • Relevant laboratory and interpretation
   • OMT in both inpatient and outpatient settings
   • Specific disease conditions
     o Stable/unstable angina
     o Myocardial infarction
     o Types of syncope
     o Arrhythmias
     o Hypertension
     o Pulmonary heart disease
• Congestive heart failure
• Thromboembolic disease
• Valvular heart disease
• Congenital heart disease
• Dissecting aneurysm
• Innocent heart murmurs
• Peripheral vascular disease
• Cardiomyopathies
• Pericardial disease
• Infection related

• Other cardiac diseases including acute rheumatic fever, autoimmune disorders, traumatic, nutritional, tumor, thyroid dysfunction, Marfan syndrome, and drug-related disorders
• Evaluation of cardiac patient for non-cardiac surgery
• Antibiotic prophylaxis for valvular heart disease
• Cardiovascular pharmacology
• Viscerosomatic reflexes and utility of osteopathic structural exam in evaluation of the cardiovascular system
• Indications and contraindications to OMT in patients with cardiovascular disease

D. The resident will focus on the following skills through interaction with patients and patient care teams

• Diagnostic
  o History and physical examination
  o Mechanics and interpretation of EKGs
  o Chest X-ray interpretation

• Therapeutic
  o Basic and advanced life support, central lines, pacemaker insertion
  o Treating arrhythmias and conduction disturbances
  o Management of acute myocardial infarction and post infarction care
  o Congestive heart failure
  o Hypertensive emergencies
  o Psychological issues of heart disease

ADDITIONAL INFORMATION

Training in cardiology is offered as a block rotation and will also be achieved through the longitudinal training experience in Internal Medicine.

Completion of the specific related section in Med Challenger is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning.

Pertinent topics are part of the Master Lecture Schedule.
DERMATOLOGY

GOALS
Internal Medicine physicians must care for a wide variety of skin problems in patients of all ages and sexes. They are some of the most perplexing of complaints in Internal Medicine. Most initial care of dermatologic problems is provided/performed by primary care physicians.

The rotation is designed to prepare the resident for these specific challenges in dermatology in the office setting, under the supervision of clinical faculty with expertise in this area. Ideally, much of the resident’s education in dermatology will be practical, with didactic sessions meant to increase resident understanding of particular dermatologic principles.

The goals of our Internal Medicine dermatology experience are primarily to expose the trainee to dermatology, and to develop a sound knowledge base from which the trainee can make decisions on which lesions to treat, how to treat them, and when referral is needed for the benefit of the patient.

OBJECTIVES
A. The ability to take an appropriate dermatologic history.
B. Ability to adequately describe skin lesions and other physical findings.
C. Demonstrate appropriate knowledge of common dermatologic pharmaceutical agents.
D. Demonstrate the ability to use the dermatology consultant appropriately.
E. Ability to assemble a reasonable differential diagnosis based on history, lesion description and location.
F. Demonstrate an appropriate cognitive knowledge of common skin conditions, including – diagnosis, history, exam, findings, differential diagnosis and treatment.
G. Ability to perform a full skin examination for skin cancer screening.
H. Demonstrate an appropriate index of suspicion for malignancies of the skin, and a solid knowledge of what lesions require biopsy.
I. Demonstrate competence in performing the common dermatology procedures, including skin biopsies, excision of lesions, cryo- and electro-cautery, and other common procedures.

ADDITIONAL INFORMATION
Training in dermatology will be accomplished over the course of the longitudinal experience in Internal Medicine. A block rotation in Dermatology is offered as an elective.

Completion of the specific related section in Med Challenger is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning.

Pertinent topics are part of the Master Lecture Schedule.
EMERGENCY MEDICINE

GOAL

Taking care of a large and diverse population almost guarantees that the primary care physician will encounter emergencies. It is essential that resident be trained in the necessary steps to take in an emergency situation. It is also important to work with colleagues in the Emergency Department when referrals are made in order to assure the best possible patient care.

Residents must show an understanding of medicolegal issues including informed consent, patient competency, do-not-resuscitate orders, chain of evidence COBRA and duty of care.

The resident must have sensitivity to, and knowledge of, the emotional aspects surrounding emergency care for both the patient and the patient’s primary care.

The primary care physician is in a unique position to offer special support to patients and families as they face emergency care.

With the above in mind, the resident should seek to develop attitudes that demonstrates an ability to communicate effectively and compassionately with patients and families and a capacity to work quickly and efficiently to assess the patient according to the urgency of the patient’s problem.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include all phases of emergency care in the Emergency Department.

B. The resident will develop a knowledge base in the following:
   - Time management
   - Assessment and management of
     - Trauma – by mechanism of injury and by site of injury
     - Neurologic emergencies including the comatose patient, status epilepticus, altered states of consciousness, spinal cord compression and stroke
     - Psychiatric emergencies – acute psychiatric breaks, suicidal patient
     - Burns including classification, outpatient management of first and second degree burns, indications for hospitalization
     - Violent patient
     - Obstetric and gynecologic emergencies including victims of sexual assault, ruptured ectopic pregnancy, miscarriage, preeclampsia and eclampsia, and vaginal hemorrhage
   - Recognition and treatment of acute life-threatening situations
     - Acute respiratory problems
     - Life-threatening arrhythmias
     - Cardiac arrest
     - Ischemic heart disease
     - Cardiovascular pharmaceuticals
     - Resuscitations – drowning/near drowning, electrocution/lightning, hypothermia/hyperthermia, neonatal/infant/child resuscitation
Acid base imbalance
- Shock
- Infectious disease emergencies, including meningitis
  - Diagnostic interpretation including EKGs, Xrays of common emergency problems
  - Environmental exposures – bites, stings, indications of rabies prophylaxis, poisonous plants, inhalations, hypersensitivity reactions
  - Toxicologic emergencies – general approach to the poisoned patient

C. The resident will focus on the following skills through interaction with patients and patient care teams:
- Airway management – nasotracheal and orotracheal intubation on adults
- Initiation of vascular access – arterial cannulation
- Artificial circulation – advanced cardiac life support skills
- Anesthesia techniques – local blocks
- Suturing lacerations including muscle, skin and subcutaneous tissue
- Plastic surgery repair of skin lacerations – eyelid, lip
- Fracture care – splint and case simple fractures

ADDITIONAL INFORMATION

Training in Emergency Medicine will be accomplished through a block rotation.

The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement to office material.

The resident is expected to attend the didactic program of the Emergency Medicine Department.

Pertinent topics are part of the Master Lecture Schedule.
ENDOCRINOLOGY

GOALS

Often the Internal Medicine physician is the “first in line” when an endocrine problem presents. Therefore, it is essential that residents obtain a solid working understanding of the elements of endocrinology.

The goal of this rotation is to enable residents to gain an understanding of the elements of endocrinology that will augment their internal medicine practice and give insight into patients’ experiences in this area of medicine.

Residents must recognize the importance of the emotional issues, concerns and anxieties in this branch of medicine, both for the patient and the patient’s primary care.

The resident should show an understanding of the importance of the patient care team in the management of these patients. The resident should develop competent management and competent referral skills.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include physical assessment, appropriate medical interviews, and daily management of medical problems encountered.

B. The resident should develop a knowledge of:
   - Basic elements of endocrinology including hormone synthesis and release and mechanisms of hormone action
   - Pancreatic hormones and Diabetes Mellitus
     - Classification of Diabetes Mellitus
     - Clinical features of Diabetes Mellitus
     - Laboratory findings in DM
     - Diagnosis of DM
     - Treatment of DM: available regimens
     - Acute complications of DM
     - Chronic complications of DM
     - Patient education and goals of treatment
   - Addison’s Disease – diagnosis and treatment
   - Cushing’s Disease – diagnosis and treatment
   - Anterior pituitary hormones including ACTH, growth hormone, prolactin, thyrotropin and LH/FSH
   - Endocrinologic evaluation of the hypothalamic-pituitary axis
   - Diabetes insipidus – diagnosis, causes and treatment
   - SIADH – diagnosis, causes and treatment
   - Clinical male gonadal disorders including Kleinefelter’s Syndrome, bilateral anorchia, Leydig Cell aplasia, cryptorchidism, impotence, infertility, gynecomastia and testicular tumors.
   - Disorders of ovarian and menstrual function
Amenorrhea
Disorders of androgen metabolism
Ovulation induction
Therapeutic use of ovarian hormones and their synthetic analogs
Inhibitors of ovarian function
Menopause
Thyroid hormone synthesis and secretion
Tests for thyroid function
Disorders of the thyroid – hypothyroidism, hyperthyroidism and thyrotoxicosis, thyroid hormone resistance syndromes, nontoxic goiter and thyroiditis
Integration of osteopathic principles in treatment of common symptoms and sequelae of endocrine disorders

ADDITIONAL INFORMATION

Training in Endocrinology will be accomplished through the longitudinal experience in Internal Medicine and is required as an OGME-3 rotation.

Completion of the specific related section in Med Challenger is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning.

Pertinent topics are part of the Master Lecture Schedule.
ENT - OTORHINOLARYNGOLOGY

GOALS

The goal of this rotation is to ground residents in the basics of this branch of medicine. The resident should be able to demonstrate proficiency in the evaluation and management of common ENT disorders.

Residents must show a sensitivity to, and knowledge of the emotional aspects surrounding ENT care both to the patient and the patient’s primary care.

The resident should be able to demonstrate skills in common ENT procedures.

The resident should develop competent management and competent referral skills.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include diagnostic assessment, therapeutic approaches and pharmacologic management techniques.

B. The resident should be able to recognize and treat:
   - Labyrinthine disorders
   - Anterior epistaxis
   - Allergic rhinitis
   - Otitis externa
   - Otitis media, acute and chronic
   - Ceruminosis
   - Foreign body in the ear
   - Perforated ear drum
   - Pharyngitis
   - Tonsillitis
   - Laryngitis
   - Tracheitis
   - Sinusitis, acute and chronic
   - Salivary gland abnormalities
   - Simple facial lacerations

C. The resident will develop the following skills, both evaluative and therapeutic through direct patient care under the supervision of the ENT preceptor:
   - Complicated infections of the ear
   - Retropharyngeal abscess
   - Mastoiditis
   - Nasal polyps
   - Vocal nodules
   - Laryngeal edema
   - Cholesteatoma

D. The resident should be familiar with:
   - The indications for tonsillectomy and adenoidectomy
• The indications for ear tube placement
• The management of posterior epistaxis
• Benign and malignant tumors of the ear, nose and throat
• Congenital abnormalities

E. The resident should be able to understand:
• How to evaluate hoarseness
• How to recognize and classify hearing disorders
• The diagnosis and management of tinnitus
• Audiometric testing and its diagnostic capabilities
• The procedure for an emergency cricothyrotomy
• OMM concepts as they apply to ENT

F. The resident will focus on the following skills through interaction with patients and patient care teams:
• Appropriate ear, nose and throat examination and history
• Cerumen removal
• Indirect laryngoscopy
• Direct nasolaryngoscopy
• Nasal packing for anterior epistaxis
• Removal of foreign body from ear and nose
• Simple facial laceration repair

ADDITIONAL INFORMATION

Training in otorhinolaryngology will be accomplished through the longitudinal experience in Internal Medicine. Training is also offered as an elective rotation.

Completion of the specific related section in Med Challenger is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning.

Pertinent topics are part of the Master Lecture Schedule.
**GASTROENTEROLOGY**

**GOALS**

The goal of this rotation is to enable residents to gain an understanding of the elements of gastroenterology that will augment their internal medicine practice and give insight into patients’ experiences in this area of medicine.

Residents must recognize the importance of the emotional issues, concerns and anxieties in this branch of medicine, both for the patient and the patient’s primary care.

The resident should show an understanding of the importance of the patient care team in the management of these patients. The resident should develop competent management and competent referral skills.

**OBJECTIVES**

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include physical assessment, appropriate medical interviews, and daily management of medical problems encountered.

B. The resident should develop a knowledge of:
   - The causes and treatment of constipation
   - The causes of and diagnostic approach to diarrhea
   - Diagnosis and treatment of proctitis, anal and rectal pain
   - Diagnosis and management of peptic ulcer disease
   - The role of somatic dysfunction in GI disease
   - The indications and complications of gastric and small bowel surgery
   - The indications and complications of colonic surgery
   - The diagnosis and treatment of pancreatic disease
   - Causes and complications of biliary tract disease
   - Inflammatory disease of the small and large bowel
   - Diagnosis and treatment of hepatitis A, B & C
   - Diagnose and manage gastrointestinal bleeding
   - Diagnose and manage the acute abdomen
   - Diagnose and manage esophageal disease, e.g. stricture, varices
   - Diagnose and manage GERD
   - Diagnose and manage cirrhosis
   - Diagnose and manage irritable bowel syndrome
   - Diagnose and manage food allergies
   - Diagnose and manage hemorrhoids/fistula, perianal abscess
   - Diagnose and manage diverticulosis/diverticulitis
   - Diagnose and manage enzyme deficiency states
   - Diagnose and manage malabsorption states
   - Diagnose and manage pilonidal cyst
   - Understand the indications, complications and limits of testing including endoscopy, liver biopsy, ultrasound, barium enema, upper GI series
• Utility of viscersomatic reflexes in evaluation and treatment of patients with gastrointestinal disorders
• Indications and contraindications for integration of Osteopathic principles and treatment in common GI presentations

C. The resident will focus on the following skills through interaction with patients and patient care teams:
• Anoscopy
• Sigmoidoscopy
• NG tube placement
• GI lavage
• Abdominal paracentesis
• Hemorrhoidal banding

ADDITIONAL INFORMATION

Training in gastroenterology will be accomplished through the longitudinal Internal Medicine experience. A block rotation in gastroenterology is required.

Completion of the specific related section in Med Challenger is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning.

Pertinent topics are part of the Master Lecture Schedule.
**GERIATRIC MEDICINE**

**GOALS**

The goal of this rotation is to enable residents to gain an understanding of the elements of geriatric medicine that will augment their internal medicine practice and give insight into patients’ experiences in this area of medicine.

Elderly patients make more visits to physicians’ offices than any other population group. Because the philosophy of Osteopathic medicine encompasses comprehensive and on-going care, the care of elderly patients is an important component of the learning experience.

Residents must recognize the importance of the emotional issues, concerns and anxieties in this branch of medicine, both for the patient and the patient’s primary care.

The resident should show an understanding of the importance of the patient care team in the management of these patients.

**OBJECTIVES**

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include physical assessment, appropriate medical interviews, and daily management of medical problems encountered.

B. The resident should gain knowledge in:
   - The normal psychological, social and environmental changes of angina, including reactions to common stresses and changes such as retirement, bereavement, relocation and ill-health, and the changes in family relationships that affect health care of the elderly
   - The underlying physiological “normal aging” changes in the various body systems including diminished homeostatic abilities, altered metabolism and effects of drugs, and other changes that directly relate to the assessment and treatment of elderly patient
   - The tendency of elderly patients toward iatrogenic disease, immobilization and its consequences, dependency or long-term institutionalization while in the process of receiving medical care
   - The unique modes of presentation of elderly patients for care, including altered and non-specific presentations of specific diseases
   - The range of services available to promote rehabilitation or maintenance of an independent lifestyle of elderly people, increasing their ability to function as long as possible in their existing family, home and social environments
   - The means for promoting health and health maintenance through screening, preventive care and early diagnosis, and the assessment of risk factors
   - The characteristics of the various types of long-term care facilities and alternative housings available to the elderly
   - The place of the house call, its indications and benefits in the assessment and management of elderly patients
   - The pitfalls of geriatric care such as polypharmacy, iatrogenic illness, over-dependency, inappropriate use of high technology, the unsupported family, etc.
• The role of OMM in treating the elderly in the outpatient and inpatient setting
• The financial aspects of health care of the elderly and the way these influence health care patterns and decisions
• The means to actively promote health in the elderly through exercise, nutrition and psycho-social counseling
• The evaluation of the functional status of the elderly patient
• The following problems, which are either especially characteristic of older patients, or differ significantly in their presentation and/or management in order adults:
  o Abuse – both physical and psychological
  o Acute abdomen
  o Alcoholism and other substance abuse
  o Altered mental status
  o Anemia
  o Anorexia
  o Atypical malignant presentations
  o Bacteriuria
  o Bereavement
  o Catheterization
  o Completed stroke
  o Confusion
  o Congestive heart failure
  o Constipation
  o Contractures
  o Degenerative joint disease
  o Dehydration
  o Dementia
  o Dentition
  o Depression
  o Diabetes
  o Dizziness
  o Drug-induced illness
  o Falls
  o Fecal impaction
  o Femoral (and other) fractures
  o Gait disorders
  o Hearing loss
  o Hypertension
  o Hypothermia
  o Hypothyroidism
  o Intensive care unit syndrome
  o Incontinence malnutrition
  o Memory loss
  o Myocardial infarction
  o Osteopenia/osteoporosis
  o Pain
  o Perioperative problems
  o Pneumonia and other respiratory infections
  o Podiatric problems
o Postural hypotension
o Pressure sores
o Psychological effects of illness
o Sexual problems
o Skin cancers
o Speech disorders
o Stiffness
o Systolic hypertension
o Temporal arteritis
o Terminal care
o Transient ischemic attacks
o Tremor/parkinsonism
o Thromboembolism
o Urinary tract infection
o Visual loss

C. The resident will focus on the following skills through interaction with patients and patient care teams:
   • Obtaining a comprehensive history and mental status examination, utilizing all available sources of information
   • Comprehensively conducting an efficient physical examination in office, hospital and nursing home settings, mindful of the patient’s modesty and mobility while balancing the need for full examination
   • Selecting and interpreting diagnostic procedures
   • Coordinating home care
   • Developing problem lists in practical, clinical functional, psychological and social terms
   • Setting appropriate priorities for investigation and treatment
   • Appropriately limiting investigations or treatment
   • Communicating to the patient proposed treatment plans
   • Communicating hope and empathy, and balancing objectivity with human involvement
   • Counseling about psychologic, social and physical stresses and changes of age, dying and death

ADDITIONAL INFORMATION

Training in the area of geriatrics is to be accomplished over the course of the residency and covers both the outpatient and inpatient experience. A block rotation in geriatrics is required.

Completion of the specific related section in Med Challenger is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning.

Pertinent topics are part of the Master Lecture Schedule.
HEMATOLOGY/ONCOLOGY

GOALS

The goal of this rotation is to enable residents to gain an understanding of the elements of hematology and oncology that will augment their internal medicine practice and give insight into patients’ experiences in this area of medicine.

Residents must recognize the importance of the emotional issues, concerns and anxieties in this branch of medicine, both for the patient and the patient’s primary care.

The resident should show an understanding of the importance of the patient care team in the management of these patients.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include physical assessment, appropriate medical interviews, and daily management of medical problems encountered.

B. The resident should gain knowledge in:
   - the principles of normal erythropoiesis
   - the diagnosis and treatment of microcytic anemia
   - the diagnosis and treatment of macrocytic anemia
   - the diagnosis and treatment of normocytic anemia
   - coagulation pathways
   - An approach to the coagulopathies
   - Transfusion reactions and use of blood products
   - Intravascular hemolysis
   - Myeloproliferative disorders
   - Indications for a bone marrow examination
   - Clinical presentations of malignant neoplasms of the lung, larynx and trachea
   - Clinical presentation of malignant neoplasms of the GI tract
   - Clinical presentation of malignant neoplasms of the breast
   - Clinical presentation of malignant neoplasms of the bone
   - Clinical presentation of Hodgkin’s and non-Hodgkin’s lymphoma
   - Clinical presentation of leukemia
   - Precepts of chemotherapy
   - Role of chemotherapy in the treatment of specific neoplastic disease
   - The role of surgery in the treatment of neoplastic diseases
   - The side effects of chemotherapy and their management
   - The side effects of radiation therapy and their management
   - The side effects of radiation therapy and their management
   - Interpretation of CBC and peripheral blood smear
   - Appropriate use of OMT and contraindications to OMT in certain patient populations
ADDITIONAL INFORMATION

Training in hematology/oncology will be accomplished over the course of the longitudinal Internal Medicine experience. A block rotation in hematology/oncology is required.

Completion of the specific related section in *Med Challenger* is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning.

Pertinent topics are part of the Master Lecture Schedule.
INTENSIVE CARE UNIT

GOAL

The goal of this rotation is to enable residents to gain an understanding of the elements of Intensive Care that will augment their internal medicine practice and give insight into patients’ experiences in this area of medicine.

Residents must recognize the importance of the emotional issues, concerns and anxieties surrounding admission to the Intensive Care Unit, both for the patient and the patient’s primary care.

The resident should show an understanding of the importance of the patient care team in the management of seriously ill patients.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include physical assessment, appropriate medical interviews, and daily management of medical problems encountered.

B. The resident should show an understanding of the following:
   - Cardiology
     - Cardiac arrhythmias: AV block, PSVT, atrial tachycardia, flutter/fibrillation, junctional rhythm, tachycardia
     - Congestive heart failure
     - Dyspnea
     - Chest pain
     - Edema
     - Hypertension
     - Ischemic cardiac disease
     - DVT
     - Stroke/TIA
   - Endocrinology
     - Adrenal insufficiency
     - Hyperadrenalism
     - Hyperaldosteronism
     - Diabetes
     - Diabetic ketoacidosis
     - Hyperosmolar coma/insulinoma
     - Thyroid imbalance
     - Goiter – hypo- and hyperfunctioning
   - Gastroenterology
     - Upper and lower GI bleeding
     - Abdominal pain, bloating, swelling
     - Diverticular disease
     - Weight loss, gain
     - Jaundice
     - Inflammatory bowel disease
Peptic ulcer disease

Hematology
- Iron deficiency anemia and sideroblastic anemia
- Megaloblastic anemia
- Anemia of chronic disease
- Hemolytic anemia

Infectious Disease
- Septic shock
- Iatrogenic infection
- Infected prosthetic devices/central lines
- Endocarditis
- Toxic shock
- Infectious pericarditis/mediastinitis
- Urinary tract infections
- Gram negative sepsis
- Tuberculosis
- Antibiotic associated colitis

Nephrology
- Hepatorenal syndrome
- Nephrolithiasis
- Acute and chronic renal failure
- Electrolyte management
- Renin-aldosterone axis
- Renal tubular acidosis
- Acid/base

Neurology
- Cephalgia
- Vertigo
- Seizures
- Dementia
- Parkinsonism

Pulmonology
- Aspiration pneumonitis
- Pneumonia/bronchitis
- Emphysema
- Pulmonary embolism
- Pneumothorax
- Atelectasis

Rheumatology
- Polyarticular disease
- Rheumatoid factor
- ANA
- Cryoglobulins
- Sedimentation rate
- Rheumatologic disorders (e.g., temporal arteritis, polymyalgia)
ADDITIONAL INFORMATION

Training in Intensive Care will be accomplished through required block rotations.

Completion of the specific related section in *Med Challenger* is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning.

Pertinent topics are part of the Master Lecture Schedule.
INFECTIONOUS DISEASE

GOALS

The goal of this rotation is to enable residents to gain an understanding of the elements of infectious disease that will augment their internal medicine practice and give insight into patients’ experiences in this area of medicine.

Residents must recognize the importance of the emotional issues, concerns and anxieties in this branch of medicine, both for the patient and the patient’s primary care.

The resident should show an understanding of the importance of the patient care team in the management of these patients.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include physical assessment, appropriate medical interviews, and daily management of medical problems encountered.

B. The resident should gain knowledge in:
   - Microbial drug resistance
   - The indication for and techniques of isolation and reverse isolation
   - Nosocomial infections and probably etiologic agents
   - Antibiotic sensitivity testing
   - The interpretation of culture reports
   - The application of antiviral therapy
   - The epidemiology of infectious disease and proper use of the health team to control infectious disease
   - The categories of antibiotics
   - The immune system in health and disease
   - Fungal diseases – their origin and treatment
   - Parasitic Diseases
   - HIV/AIDS including definitions, laboratory testing, indication for testing, test results and counseling, clinical manifestations, treatment and patient-care issues and psychosocial and ethical issues

C. The resident shall learn the following skill:
   - Interpretation of the gram stain

ADDITIONAL INFORMATION

Training in infectious disease will be accomplished over the course of the longitudinal Internal Medicine experience. A block rotation is also available as an elective.

Completion of the specific related section in Med Challenger is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning.

Pertinent topics are part of the Master Lecture Schedule.
INTERNAL MEDICINE

GOALS

To provide the house staff with the opportunity for comprehensive hospital care of the general internal medicine patient. This will encompass all aspects of patient care from admission through discharge. House staff will be given the opportunity to be responsible for total patient care. Through this model our belief is that the resident will have the best opportunity to gain confidence and understanding related to the hospitalized patient.

Your goal should be to strive for superior patient care. Mediocrity is not the goal, and leaving work for others will not be tolerated. Attention to detail, communication and cooperation should be your keys to excellent patient care.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include physical assessment, appropriate medical interviews, and daily management of medical problems encountered.
B. The resident should show an understanding of:

Allergy/Immunology
- asthma
- serologic testing for connective tissue disorders
- urticaria, angioedema
- vasculitis
- see allergy/immunology curriculum

Cardiology
- cardiac arrhythmias: AV block, PSVT, atrial tachycardia, flutter/fibrillation, junctional rhythm, tachycardia
- congestive heart failure
- dyspnea
- chest pain
- edema
- hypertension
- ischemic cardiac disease
- claudication
- DVT
- stroke/TIA
- see Cardiology curriculum

Endocrinology
- adrenal insufficiency
- hyperadrenalism
- hyperaldosteronism
• diabetes
• diabetic ketoacidosis
• hyperosmolar coma/insulinoma
• thyroid imbalance
• goiter – hypo – and hyperfunctions
• see Endocrine curriculum

Gastroenterology
• upper and lower GI bleeding
• abdominal pain, bloating, swelling
• diverticular disease
• irritable bowel syndrome
• weight loss, gain
• jaundice
• inflammatory bowel disease
• peptic ulcer disease
• see Gastroenterology curriculum

Hematology
• iron deficiency anemia and sideroblastic anemia
• megaloblastic anemia
• anemia of chronic disease
• hemolytic anemia
• see Hematology curriculum

Infectious Disease
• septic shock
• iatrogenic infection
• infected prosthetic devices/central lines
• endocarditis
• toxic shock
• human and animal bites
• infectious pericarditis/mediastinitis
• urinary tract infections
• gram negative sepsis
• tuberculosis
• antibiotic associated colitis
• see Infectious Disease curriculum

Nephrology
• hepatorenal syndrome
• nephrolithiasis
• acute and chronic renal failure
• electrolyte management
• rennin-aldosterone axis
• renal tubular acidosis
• acid/base
• see Nephrology curriculum

Neurology
• cephalgia
• vertigo
• seizures
• dementia
• Parkinsonism
• see Neurology curriculum

Pulmonology
• aspiration pneumonitis
• pneumonia/bronchitis
• emphysema
• pulmonary embolism
• sleep apnea
• pneumothorax
• atelectasis
• see Pulmonology curriculum

Rheumatology
• polyarticular disease
• rheumatoid factor
• ANA
• cryoglobulins
• sedimentation rate
• rheumatologic disorders (eg, temporal arteritis, polymyalgia)
• see Rheumatology curriculum

Women’s Medicine
• pelvic infection/sexually transmitted disease
• post-menopausal bleeding
• post-menopausal osteoporosis
• see Women’s Medicine curriculum

ADDITIONAL OBJECTIVES
A. Be ready and willing to work and learn.
B. Make it your goal to earn the patients’ and attendings’ confidence and respect.
C. Continued to strive for excellence. Mediocrity will not be the standard. Again, these patients are entrusting you with their lives – act accordingly.
D. Live by Loeb’s Laws of Medicine:
   a. If what you are doing is working, leave it alone
   b. If what you are doing isn’t working, stop what you are doing and figure out what the right thing to do is.
c. If you don’t know what you are doing, don’t do anything until you have gained enough knowledge or have asked for help.

**MODEL AND CONCEPT**

**Hospitalist and Team Approach**

A. There will be assigned teams or team that will be directed by a specific attending.
B. Each team will consist of residents, and students (varying numbers based on house staff for the month).
C. The resident(s) will be responsible for inpatient internal medicine patients, supervised by the attending of that team.
D. Teams will be involved in internal medicine admissions and consults, as well as assisting in inpatient emergencies.
E. Residents and students will be expected to have a complete understanding of their patient’s medical conditions. This will allow continuity of patient care with one house staff and one attending.
F. Evidence-based medicine will be stressed in all aspects of patient care.
G. Teams will communicate daily and educationally relevant patients may be discussed and/or examined by the team together.

**Team Make-Up**

A. One 2nd or 3rd year internal medicine resident (when available)
B. One to three OGME 1’S
C. Students as available
D. The number of patients will vary per team, but the attending will strive to maintain balance between inpatient teams.

**Team Responsibilities**

A. Internal Medicine Resident (OGME 2 & 3)
   1) Delegation of duties to interns and students
   2) Patient assignment with attending collaboration
   3) Supervise patient care plans of house staff
   4) Implement team didactics and assign topics for reading with attending collaboration
   5) Evaluation of interns and students
   6) Supervision of all procedures and perform all stress tests
   7) Respond to emergencies
   8) General leader of the team, and should be aware of place of care for all patients on his/her team.
B. Internal Medicine Resident (OGME 1)
   1) Take total responsibility of the patients assigned to them
   2) Evaluation, diagnosis, treatment and discharge of general Internal Medicine patients
   3) Floor call for Internal Medicine and subspecialty patients
   4) Student didactics and supervision
   5) Student evaluations
   6) Respond to all inpatient emergencies
C. Student Responsibilities
   1) Be involved in the evaluation, diagnosis and treatment plans for general Internal Medicine patients
   2) Responsible for daily laboratory, x-ray and review of data for patients designated for them by the resident or attending
   3) Evaluation, diagnosis and treatment plan assistance for all “off-service” patients when asked by your resident or attending
   4) Respond to all emergencies

D. Attending Responsibilities
   1) Patient assignments
   2) Daily guidance of work assignments
   3) Clinical rounds and teaching (after hospitalist rounds and other times throughout the day when time permits) – “pointed intellectual medical questions.”
   4) Constructive teaching points (not criticism)
   5) These are working rounds for the hospitalist attending. Your clinical education will come from evaluating patients, formulating differential diagnoses and treatment plans, as well as continuity of patient care. Daily input from you attending will help guide your progress and direct your thinking. The more thorough you are with patient care, the better the attending can facilitate teaching rounds.

E. Daily Resident Responsibilities
   1) 7 am-8 am – didactics
   2) 8:15 am – 8:45 am – Hospitalist Huddle/Handoff
   3) 8:30 am – noon – Rounding and admissions
   4) Noon – 1 pm – Didactics/lunch
   5) 1 pm-7 pm – Rounds and admissions

Continuity of care should be of paramount importance.

Communication with your colleagues is essential for excellent patient care.
NEPHROLOGY

GOALS

The goal of this rotation is to ground residents in the basics of this branch of medicine. The resident should be able to develop an understanding of nephrological disorders and how they relate to conditions which present in primary care patients.

The resident should develop competent management and competent referral skills.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include diagnostic assessment, therapeutic approaches and pharmacologic management techniques.

B. The resident should be able to show an understanding of:

- The mechanisms of salt and water balance
- Acid base balance
- An approach to hematuria
- An approach to proteinuria
- The nephropathies
- The causes of acute and chronic renal failure
- The pathophysiology of SIADH
- The etiology and treatment of the nephritides
- The adverse effects of medication on the kidneys
- The appropriate use of diuretics
- The interpretation of creatinine clearance
- The interpretation of serum BUN/creatinine
- The indications for and complications of renal transplantation
- The appropriate indications for renal imaging
- Utility of viscerosomatic reflexes in evaluating patients with urological disorders
- Indications and contraindications to the use of OMT in patients with renal disease

ADDITIONAL INFORMATION

Training in Nephrology will be accomplished over the course of the longitudinal Internal Medicine experience. A block rotation in nephrology is required.

Completion of the specific related section in Med Challenger is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning.

Pertinent topics are part of the Master Lecture Schedule.
NEUROLOGY

GOALS

The goal of this rotation is to enable residents to gain an understanding of the elements of neurology that will augment their internal medicine practice and give insight into patients’ experiences in this area of medicine.

Residents must recognize the importance of the emotional issues, concerns and anxieties in this branch of medicine, both for the patient and the patient’s primary care.

The resident should show an understanding of the importance of the patient care team in the management of these patients. The resident should develop competent management and competent referral skills.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include physical assessment, appropriate medical interviews, and daily management of medical problems encountered.

B. The resident should develop a knowledge of:

- Disorders of consciousness including stupor, coma, increased intracranial pressure, syncope and seizures
- Disorders of motor function including incoordination, involuntary movements and upper and lower motor neuron disorders
- Disorders of sensation, both central and peripheral
- Disorders of vision
- Cerebrovascular disease
- Multiple sclerosis
- Dizziness and disorders of hearing
- Dementia
- Encephalopathy
- Headache including migraine, cluster, tension, traction
- Brain tumors
- Infections spinal cord disorders
- Peripheral nervous system disorders
- Congenital disorders
- Developmental disorders including language disorders, dyslexia, ADHA, autism
- Psychiatric disorders mimicking neurologic disease including pseudoseizures, pseudodementia, hysteriacovert reaction, disorders of somatization and hypochondriasis, malingering
- Normal growth, development and senescence of the nervous system
- The temporal sequence of common neurologic disorders
- Neurologic complications of systemic illness
- Prevention of neurologic disease
- Neuropathic pain
- Complex regional pain syndrome
Applications of OMT to patients with common neurologic disorders

C. The resident will focus on the following skills through interaction with patients and patient care teams. Knowing the indication, contraindications, risks and significance of ancillary tests.

- Lumbar puncture
- Electroencephalogram
- Visual, brain stem auditory and somatosensory evoked potentials
- Nerve conduction study and electromyography
- Muscle and nerve biopsy
- Angiography
- Myelography
- Carotid doppler

ADDITIONAL INFORMATION

Training in neurology will be accomplished over the course of the longitudinal internal medicine experience. A block rotation in neurology is required.

Completion of the specific related section in Med Challenger is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning.

Pertinent topics are part of the Master Lecture Schedule.
OSTEOPATHIC MANIPULATIVE MEDICINE

GOALS

The goal of this rotation is to enable residents to recognize the interrelationships among the biologic, psychologic, and social factors in all patients.

DO’s, by nature of their training, are frequently called upon by both their patients and their colleagues to provide Osteopathic manipulation for a variety of complaints, including musculoskeletal and systemic symptoms and disorders. The primary care physician should be prepared to recognize clinical situations where OMT is an appropriate adjunct to a total health care approach, and be able to evaluate and treat patients in both the inpatient and outpatient settings with a variety of treatment techniques.

Residents must recognize the importance of the relationship that exists between the patient and his or her primary care. The resident must have a sensitivity to, and knowledge of, the emotional aspects of organic illness.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include physical assessment, appropriate medical interviews, and daily management of medical problems encountered.

B. The resident should gain knowledge in:
   - Normal anatomy and physiology of all systems, especially neuromusculoskeletal
   - Appropriate history-taking for individual clinical setting
   - Basic principles of Osteopathy
   - Viscerosomatic reflexes as both diagnostic and treatment aids
   - Osteopathic structural exam, both performance and documentation
   - Principles of HB/LA
   - Principles of muscle energy treatment
   - Principles of counterstrain
   - Principles of balanced ligamentous and balanced membranous tension techniques
   - Contraindications of OMT in specific clinical circumstances
   - Integration of OMT into treatment plan that includes physical therapy and other modalities

C. The resident will focus on the following skills through interaction with patients and patient care teams:
   - Osteopathic structural exam as part of a complete neuromusculoskeletal exam
   - Ability to formulate rationale for treatment and treatment plan specific to individual clinical situations
   - Appropriate documentation, coding and billing for OMT
   - Competence in and rational use of above treatment modalities, as well as others determined by practitioner’s skills and interests

ADDITIONAL INFORMATION

Training is provided as applicable in the IM setting over the course of the residency.
PALLIATIVE CARE

GOALS

The goal of this rotation is to enable residents to gain an understanding of the elements of palliative care that will augment their internal medicine practice and give insight into patients’ experiences in this area of medicine.

In patients for whom a cure is not possible, there remains an enormous amount of care and support that can and should be provided for patients and their families.

Residents must recognize the importance of the emotional issues, concerns and anxieties in this branch of medicine, both for the patient and the patient’s primary care.

The resident should show an understanding of the importance of the patient care team in the management of these patients.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include physical assessment, appropriate medical interviews, and daily management of medical problems encountered.
B. The resident should gain knowledge in:
   • The philosophy of palliative care, including the home-based approach, the primary care as the care unit, pain control and symptom control
   • Hospice team roles for physician, social worker, pharmacists, home healthcare aids and volunteers
   • Identification of appropriate patients for hospice care: cancer-related, noncancer-related, the referral process, and reimbursement issues
   • Prognosis of terminal illness including the accuracy of prognosis, clinical indicators or time until death, value of medical therapy and psychosocial stages of the dying process for patient and primary care
   • Major physiologic pain syndromes: neuropathic, bone pain and visceral pain
   • Non-physiologic etiologies of pain
   • Pharmacology of pain control: opiates, non-opiates, addiction, habituation and dependence
   • Non-pharmacologic pain control measures
   • Causes and treatment of non-pain syndromes: nausea, shortness of breath, loss of appetites, vomiting, sleeplessness, depression, anxiety, cough, constipation, diarrhea and xerostomia
   • Common non-cancer-related terminal illnesses: pulmonary, cardiovascular, neurologic and infectious
   • Nutrition and hydration in the terminally ill: artificial feeding, intravenous fluids
   • Care locations: emergency department, inpatient, outpatient, extended-care facilities and home
• Data related to end-of-life care in the United States: aging populations, most common chronic illnesses, most common causes of death by age, cost of care for the terminally ill in various settings
• The bereavement process
• Legal issues: patient competency, advance directives, estate planning, pronouncement of death and completion of death certificates
• Issues related to withdrawing and withholding life support
• Complementary and alternative medicine practices commonly encountered

C. The resident will gain exposure to the following skills through interaction with patients and patient care teams:
• Physical assessment with attention to common findings of the terminally ill patient
• Correct compliance with regulations pertaining to use of controlled substances in the terminally ill patient in and outside hospice
• Development of an initial and ongoing analgesic regimen to include the use of morphine equivalent dosages and other narcotic equivalents
• Effective use of alternative routes of analgesia
• Use of pain scales to adjust medication dosage
• Effective referral to available social services for both inpatient and primary care
• Effective counseling of primary care and others

D. The resident should exhibit awareness and sensitivity to:
• The process of “breaking bad news” including choice of setting, talking with the patient and primary care members, summarizing and using appropriate wording and questioning, and the impact of this process on the patient and primary care
• Psychosocial issues and primary care dynamics affecting the terminally ill patient
• Spiritual issues affecting the terminally ill patient
• Special issues associated with children, either as terminally ill patients or as primary care members of a terminally ill patient
• Primary care cultural issues and particular customs in the context of death and dying
• One’s own attitude and experiences about death and dying and awareness of the impact of those attitudes on how we care for terminally ill patients

ADDITIONAL INFORMATION

Training in palliative care will be accomplished over the longitudinal internal medicine experience. A block rotation in palliative care is offered as an elective.

Completion of the specific related section in Med Challenger is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning.

Pertinent topics are part of the Master Lecture Schedule.
GOALS

The goal of this rotation is to enable residents to gain an understanding of the elements of pulmonary medicine that will augment their internal medicine practice and give insight into patients’ experiences in this area of medicine.

Residents must recognize the importance of the emotional issues, concerns and anxieties in this branch of medicine, both for the patient and the patient’s primary care giver.

The resident should show an understanding of the importance of the patient care team in the management of these patients.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, and readings.
B. The resident will acquire the skills to perform a physical assessment, appropriate medical interviews, and daily management of medical problems encountered.
C. The resident will focus on the following skills through interaction with patients and patient care teams:
   - Interpret arterial blood gases
   - Interpret pulmonary function studies
   - Diagnose and treat somatic dysfunction of the thoracic area
D. Upon completion of the rotation, the resident should be able to:
   - Diagnose and manage chronic obstructive lung disease
   - Diagnose and manage chronic bronchitis
   - Diagnose and manage asthma
   - Diagnose and manage pneumonia
   - Diagnose and manage sleep apnea
   - Diagnose and manage pleural effusion
   - Utilize viscerosomatic relationships in both diagnosis and treatment of pulmonary disorders
   - Recognize indications and contraindications of the use of OMT in patients with pulmonary disorders

ADDITIONAL INFORMATION

Training in pulmonary medicine will be accomplished over the course of the longitudinal internal medicine experience. A block rotation in pulmonology is required.

Completion of the specific related section in Med Challenger is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning.

Pertinent topics are part of the Master Lecture Schedule.

Additional pulmonary training is covered during the ICU rotation.
RHEUMATOLOGY

GOALS

The goal of this rotation is to enable residents to gain an understanding of the elements of rheumatology that will augment their internal medicine practice and give insight into patients’ experiences in this area of medicine.

Residents must recognize the importance of the emotional issues, concerns and anxieties in this branch of medicine, both for the patient and the patient’s primary care giver.

The resident should show an understanding of the importance of the patient care team in the management of these patients. The resident should develop competent management and competent referral skills.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, and readings.
B. The resident will assimilate knowledge through patient care, case study, reading and didactics.
   Patient care experiences should include physical assessment, appropriate medical interviews, and daily management of medical problems encountered.
C. The resident should develop a knowledge of:
   • Normal musculoskeletal system, anatomy an physiology
   • The role of immunologic mechanisms on the pathogenesis of rheumatic disease
   • The effects of aging on rheumatic conditions
   • Evaluation of the patient including history, screening examination, functional assessment, laboratory evaluation and imaging techniques
   • Indication for arthroscopy
   • Indications for arthrocentesis
   • Indications for tissue biopsy
   • Etiology, pathophysiology, epidemiology, clinical presentation and criteria for diagnosis of:
     - Osteoarthritis
     - Rheumatoid arthritis
     - Juvenile arthritis
     - Lupus erythematosus
     - Scleroderma
     - Ploymyositis/dermatomyositis
     - Necrotizing vasculitis, - polyarteritis nodose, serum sickness, Henoch-Schonlein purpura, granulomatous arteritis, Kawasaki disease, Behset’s disease
     - Sjogren’s syndrome
     - Spondyloarthritis – ankylosing, Reiter’s, psoriatic and arthritis associated inflammatory bowel disease
     - Infectious arthritis: direct including bacterial, viral, fungal spirochetal and rickettsial; indirect including acute rheumatic fever, SBE, post-dysenteric, post-immunization
     - Crystal arthropathies including gout, pseudogout, hydroxyapatite deposition, intra-articular steroid-induced arthritis
     - Neoplasms that cause arthritis
Bone and cartilage disorders including osteoporosis, osteomalacia, Paget’s avascular necrosis, costochondritis, condromalacia patella
Extra-articular problems including bursitis, tendinitis and low back pain
Fibromyalgia syndrome
Drug-induced arthralgia
Other diseases including polymyalgia rheumatica, relapsing panniculitis and erythema nodosum

- Pharmacology of anti-inflammatory drugs, slow-acting antirheumatic drugs, corticosteroids, anti-gout drugs, antibiotics
- Rehabilitation
- Indications for surgical treatment of arthritis

ADDITIONAL INFORMATION

Training in rheumatology will be accomplished over the course of the longitudinal internal medicine experience. A block rotation in rheumatology is required.

Completion of the specific related section in Med Challenger is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning.

Pertinent topics are part of the Master Lecture Schedule.
RISK MANAGEMENT

GOALS

The goal of this rotation is to enable residents to gain an understanding of the elements of risk management that will augment their internal medicine practice and give insight into patients’ experiences in this area of medicine.

OBJECTIVES

A. The resident will be able to discuss and apply all aspects of the medical curriculum to the clinical practice of Internal Medicine.

B. Demonstration of the knowledge in the following areas should be evident:
   • The risk management process including:
     o The identification of risk or potential risk
     o Calculation of probability of adverse events from risk situation
     o Estimation of the impact of adverse events
     o The control of risk
   • The definition of physician/patient relationship and issues related to it, e.g. termination and abandonment
   • The components of informed consent and special situations that include:
     o The treatment of minors
     o Mental incompetence
     o Emergencies
   • Elements of effective communication:
     o With patients – time spent, understandable language, attentive listening, sensitivity, flexibility, and including a mechanism for addressing patient complaints
     o Staff communication with patients
     o Response to request for records
     o Legal system: subpoenas, depositions, notice of suite, court appearances
   • Legal definitions as follows:
     o Sources of law: supreme law, statutory law, decisional law, quasi-judicial law
     o General legal liability: contracts, torts, intentional negligence
     o Duty to exercise care
     o Applicable standard of care
     o Breach of standard care
     o Relationship between breach of duty and injury
     o Statute of limitations
     o Statutory immunity
   • Documentation including:
     o Elements of a complete physician record including patient examination, updated history, plans, return visits, referrals, follow-up systems, telephone calls, reports of tests and technical matters of form (preprinted forms, entries signed and dated, missed or cancelled appointments noted, problem list)
     o Legibility
     o Proper corrections and modifications
- Timely completion of medical records
- Confidentiality

- Issues of physician competency
- Most frequent allegations resulting in liability complaints
  - Failure to diagnose or delay in diagnosis in cancer, MI, appendicitis, infection
  - Failure to diagnose or negligent management of fractures or trauma
  - Negligent treatment with drugs
  - Failure to obtain timely consultation
  - Negligent performance of a procedure
  - Negligent obstetric practices
  - Failure to obtain informed consent
  - Inadequate rapport and communication with patients

- Malpractice insurance, including policy types and limits
- Malpractice reporting agencies
  - National Practitioner Data Bank
  - State Licensing Board
  - Federation of State Medical Boards

**ADDITIONAL INFORMATION**

Risk management training and topics will be ongoing throughout the 3 year residency curriculum.
SUBSTANCE ABUSE

GOALS

The goal of this rotation is to enable residents to gain an understanding of the elements of substance abuse that affect their patients and may affect colleagues or themselves. Residents should be aware of these aspects of medicine in order to give insight to patients.

Residents must recognize the importance of the emotional issues, concerns and anxieties inherent in this branch of medicine along with the importance that physician and family members assume in the treatment process.

OBJECTIVES

A. The resident will be able to discuss and apply all aspects of substance abuse and apply these elements to the clinical practice of Internal Medicine.

B. Demonstration of the following attitudes and knowledge should be evident during the rotation:
   - Residents should develop an understanding that substance dependence is a preventable, diagnosable and treatable chronic, relapsing and remitting individual and primary care disease
   - As with other medical problems, individuals and families with substance use disorders are to be respected, supported and treated by their primary care physicians
   - Expressions of denial, dishonesty, anger, irrationality and other potentially offensive behaviors are often inherent symptoms of substance use disorders, to be expected, understood, accepted and managed by physicians
   - Physicians, working in concert with other medical and mental health professionals and lay self-help groups, can maximize the effectiveness of the treatment of substance use disorders
   - Residents should be aware of their own attitudes and their attitude’s therapeutic implications
   - Concepts of tolerance, cross-tolerance, physical dependence psychologic dependence, addiction and withdrawal
   - Routes of administration and physiologic effects of commonly abused drugs
   - Response effect of alcohol in commonly used medications
   - Signs and symptoms of early and later substance use disorders, including
     - Psychosocial and behavioral changes in the individual and the primary care
     - Symptoms, physical signs and laboratory evidence
     - Associated biomedical and psychiatric diagnoses
   - Information on treatment including
     - Different stages of the disease and the relevant goals of treatment
     - Brief office intervention
     - Success rates of treatment
     - Primary care dynamics
   - Information on health professional impairment, including
     - Preventive measures, including coping strategies, stress reduction and self-monitoring
     - Symptoms and signs of substance use disorders
o Legal requirements and ethical implications for health professionals who suspect impairment in a patient
o The role of hospital-based impaired-physician committees, state impaired physician programs and state licensure boards

ADDITIONAL INFORMATION

Training in substance use disorders will be accomplished over the course of the longitudinal experience in the ambulatory clinic.

Pertinent topics are part of the Master Lecture Schedule.

Additionally, the resident is directed to: Liese, BS, Chiauzzi, E. Alcohol and Drug Abuse. Home Study Self-Assessment Program. No. 198, Kansas City MO
PERI-OPERATIVE SURGERY

GOALS

The goal of this rotation is to enable residents to gain an understanding of the management of surgical patients in order to augment their internal medicine practice and give insight into patients’ experience in this area of patient care.

Residents must recognize the importance of the emotional issues, concerns and anxieties of patients who are preparing to undergo or have undergone surgery.

The resident should show an understanding of the importance of the patient care team in the management of these patients.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, and readings.
B. The resident will assimilate knowledge through patient care, case study, reading and didactics.
   Patient care experiences should include physical assessment, appropriate medical interviews, and daily management of medical problems encountered.
C. The resident should develop a knowledge of:

   **Role of the medical consultant, approach to preoperative evaluation and testing**
   
   - Appreciate concepts of effective consultations
   - Recognize factors that enhance compliance with consultant recommendations
   - Display professionalism in communication with patients and primary services
   - Communicate effectively with primary services
   - Recognize which blood and urine tests are appropriate in the preoperative assessment
   - Define when a 12 lead ECG is appropriate in the preoperative assessment
   - Recognize when it is appropriate to perform specialized testing
   - Recognize perceived and actual pros and cons with regard to regional vs. general anesthesia
   - Understand medication management in the peri-operative period.

   **Preoperative cardiac risk assessment and postoperative management**
   
   - Cardiac Risk Assessment
     - Components of the revised cardiac risk index.
     - Quantify exercise capacity and its usefulness.
     - Surgical risk categorization.
     - Appreciate the impact of prior revascularization.
     - Appropriate use of preoperative ischemia studies
   - Cardiac Risk Reduction
     - Proper use of perioperative beta-blockade.
     - The importance of statins.
     - Proper use of preoperative revascularization.
     - Proper antiplatelet management perioperatively.
     - Recognition of the atypical presentations of postoperative myocardial infarctions.
     - Recognize the appropriate intra and postoperative management of a patient with CAD
Thromboembolic prevention and treatment

- Appreciate the magnitude of the problem
- Define which patients are at high risk for venous thromboembolism
- Recognize contraindications to anticoagulation
- Define appropriate medical prophylaxis for a variety of clinical situations and the appropriate duration of prophylaxis
- Recognize alternative strategies to thromboembolic prophylaxis
- Define appropriate diagnostic strategies in working up venous thromboembolism

Consultation on the patient with neurologic disease and postoperative delirium

- Recognize management issues and goals with regard to hypertension in the post-CVA patient and the patient with SAH
- Recognize and be able to treat electrolyte abnormalities common to neurologic patients
- Recognize risk factors for delirium
- Define management strategies for delirium

Medical illness in the psychiatric patient

- Appreciate communication issues that may arise in evaluating the psychiatric patient
- Recognize medical illnesses that may mimic psychiatric disorders
- Be able to perform pre-ECT risk assessment
- Recognize common side effects of psychiatric medications

Preoperative pulmonary risk assessment and postoperative management

- Be able to assess the perioperative risk in patient with known lung disease
- Define when it is appropriate to prescribe preoperative steroids
- Be able to counsel a smoker about when/if it is appropriate to quit smoking prior to surgery
- Recognize postoperative management strategies to prevent complications in the patient with known lung disease
- Be able to evaluate the dyspnea or hypoxic patient on a non-medicine service

Prophylactic antibiotic use and postoperative infectious complications

- Define risk factors for surgical site infections
- Recognize appropriate timing and appropriate antibiotics to prevent surgical site infections
- Recognize how to diagnose nosocomial pneumonia and recognize the appropriate treatment
- Recognize how to diagnose C. difficile associated diarrhea and the appropriate treatment

Hematological complications of surgery and management of anticoagulation during the perioperative period

- Define when it is appropriate to prescribe red blood cell transfusion for which patients
- Recognize the appropriate evaluation for a coagulopathy
- Recognize the appropriate evaluation for a drop in hemoglobin
Recognize which procedures are not indications for reversal of anticoagulation
Recognize treatment strategies for patients on chronic anticoagulation that need reversal at the time of surgery

**Common endocrine disorder in medicine consultation**

- Recognize appropriate management principles in the perioperative patient with diabetes
- Recognize adverse effects of medications used to treat diabetes
- Recognize when it is appropriate to administer stress dose steroids
- Recognize the appropriate evaluation and management of the hypothyroid patient

**Medical problems during pregnancy**

- Appreciate the physiologic changes associated with pregnancy
- Recognize appropriate treatment of the pregnant patient with hypertension
- Recognize appropriate treatment of the pregnant patient with asthma
- Recognize risk factors associated with venous thromboembolism in the pregnant and puerperal patient
- Recognize appropriate treatment of the pregnant patient with diabetes

**Acute renal failure and perioperative care for the patient with impaired renal function**

- Recognize risk factors for acute renal failure and preventative strategies
- Recognize complications of chronic renal failure that would preclude non-urgent surgery
- Define the appropriate initial evaluation of a patient with acute renal failure
- Define appropriate evaluation and management of common electrolyte disorders (hypo and hypernatremia, hypo and hyperkalemia)

**Assessment and Management of Sleep Apnea**

- Screening for undiagnosed sleep apnea.
- Initiation of CPAP in the perioperative period.
- Proper monitoring of sleep apnea patients in the postoperative period.

**Cirrhosis and Surgery**

- Appreciation of the risk carried by cirrhotic patients undergoing surgery.
- Management in the perioperative period.

Completion of the specific related section in *Med Challenger* is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning.
GOALS

The goal of this rotation is to enable residents to gain an understanding of the elements of urology that will augment their IM practice and give insight into patients’ experiences in this area of medicine.

Residents must recognize the importance of the emotional issues, concerns anxieties in this branch of medicine, both for the patient and the patient’s primary care.

The resident should show an understanding of the importance of the patient care team in the management of these patients.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include diagnostic assessment, therapeutic approaches and pharmacologic management techniques.

B. The resident should gain knowledge in the following:
   - Perform a urological examination: newborn period, childhood, adolescence, adulthood and geriatric period
   - Understand the benign diseases of the male genital tract, including
     - Penile anomalies: Peronei’s disease, condylar, primroses/paraphimosis, epispadiasis/hypospadias
     - Scrotal abnormalities: undescended testicle, testicular torsion, hydroceles, spermatoceles/epididymal cysts, vericoceles
     - Lower urinary tract symptoms: obstructive – BPH and urethral stricture, and irritative – cystitis, prostatodynia
     - Bladder dysfunction: incontinence, enuresis, neurogenic disease
     - Kidney diseases: masses, cysts, stone disease, pyelonephritis
     - Genital trauma
   - Understand neoplastic disease of the male genital tract including penile carcinoma, testicular carcinoma, scrotal carcinoma, prostatic carcinoma, bladder carcinoma
   - Be familiar with normal physiology/anatomy, infertility, vasectomy, effects of aging on sexuality and reproduction, reproductive responsibility
   - Be familiar with the diagnosis and treatment of sexual dysfunction: erectile dysfunction, ejaculatory dysfunction, decreased libido

C. The resident will focus on the following skills through interaction with patients and patient care teams:
   - Foley catheter placement
   - Urethral swab for sexually transmitted diseases

ADDITIONAL INFORMATION

Training in urology will be accomplished over the course of the longitudinal experience in Internal Medicine. A block rotation in urology is offered as an elective. Completion of the specific related section in Med Challenger is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning. Pertinent topics are part of the Master Lecture Schedule.
WOMEN’S HEALTH

GOALS

The goal of this rotation is to enable residents to gain an understanding of the elements of Women’s Health that will augment their IM practice and give insight into patient’s experiences in this area of medicine.

Residents must recognize the importance of the emotional issues, concerns and anxieties in this branch of medicine, both for the patient and the patient’s family.

The resident should show an understanding of the importance of the patient care team in the management of these patients.

OBJECTIVES

A. The resident will assimilate knowledge through patient care, case study, reading and didactics. Patient care experiences should include physical assessment, appropriate medical interviews, and daily management of medical problems encountered.

B. The resident should develop a knowledge of:

- Normal growth and development and variants
- Gynecological examination from pediatrics to geriatrics
- Menstruation
  - Physiology of menstruation
  - Abnormal uterine bleeding
  - Premenstrual syndrome
- Reproductive-tract infections and diseases
  - Sexually transmitted diseases
  - Pelvis inflammatory diseases
  - Endometriosis
  - Benign and malignant disease of the female genital tract
    - Breast fibrocystic disease and malignancy
    - Ovarian cancer
    - Endometrial cancer
    - Premalignant and malignant disease of the cervix
  - Effects of DES
  - Chronic pelvic pain
  - HIV infection
  - Vaginitis
- Reproduction
  - Normal physiology
  - Infertility
  - Contraception
  - Adoption
  - Abortion
- Sexuality
  - Normal sexual response
• Diagnosis and treatment of sexual dysfunction
• Alternative lifestyles
• Public perception of women (media representation, breast implants, liposuction, etc)
• Awareness of female circumcision/female genital mutilation
• Prevention/early detection
  • Nutritional needs
  • Cancer screening including the pap test, mammography and pelvic and breast examinations
  • Exercise
  • Osteoporosis
  • Smoking
  • Coronary heart disease
  • Motor vehicle safety
• Menopause
  • Normal physiology
  • Hormone replacement therapy
  • Emotional and sexual impact of the climacteric
• Pelvic floor dysfunction
• Psychosocial issues including domestic violence, rape, sexual harassment, sexual abuse, family structure, effects of poverty on women and children
• Mental health including effects of sexual abuse, anxiety disorders, problems with self-esteem, eating disorders and substance abuse
• Community issues including women’s access to health care, epidemiology of prenatal care and infant mortality, women and HIV, and prevention of teenage pregnancy
• General medical problems
  • Coronary heart disease
  • Hypertension
  • Thyroid disorders
  • Connective tissue diseases
  • Headaches
  • Lung cancer
  • Urinary tract infections
  • Cholecystitis
  • Weight disorders
  • Diabetes
  • Chronic obstructive pulmonary disease
  • Skin disorders
• Utility of an Osteopathic approach to women’s health care with appropriate integration of OMT
• The resident will focus on the following skills through interaction with patients and patient care teams:
• Control of fertility
  • Counseling for all forms of birth control
  • Use of oral contraceptives
  • IUD insertion and removal
- Diaphragm fitting
- Use of Depo-Provera
- Surgery/diagnostic
  - Cervical cytology
  - Breast examination
  - Breast cyst aspiration
  - Endometrial biopsy/aspiration and curettage
  - Cervical biopsy/polypectomy
  - Colposcopy
  - Microscopic diagnosis of urine and vaginal we preparation
  - Bartholin cyst drainage and marsupialization
  - Dilation and curettage for incomplete abortion

**ADDITIONAL INFORMATION**

Training in women's health will be accomplished over the course of the longitudinal internal medicine experience. A block rotation in women’s health is required.

Completion of the specific related section in *Med Challenger* is required. The resident is expected to read articles and sections of textbooks as assigned by the attending to supplement clinical learning.

Pertinent topics are part of the Master Lecture Schedule.
INTERNAL MEDICINE POLICIES
POLICY: Internal Medicine Resident Supervision

PURPOSE: To provide resident supervision guidelines for internal medicine residents.

EFFECTIVE: July 1, 2012

It is the goal of the Department of Internal Medicine to train residents to become excellent physicians. In order to achieve this goal, the Department must provide sufficient support, mentorship, and guidance with regard to the supervision of physicians-in-training. These actions facilitate education and provide excellent patient care, while providing sufficient autonomy for residents to develop into independent practitioners.

To ensure the appropriate supervision of residents, the Department has outlined the policies described below. These are guidelines only. It is the responsibility of the attending physician to determine if more than the outlined supervision is required in certain contexts and act appropriately to provide excellent patient care.

Inpatient Services

1. Each patient admitted to Lakeland HealthCare has a member of the medical staff as his/her attending physician. Each patient admitted to a teaching service is admitted by a resident under the direct supervision of an attending physician. A resident, under the guidance of an attending physician, will write orders and admitting/progress notes.

2. All admissions must have an attending’s note or attestation on the chart within an appropriate interval of time.

3. A resident performs procedures on his/her patient under the direct supervision of the attending physician. A resident may only perform those procedures for which the attending physician has privileges. A resident may perform minor procedures without direct supervision only upon approval of the attending physician. The attending physician is responsible for judging the resident’s competence to perform such procedures without direct supervision. Minor procedures are those that are minimally invasive with a low risk of complications, including those procedures typically performed by non-physicians in the hospital.

4. As physicians, residents may act in the best interests of patients in emergency situations, subject to subsequent review by the attending physician and the usual quality assurance measures of the medical staff of Lakeland HealthCare.

5. A resident may request the physical presence of an attending at any time and is never to be refused. Attendings will be available for immediate consultation by electronic communication (Vocera/pager/phone) 24 hours a day.

6. In the setting of a primary resident being supervised by an upper level resident, it is expected that the supervising resident is credentialed in the procedure, and examines and evaluates the patient at least daily. The senior resident and junior resident should maintain clear communication about the patient’s care. Attending supervision of these patients should be
adequate to provide quality patient care, and at times will require the daily examination and evaluation of the patient. At other times this supervision may be accomplished via discussion at teaching rounds.

7. All other acute hospital patients will be seen and documented by attendings on a daily basis.

8. Any significant change in a patient’s condition should be reported immediately to the attending physician. Listed below are situations that automatically qualify as “significant changes” in the patient’s condition and require that the resident notify the attending:
   - Admission to hospital of any unstable patient
   - Transfer of the patient to the intensive care unit
   - Need for intubation or ventilatory support
   - Cardiac arrest or significant changes in hemodynamic status
   - Development of significant neurological changes
   - Development of major wound complications
   - Medication errors requiring clinical intervention
   - Any significant clinical problem that will require an invasive procedure or operation

9. All patients scheduled for discharge should be discussed with the attending prior to the discharge.

**Ambulatory Services**

1. Each patient evaluated by a resident in the ambulatory setting has a member of the medical staff as his/her attending physician who is physically present and readily available during the entire clinical encounter.

2. The residents will perform a history and physical examination on the patient and review these findings with the supervising attending physician.

3. The resident will develop an assessment and plan for the patient and this will be discussed with the supervising attending. A plan of care for the patient will be agreed upon and set in motion after said discussion.

4. The resident will generate a problem-based note summarizing the history, physical examination, assessment and plan for the patient. Each note will be reviewed and signed by the supervising attending.

5. The resident will provide continuity care for his/her patient with the guidance of the supervising attending.
Monitoring and Enforcement

Monitoring the Supervision Policy is the responsibility of the GMEC and Program Directors. Monitoring is accomplished, in part, by a thorough review of faculty and resident evaluations related to specific rotations—i.e. every four weeks. In addition, resident interviews are used to monitor compliance and are performed at least quarterly. The faculty members have been informed to contact the Program Director or DME with any concerns and supervisions issues. Enforcement is managed through the Program Directors and their oversight of both faculty and residents. Corrective measures are taken at the Program Director’s discretion and reported to the GMEC.

Residents who do not follow the above guidelines are subject to the disciplinary policies of the residency program. The above guidelines apply to residents in all years of training.

*This policy is consistent with the Supervision Policy described in the House Staff Manual and the reader is directed to that document for further details.*
POLICY: Internal Medicine Resident Service Policy

PURPOSE: To provide a service policy for internal medicine residents.

EFFECTIVE: July 1, 2012

The Internal Medicine program is approved to accept up to 6 residents per year. Rotations are four weeks in length. The programming provides 3-5 rotations of daytime hospitalist rotations and 1-2 rotations of nocturnist rotations per resident per year. In addition, rotations include one on the ICU service, and 2-6 rotations per resident per year in subspecialty or elective rotations that take place either in inpatient or ambulatory settings.

Resident workload and duty hour restrictions allow the resident to admit or provide consult to no more than 5 patients per day for OGME 1’s and 10 for OGME 2’s, and carry a total of 12 patients per day. Residents are limited to 24 hours of continuous work duty and up to 80 hours per week averaged over a four week period. Duty hours include working hours, formal didactic hours, and approved moonlighting hours.

The team structure for inpatient care varies depending on whether the resident is assigned to the ICU, hospitalist service, or on an elective/consult service. For elective subspecialty consult services, the resident will work at the direction of an attending consultant and perform tasks as assigned in a consultative and procedural role. The consultant attending will serve in a volunteer “faculty” role, teaching during the course of patient care or as scheduled for formal didactics.

For ICU and hospitalist services, there is a team structure with the resident assuming direct care responsibilities for their portion of the service census. This service design is accomplished under the supervision of the team leader from the hospitalist group (an attending) or his/her designee; and in the instance of the first year resident (intern), under the supervision of the more senior resident and oversight by the hospitalist (attending) on the team. The resident assigned to night shift is supervised by the nocturnist (attending) on duty. The resident assigned to the ICU is supervised by the Intensivist (attending) on duty.

Internal Medicine team roles are as follows:

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Resident Duties</th>
<th>Oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalist – SJ/Niles</td>
<td>Direct care of leader portion of census</td>
<td>Senior hospitalist/team</td>
</tr>
<tr>
<td>ICU</td>
<td>Direct care of assigned patients</td>
<td>Intensivist on duty</td>
</tr>
<tr>
<td>Night Hospitalist</td>
<td>Direct care of portion of admissions</td>
<td>Nocturnist</td>
</tr>
</tbody>
</table>

The care teams include residents from all disciplines (e.g. Emergency Medicine, Family Medicine and Internal Medicine). Care teams are comprised of the following:

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalist SJ</td>
<td>Team leader: Hospitalist</td>
</tr>
<tr>
<td>(6 members)</td>
<td>One or two first year residents or</td>
</tr>
<tr>
<td></td>
<td>Two second year residents</td>
</tr>
</tbody>
</table>
One third year resident
Two to three staff hospitalists
One nurse practitioner/team support person

Rotation

Hospitalist Niles
(2 members)

Team leader: Hospitalist
One second or third year resident
One nurse practitioner/team support person

ICU SJ

Team leader: Intensivist on duty
Up to three residents including first year residents
Nurse practitioner(s)

“Block” nights SJ

Hospitalist nocturnist
One to two residents

“Block” nights Niles

One to three residents

DIDACTICS

There are several didactic functions that intertwine with existing hospitalist service functions allowing safe quality care.

Morning Report: Morning report is held 8-10 mornings per month. Morning report requires a resident or student case or admission presentation. The morning report is monitored by an attending physician, for instruction and experienced input. This formalized process reviews the most interesting cases of the most recent days, and serves as a platform for educating medical staff on unusual clinical scenarios, and discussing routine care for common topics as well.

Morbidity/Mortality Review: Residents working with an attending may be required to present at this monthly or bimonthly event.

Daily faculty rounds: Faculty members assigned to the inpatient service teach residents and medical students during active patient care. Also, formal instruction occurs on weekdays and is considered “Teaching Rounds.” Teaching rounds include presentations by medical students or interns or admission or consult cases within the past day, followed by a didactic on a related subject. Following that, the same attending faculty member reviews the resident assigned case list with the senior resident on service, completing documentation for supervising care and billing.

OTHER TRAINING

Geriatrics/hospice/home care: First year residents have one month of nursing home, hospice and home care as a rotation.

Public health and continuum of care management, leadership training and hospital management: 2nd and 3rd year residents attend committees, shadow administrators in public health, infection control, and hospital management, and attend leadership training that is already offered to our current staff.
International health: With our broad experience and interest in health outside of the United States, we provide the opportunity for an overseas experience as an elective.

Moonlighting limitations: Moonlighting hours are limited. Note the “moonlighting policy” in the House Staff Manual according to AOA policy.

Call room facilities: Adequate call facilities are available.

Faculty assignments: The hospitalist team leader on the inpatient hospitalist service provides oversight and teaching to the residents rotating on that service. Faculty hospitalists are expected to apply for and be approved as a “Clinical Instructor” by Michigan State University’s College of Osteopathic Medicine.

Didactics: All Internal Medicine residents attend formal didactics, regardless of assigned rotation. Residents are given a 70% attendance requirement to allow for those times when attendance will incur a duty hour violation, or when extensive travel time required for attendance would prove disruptive to the rotation, or when urgent/emergent patient care needs prevent the resident from attending the didactic. Exclusive of the previous allowances, residents are expected to attend all formal didactics. If the occasion arises when the resident is actively needed for patient care, the attending physician should assume the care responsibility and release the resident as soon as he/she is not needed for further patient care or safety. The didactic schedule is available on the Lakeland HealthCare website.

**IM Resident Work and Education Schedule**

<table>
<thead>
<tr>
<th>Time</th>
<th>Day</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DAILY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6:30a – 8a</td>
<td>M-F</td>
<td>Handoff and Morning report (M, most Th &amp; T-note below)</td>
</tr>
<tr>
<td>8a – 12p</td>
<td>M-F</td>
<td>Huddle/Morning Rounds</td>
</tr>
<tr>
<td>12p – 1p</td>
<td>M-F</td>
<td>Lunch and/or Lecture</td>
</tr>
<tr>
<td>1p – 7p</td>
<td>M-F</td>
<td>Teaching Rounds, Charting, Admissions</td>
</tr>
<tr>
<td>7p – 7:30p</td>
<td>M-F</td>
<td>Handoff to Nocturnist/Night Resident</td>
</tr>
<tr>
<td><strong>WEEKLY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6:30a – 8a</td>
<td>F</td>
<td>Harrison’s Club</td>
</tr>
<tr>
<td>12p – 1p</td>
<td>F</td>
<td>System Lecture</td>
</tr>
<tr>
<td>½ day per week</td>
<td>Varies</td>
<td>Resident Outpatient Clinic</td>
</tr>
<tr>
<td><strong>MONTHLY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7a – 8a</td>
<td>2nd W</td>
<td>M&amp;M Conference</td>
</tr>
<tr>
<td>7a – 8a</td>
<td>2nd T</td>
<td>Journal Club</td>
</tr>
<tr>
<td>7a – 8a</td>
<td>4th T</td>
<td>OMM</td>
</tr>
<tr>
<td>8a – 4p</td>
<td>3rd Th</td>
<td>SCS Education Day</td>
</tr>
<tr>
<td><strong>BIANNUALLY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct &amp; April</td>
<td></td>
<td>OMM Seminar</td>
</tr>
</tbody>
</table>

The Service Policy is monitored by the Program Director using multiple tools including resident evaluations, logs, structured schedules and attendance recordings. Discussions, both formal and informal, are held with faculty members. They are to report any deviations from this policy. Enforcement is managed by the Program Director according to the House Staff Manual policies and in conjunction with the GMEC’s understanding and input.
POLICY: Internal Medicine Paid Time Off/Vacation

PURPOSE: To provide detailed direction to resident physicians regarding vacation/leave time and ensure adequate education and proper patient care are maintained.

EFFECTIVE: July 1, 2012

Internal Medicine Residents are allowed twenty (20) paid business days off per academic year. These days can be taken during the following service months:

- Hospitalist
- 2nd month of nocturnist for OGME-1 only
- In-house elective

Residents are allowed to take up to 5 days total per rotation.

Time off requests must be submitted to the Program Director in writing at least thirty (30) days prior to the requested time off.

All requests must be approved in writing by the Program Director and Director of Medical Education.

No more than one (1) resident is allowed to be off from any particular service at a time.

This policy is in conjunction with the Leave Policy in the current House Staff Manual.
<table>
<thead>
<tr>
<th>Requirement</th>
<th>Task</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Annual Report</td>
<td>Complete Online</td>
<td>Annually, by July 31</td>
</tr>
<tr>
<td>Program Director Annual Report</td>
<td>Review with Program Director prior to Program Director submitting to ACOI</td>
<td>Annually, by July 31</td>
</tr>
<tr>
<td>Resident Patient Evaluation (Supervised H&amp;P)</td>
<td>Complete Satisfactorily</td>
<td>Once per program before year 2 completion</td>
</tr>
<tr>
<td>Annual ACOI In-Service Exam</td>
<td>Complete every March</td>
<td>Annually</td>
</tr>
<tr>
<td>Resident Evaluation of Service</td>
<td>Complete as per program requirements and submit to Program Director</td>
<td>After each rotation</td>
</tr>
<tr>
<td>Resident Clinic Panel Log and Continuity Clinic Log</td>
<td>Complete and maintain at clinic site for ACOI clinic inspections</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

*Financial penalties apply to reports that are not submitted on time. Certification board eligibility depends on submission of all reports. All residents must complete reports by July 31 of each year. If the program completion date is in a month other than June, the final reports must be submitted within 30 days of the completion of the program.*