

General Medicine Inpatient Ward Service Curriculum Temple University Internal Medicine Residency Program

*Adapted from the Michigan State University Internal Medicine Inpatient Curriculum dated December, 2003

I. Educational Goals

The general medicine ward service remains the fundamental inpatient educational experience of the Temple University internal medicine residency. With graded responsibility and appropriate supervision, our residents actively participate in the care of the wide variety of patients seen on the internal medicine service. From direct experience, they hone their skills in history taking, physical examination, differential diagnosis, clinical decision making, and communication. In the process, our residents expand their knowledge of the diseases seen in internal medicine, foster altruistic attitudes, learn to actively improve their own practice of medicine, and appreciate the delivery of their patients' care in the larger context of the U.S. health care system. The ward service experience is a key element in promoting the professional and personal growth of our residents.

II. Principal Teaching Methods

A. Supervised direct patient care

- i. The ward team – The ward team consists of an attending physician, one upper year resident, one intern, at times interns from non-medical services such as emergency medicine or obstetrics/gynecology, and any participating students from the schools of medicine, pharmacy, or podiatry. The ward attending is the attending of record for any patient on the service without a private admitting physician, typically ~80% of those cared for.
- ii. First encounter – Patients cared for on the medicine service may be admitted through the emergency department or directly from a Temple University outpatient practice, may be transferred from the RICU or CCU, or may be transferred from other services in the hospital when internal medicine problems supersede the problems being cared for on the non-medicine service. Once a patient has been assigned to a service from one of these sources, the resident on the receiving team performs the initial evaluation. This initial evaluation is expected to include a comprehensive history and physical, review of appropriate medical records, and generation of a comprehensive assessment and plan, all of which are recorded in the medical record. Any laboratory or radiographic studies that are immediately obtainable and necessary to the immediate evaluation of the patient are expected to be performed. Within two hours of the completion of the initial evaluation, the resident presents that patient in person or by phone to the attending physician of record. The attending is responsible for personally confirming the history and physical in a timely fashion, but within a period not to exceed 24 hours.
- iii. Follow up patient care – The ward team, minus the attending, performs the initial patient re-evaluation each day on work rounds that immediately follow the pick up of sign out from the team covering the service overnight. The ongoing care of the patients assigned to a service are discussed at least daily with the attending physician of record, including weekends. The diagnostic and therapeutic plan is communicated

both in the daily progress notes in the medical record and verbally in person or by phone. The attending of record is responsible for personally confirming the interim history and physical exam on a daily basis.

- iv. Teaching attending rounds – Teaching attending rounds occur for 1 ½ hours, 5 days per week, except on days with professor’s rounds. Bedside teaching is complemented by more formal didactic sessions. Because the majority of the patients on a service are under the care of the ward attending, most of the educational content of teaching attending rounds springs directly from the care of the patients on service. Although day-to-day management discussions occur as part of teaching attending rounds, the emphasis is strongly on education. The educational content typically includes medical knowledge, the association of findings and data with underlying pathology, modeling productive, respectful interactions with patients, the principles of clinical decision making, the application of medical literature to clinical scenarios, ethics and professionalism, and the appropriate utilization of health care resources. Bedside teaching promotes the direct observation by the attending of the patient interactions and physical examinations of the resident.
- v. Discussions outside of teaching attending rounds – Additional face-to-face or phone encounters occur throughout the typical work day related to patient care, supplementing teaching attending rounds on weekdays and serving as the primary management discussions on weekends. Although usually focused on the execution of the care plan, they offer additional focused teaching opportunities.

B. Conferences – See the Core Conference Schedule for a detailed description

III. Schedules

A. Weekly schedule

	Monday	Tuesday	Wednesday	Thursday	Friday	Weekend	
7:30 AM							
8:00	Work Rounds	Work Rounds	Work Rounds	Work Rounds	Work Rounds	Work Rounds	
8:30							
9:00	Morning Report	Morning Report	EBM, Attending Morning Report	Intern Conference	Friday Case Conference		Patient Care (Sign out when work is completed)
9:30							
10:00	Patient Care	Teaching Attending Rounds	Teaching Attending Rounds	Patient Care	Patient Care		
10:30	Teaching Attending Rounds			Teaching Attending Rounds	Teaching Attending Rounds	Teaching Attending Rounds	
11:00							
11:30	Patient Care	CPC, M&M, Resident only M&M	Grand Rounds				
12:00	Core Curriculum, Ambulatory						
12:30					Patient	Patient	

		Patient Care	Patient Care	Care	Care	
1:00 ↓ 5:00	Patient Care					

- B. Sign out – Sign out is picked up from the night float by 7:30 AM on Mondays and Tuesdays, 8:00 AM on other days of the week. Sign out is given to the Extra resident at the conclusion of the day’s work, typically around 5:00 PM.
- C. Short call – On weekdays, every ward team that is not on call or post-call is eligible for short call admissions, which can be taken from 8:00 AM to 3:00 PM.
- D. Overnight call – The overnight on-call teams begin to take admissions at 3:00 PM. Overnight call continues until 8:00 AM the next morning. Overnight call occurs every fifth day, except in the months of January and February when it occurs every fourth day.
- E. Service cap – General internal medicine ward services are limited to 16 patients per service.
- F. Duty hour accommodations
 - i. One day off per week – It is the responsibility of the upper year resident to ensure that each resident on the team receives one day off in seven averaged over the block. To accomplish this, the upper year resident may at times excuse the intern from work on a single work day during the week. That intern is also excused from attending any of the scheduled educational conferences on that day.
 - ii. 24/6 – An overnight on-call team rounds early in the morning post-call with the ward attending. After rounds, the team finishes its patient care work, signs out to the covering resident, and leaves the hospital no later than 1:00 PM. Post-call residents are excused from attending any of the scheduled educational conferences. Additionally, residents are not required to write a daily progress note on any of their patients on post-call days. The attending note stands as the progress note for that day.

IV. Educational Resources

- A. The patients cared for – Temple University Hospital is located in and serves the poor, urban, largely minority population of North Philadelphia. The vast majority of patients on the ward service is local residents and reflects the demographic and ethnic mix of the neighborhood. Encountered patients present with the broad spectrum of common, and occasionally rare, disease processes prevalent in a large, diverse, urban community. The majority of patients cared for speak English, although about 10% of admitted patients list Spanish as their primary language.
- B. The ward attending – Ward attendings are a select group of faculty members chosen from the department of medicine, the department of family and community medicine, and the Temple University hospitalist group, who have demonstrated skill and interest in resident education. Their success as educators as measured by resident evaluations, the residency program director, and their section chief or department head influences their individual salaries. A ward attending’s role includes, but is not limited to, expanding their assigned residents’ fund of knowledge, refining their clinical judgment and medical decision making skills, identifying gaps in knowledge or skills for the resident to remediate, modeling productive and respectful interactions with patients and colleagues, exemplifying professional and ethical behavior, sharing their experiences about cultural

barriers to care and health maintenance in the North Philadelphia community, and serving as a role model as an educator. The ward attending also has the role of reviewing the tiered objectives organized by competency with the resident at the beginning of the rotation.

- C. Medical library – The medical library at Temple University, across the street from the hospital, is available to the residents during its normal business hours. Available in its holdings are basic textbooks of internal medicine and subspecialty medicine, basic textbooks of other specialties outside of internal medicine, current and bound journals reflecting the broad spectrum of medical literature, and searchable computer-based databases for finding and retrieving information from the published medical literature. Library staff is available to assist and educate in carrying out literature searches. By fall 2009 at the latest, the library will move one block north to a state-of-the-art facility in the new medical school building.
- D. Internet-based computer resources – Residents have immediate internet access at all nurses stations, on call rooms, and department of medicine conference room. Much of the medical library’s resources are available remotely. Additionally, residents have free access to the on-line text Up-to-Date via institutional subscription.
- E. Program database – The program maintains a database of slides and other supporting materials from all presentations that are part of the curriculum. Residents can access the database and review presentations or topics.
- F. EKG interpretation tutorial – PGY-3 residents are given a packet of 100 EKG’s to interpret and complete a quiz based on those EKG’s. A minimum passing score is required. After all residents have completed the quiz, the EKG’s with the correct answers are reviewed by a cardiology fellow.
- G. Basic and advanced cardiac life support – PGY-1 residents are expected to achieve certification in basic and advanced cardiac life support by the completion of their first year. Basic and advanced cardiac life support classes are offered via the hospital throughout the year free of charge. PGY-3 residents may re-certify free of charge if they want to.
- H. Dialogues
 - i. Physician consultants – Residents routinely engage the assistance of consultants from within and outside of the specialties of internal medicine in the course of their patient care. Along with their care, these consultants are expected to be readily accessible to residents to answer questions about the basic science, up to date interpretation of medical literature, and accepted evidence-based and consensus management algorithms for diagnoses in their field.
 - ii. Case managers and social workers – Residents routinely engage the expertise of case managers and social workers to navigate the often complex systems of health care delivery. These professionals educate the residents about the third-party payer system, services available to uninsured or underinsured patients, access to mental health and substance abuse treatment, discharge guidelines, and resource management in the course of their interactions. The inpatient case management department has been reorganized this year to make the case managers more visible on the floors and available to the inpatient teams.
 - iii. Clinical pharmacists – Residents frequently interact with the hospital-based clinical pharmacists in the course of the care of their patients. These pharmacists provide

- information on scheduling, dosing, drug-drug interactions, cost, availability, and adverse reactions.
- iv. Physical and occupational therapists – In the course of caring for patients with rehabilitation issues, residents interact with physical and occupational therapists who educate in identifying rehabilitation needs, setting discharge goals, and utilizing accommodative equipment and techniques.
 - I. Program directors – Issues may arise in the course of clinical care that the resident feels are best discussed with an individual outside the health care team (e.g. interpersonal conflicts, breaches of professionalism). The program directors invite the residents and maintain easy accessibility for them to discuss any such issues. At all times, the program directors will model superlative interpersonal interactions, professional behavior, and ethical conduct.
 - J. Simulation center – In the last 3 years, the department of medicine has developed simulation-based educational modules delivered in Temple’s simulation center. These modules currently include phlebotomy, insertion of an IV, arterial puncture, Pap smear, placement of a central venous catheter, and rapid response scenarios. The department intends to add additional modules as they are developed.

V. Methods of Evaluation

- A. Resident Performance - Evaluation of the resident occurs by:
 - i. faculty
 - 1. Rotation – Each resident on a ward service is evaluated by each teaching attending who works with him for more than one week. For time spent together exceeding two weeks, additional feedback at the mid-point of the time together is expected. The evaluation is communicated both verbally in a face-to-face meeting between the attending and resident, and electronically via the New Innovations software package in a competency-based format developed along internal medicine RRC guidelines. The electronic evaluation remains available to the resident to review on-line, but at the present time is also printed and placed in the resident’s folder. Additionally, each of those evaluations is reviewed by the program director, deputy program director, or associate program director in the presence of the resident in a biannual meeting. Because the teaching attending is also the attending of record for the majority of patients cared for by the resident on the ward service, opportunities for evaluation occur not only in didactic sessions and discussions, but also on bedside rounds, in review of all of the resident’s admission and daily progress notes, and in direct observation of the resident addressing and examining patients and interacting with colleagues in the course of the delivery of medical care.
 - 2. mini-CEX – Bedside observation of residents interacting with patients occurs on an almost daily basis. Feedback regarding these interactions occurs as part of the evaluation by the attending, but may at times be formalized and documented in the format of a mini-CEX.
 - 3. Procedures – Those residents or fellows who have been established as competent in performing a given procedure, and attendings, may supervise a resident attempting that procedure. By direct observation, the supervisor confirms that the resident is able to complete the procedure with efficiency, skill, techniques to

- minimize patient discomfort, and attention to the safety of the patient, the resident, and other medical staff. Review of the chart assures that appropriate documentation of successful and unsuccessful procedures is recorded. Residents document their procedures electronically in New Innovations. The supervisor provides confirmation of the above observations by his electronic signature. A review of each resident's success in completing and documenting procedures occurs in the resident's biannual meeting.
4. Morning report – Each resident who presents at morning report receives a written evaluation from both an attending and chief resident for that presentation. The content of the evaluation includes organization, content, synthesis of the material reviewed, and presentation skills. The evaluation is available to the resident on-line in New Innovations and is filed in his folder and reviewed by the program director, deputy program director, or associate program director in the presence of the resident in the resident's biannual meeting.
 - ii. peers – Residents are encouraged to provide evaluations on the other residents with whom they work on service. These evaluations include assessments of medical care, interpersonal and communication skills, professionalism, and collegiality, and may remain confidential if desired by the submitting resident.
 - iii. medical students – The medical students on a ward service complete an electronic evaluation at the end of the rotation on each of the residents with whom they worked. These evaluations include assessments of the resident's enthusiasm, teaching, role modeling, contribution of the resident to the student's professional growth, and provision of feedback to the student. The evaluation is reviewed by the medicine clerkship director, filed in the resident's folder, available for the resident to review, and reviewed by the program director, deputy program director, or associate program director in the presence of the resident in the resident's biannual meeting.
- B. Teaching Attending Performance – Evaluation of the teaching attendings occurs by:
- i. residents - Residents evaluate their teaching attending in a written format for each rotation and may provide verbal feedback in their face-to-face evaluation meeting. The written evaluation may remain confidential, but is most commonly returned to the attending for review. The program director reviews all evaluations and annually provides to each ward attending an aggregate summary of his evaluations.
 - ii. students – The medical students on a ward service evaluate their teaching attending in a written format and may provide verbal feedback in their face-to-face evaluation meeting. The written evaluations may remain anonymous. The clerkship director collects the evaluations and returns a copy of each to the attending.
- C. Program Performance – Residents may provide verbal or written feedback regarding the residency program at any time to their ward attending or to a program director, deputy program director, or associate program director. The program director and deputy program director maintain a bi-monthly interactive feedback session soliciting resident concerns. Additionally, at the biannual meeting with each resident, the program director, deputy program director, or associate program director actively solicit resident comments about the program as part of the meeting's agenda. Residents may also report concerns or problems directly to the institution's graduate medical education office.

VI. Tiered Objectives Organized by Competency

Note: Some objectives may address more than one competency. Such instances are identified with the additional competencies noted in italics following the item.

Where tiered objectives are listed, it is expected that residents in each year will have mastered the competencies outlined for the previous levels of training.

A. Patient Care

i. History taking

1. PGY-1 residents will:

- (a) efficiently elicit a thorough, hypothesis-driven history from the patient or patient's representative.
- (b) incorporate verbal and non-verbal techniques in their history taking to promote disclosure of relevant information and maintenance of patient comfort.
- (c) use translator services appropriately.
- (d) include in the information they elicit their patients' emotional feelings about their illnesses and their beliefs about its causes and remedies. (*interpersonal and communication skills*)

2. PGY-2 residents will take the history more efficiently without compromising accuracy or thoroughness. (*interpersonal and communication skills*)

ii. Researching medical records

1. PGY-1 residents will:

- (a) supplement the history obtained from the patient with appropriate information gleaned from medical records, including but not limited to labs, radiologic studies, electrocardiograms, echocardiograms, stress tests, pulmonary function tests, pathology, records of previous inpatient admissions, records from outside institutions, and records from the primary care physician.
- (b) understand how to access the variety of information systems in the hospital to retrieve appropriate past medical records and studies.
- (c) understand the process by which outside medical records are obtained. (*system-based practice*)

2. PGY-2 residents will:

- (a) routinely identify and prioritize the important records to be obtained.
- (b) know how and when to access the records of the department of public health. (*system-based practice*)

iii. Physical examination

1. PGY-1 residents will:

- (a) perform a systematic, comprehensive physical examination, obtained discretely, with attention to patient comfort and privacy.
- (b) consistently and reliably identify abnormal findings.
- (c) be able to report the physiologic and anatomic bases of normal and abnormal findings.

2. PGY-2 residents will:

- (a) anticipate and detect subtle findings.
- (b) teach physical exam skills to interns and medical students.

- iv. Charting – Residents at all levels will record data in the medical record in a thorough, legible, systematic manner and at regular, timely intervals. Such documentation will include not only documentation of the facts, but will also reflect the reasoning underlying the resident’s decision making. (*interpersonal and communication skills*)
- v. Procedures
 - 1. PGY-1 residents will:
 - (a) understand the indications, contraindications, necessary equipment, specimen handling, potential complications, and patient after-care of commonly performed procedures. Procedures will be performed with attention to the safety of the patient, the resident, and other medical staff. Techniques to minimize patient discomfort will be utilized. (*medical knowledge*)
 - (b) obtain appropriate informed consent and will assist in patient decision-making. Timely documentation of successful and unsuccessful procedures will be recorded in the chart. (*interpersonal and communication skills*)
 - (c) focus primarily on learning the skills and techniques that lead to successful procedural outcomes.
 - (d) achieve and maintain basic cardiac life support and advanced cardiac life support certification. (*medical knowledge*)
 - 2. PGY-2 residents will:
 - (a) hone their own procedural skills.
 - (b) be willing and able to assist junior colleagues in skill acquisition for procedures in which they have acquired proficiency. (*professionalism*)
 - 3. PGY-3 residents will ensure that they have mastered the procedures required for certification by the ABIM. (*practice based learning and improvement*)
- vi. Medical decision making, clinical judgment, and management plans
 - 1. PGY-1 residents will:
 - (a) interrelate findings and disease processes, including the correct interpretation of
 - (i) symptoms and abnormalities on physical examination
 - (ii) routine lab studies, including the basic metabolic panel, liver function tests, complete blood count, peripheral blood smear, coagulation studies, urinalysis, and arterial blood gases
 - (iii) microbiologic studies, including gram stains and culture results
 - (iv) chest roentgenograms and abdominal plain films
 - (v) electrocardiograms
 - (vi) pulmonary function tests (*medical knowledge*)
 - (b) be able to create a focused, thorough, appropriately prioritized problem list.
 - (c) be able to suggest a diagnostic and therapeutic plan of action based on their problem list that reflects the identified priorities and respects patient preferences.
 - (d) utilize evidence-based strategies or practice guidelines whenever applicable. Cost effective strategies will be emphasized. (*system-based practice*)
 - (e) understand the risks and benefits of the proposed diagnostic studies and therapeutic interventions. Particular attention will be given to communicating to the patient those risks and benefits and ensuring that the patient has a clear

understanding of the course of action. (*interpersonal and communication skills*)

- (f) understand how to evaluate the success of therapeutic interventions, including measurement of the desired response and recognition of complications.
- (g) recognize and respond appropriately to situations in which urgent or emergent intervention is required.

2. PGY-2 residents will:

- (a) be able to identify alternate strategies to the one they have proposed and discuss the risks and benefits of those strategies.
- (b) continually reassess clinical information and data and alter the initial plan when appropriate.
- (c) be able to identify the limitations in the execution or interpretation of proposed diagnostic studies. (*medical knowledge*)
- (d) not only have knowledge of the complications associated with therapeutic interventions, but will anticipate them.
- (e) identify when consultation of an appropriate specialist can augment patient care. (*practice based learning and improvement, system-based practice*)
- (f) anticipate when medical care can be completed in a non-hospital setting.
- (g) be able to anticipate the likely condition of the patient at the conclusion of the hospital stay and identify and arrange for the resources necessary to ensure safe transition of care to the next setting. (*system-based practice*)

3. PGY-3 residents will:

- (a) develop plans that are not overly reliant on tests and procedures.
- (b) make decisions in situations in which there is insufficient or ambiguous literature to make definitive recommendations.
- (c) teach junior residents and medical students clinical judgment skills and decision making principles.

B. Medical Knowledge

i. PGY-1 residents will:

- 1. be able to recall the basic differential diagnosis for each item in their problem list with particular attention to those diagnoses that are immediately life threatening or which require immediate intervention.
- 2. recall the approach to therapy for common diagnoses, including the information that is necessary to guide clinical decision making.
- 3. be able to deliver the initial care in medical emergencies such as hypotension, acute respiratory distress, hyperkalemia, and unresponsiveness.
- 4. recall the typical presentations of diseases common to internal medicine.
- 5. supplement their medical knowledge with information from sources including textbooks, review articles, and on-line databases. They will begin to understand and apply information from current medical literature. (*practice based learning and improvement*)

ii. PGY-2 residents will:

- 1. be able to recall an expanded differential diagnosis including common and uncommon causes of the patient's problems.
- 2. recall the specific indications and contraindications for the treatment of common diagnoses.

3. recall unusual presentations of diseases common to internal medicine.
 4. understand the indications for hospitalization of patients who present to the hospital. (*system-based practice*)
 5. recognize the indications for transfer of patient care to an intensive care unit setting. (*system-based practice*)
 6. begin to critically evaluate current medical literature as it applies to the care of their patients. (*practice based learning and improvement*)
 7. recognize cultural barriers to treating disease and maintaining good health. These barriers will be addressed with sensitivity and with respect for the patient's beliefs. (*interpersonal and communication skills*)
- iii. PGY-3 residents will:
1. be able to recall a comprehensive differential diagnosis, including rare causes of the patient's problems.
 2. recall the various options for treatment of common diagnoses and understand the specific indications and contraindications for each of those options.
 3. recognize presentations of common diseases usually cared for by non-medicine services. The resident will recall usual first line treatments for those diseases.
 4. actively access and critically evaluate current medical literature as it applies to the care of their patients. (*practice based learning and improvement*)
- C. Practice Based Learning and Improvement
- i. PGY-1 residents will:
1. recognize their limitations and seek help in situations in which they would benefit from the assistance of an upper year resident or attending.
 2. identify their own weaknesses compared to the skills of their peers.
 3. be receptive and responsive to constructive criticism.
 4. routinely reevaluate their clinical decision-making when unexpected negative outcomes are encountered.
 5. continuously seek to expand their medical knowledge. (*medical knowledge, professionalism*)
 6. deliver care that reflects learning from previous experiences.
- ii. PGY-2 residents will:
1. reflect on the types of mistakes they have made in the care of their patients and look for common themes among those mistakes.
 2. understand how their personal beliefs, biases, emotions, response to stress, and approach to decision making may have an impact on the quality of the medical care they deliver.
- iii. PGY-3 residents, with the knowledge gained from self-reflection, will display vigilance for and develop strategies to overcome the types of mistakes they are prone to make based on their personal beliefs, biases, emotions, response to stress, and approach to decision making.
- D. Interpersonal and Communication Skills
- i. PGY-1 residents will:
1. develop effective and respectful relationships with patients, students, peers, supervisors, and other medical and administrative workers.
 2. be effective listeners in medical and professional encounters, including recognizing verbal and non-verbal cues from the people with whom they interact.

3. communicate respect, empathy, and concern in their encounters.
 4. write legibly in all situations.
 5. remain quickly, reliably, and easily accessible by beeper when on duty. (*professionalism*)
 6. provide effective and detailed sign-out to allow covering physicians to knowledgeable and efficiently continue their patients' care. (*system-based practice*)
 7. continually communicate to their patients in understandable terms the nature of their care, including diagnoses, the level of certainty regarding those diagnoses, the diagnostic and therapeutic plan, indications for and adverse effects of prescribed medications, and follow-up after hospitalization.
 8. effectively coordinate the transition of patient care from inpatient to non-hospital settings, with particular attention given to communicating with the primary care physician. (*system-based practice*)
 9. develop skills for dealing with difficult patients and stressful situations.
 10. develop skills for handling situations of unprofessional behavior by other health care professionals.
 11. provide constructive feedback regarding the residency program. (*professionalism, system-based practice*)
- ii. PGY-2 residents will:
1. model effective and respectful relationships with patients, students, peers, supervisors, and other medical and administrative workers.
 2. model skills for dealing with difficult patients and stressful situations.
 3. model skills for handling situations of unprofessional behavior by other health care professionals.
 4. be able to direct sensitive or difficult interactions with patients or their representatives, including the delivery of bad news or initiation of end-of-life discussions.
 5. manage and direct the intern and students on the service to ensure timely and effective completion of the tasks of patient care.
 6. anticipate duty hours issues and proactively develop a plan that ensures compliance of all team members with the requirements. (*system-based practice, professionalism*)
 7. effectively educate the students and intern in such a way as to improve their understanding and practice of internal medicine and to promote their professional success. (*professionalism*)
- E. Professionalism
- i. PGY-1 residents will:
1. comply with all locally and nationally accepted standards of behavior for health care professionals, including but not limited to those mandated by law.
 2. in all activities demonstrate a commitment to excellence.
 3. in nearly all situations, put the needs of their patients ahead of their own.
 4. ensure adequate attention to their own needs, particularly those of rest, sleep, and personal relationships, to optimize their readiness to provide the highest quality care for their patients.

5. take ownership of the well being of the patients assigned to their care, no matter how brief the assignment.
 6. act as patient advocates.
 7. show respect at all times for the unique and individual perspectives of patients and their families.
 8. show respect for the opinions and skills of their colleagues.
 9. be committed to participating in the organized curricular program offered by the residency. This participation includes attendance and, when appropriate, making contributions to enhance the education of others.
 10. manage work efficiently to allow attendance at educational conferences.
 11. acknowledge errors and work to minimize them. (*practice based learning and improvement*)
 12. respond to unpleasant patient or professional interactions with restraint, insight, and empathy. The betterment of patient care will remain the priority in all attempts at conflict resolution. (*interpersonal and communication skills*)
 13. reflect on their own behavior after difficult or unpleasant interactions. (*practice based learning and improvement*)
 14. act as a role model for medical students.
- ii. PGY-2 residents will:
 1. actively seek to provide feedback in a constructive fashion for the students and interns with whom they work. (*interpersonal and communication skills*)
 2. be willing to challenge the accepted plan of care when their professional judgment differs from that of other providers.
 3. recognize situations in which junior colleagues would benefit from their assistance.
 4. act as a role model for interns and fellow residents.
 - iii. PGY-3 residents will anticipate situations in which their junior colleagues would benefit from their assistance.
- F. System-based Practice
- i. PGY-1 residents will:
 1. utilize hospital resources to deliver effective, efficient, high quality patient care.
 2. remain sensitive to health care costs while providing high quality care.
 3. provide timely dictation of the patient records assigned to them. Note that PGY-1 residents are not assigned charts for dictation until they have completed 6 months of their training. (*interpersonal and communication skills, professionalism*)
 4. be cooperative in complying with performance improvement initiatives developed by the hospital administration. (*practice based learning and improvement, professionalism*)
 - ii. PGY-2 residents will:
 1. identify resources at the time of discharge that will benefit the patient in their post-hospital care. The resident will work with the case manager and social worker to integrate these resources into the discharge plan.
 2. demonstrate awareness of the insurance status of their patients and its impact on their care options.
 3. identify ways to improve the process of patient care, including error reduction, and participate in their development.

4. participate in the improvement of residency education by actively contributing their insights, opinions, energies, and leadership. (*professionalism*)
- iii. PGY-3 residents will:
1. demonstrate adaptability to change.
 2. recognize the ways in which individual practice decisions affect other health care providers, the health care system, and society.