MEDICINE ROTATIONS

Overview: On your medicine rotations, you will spend time at BIDMC and the West Roxbury VA Hospital. The hours are 7:00 am to variable times in the afternoon, depending on whether you are on short call or long call. Your medicine months consist of: OMED (inpatient oncology), general wards at the VA and BI.

OMED: It is by far one of the hardest months of intern year. The patients are extremely sick and it can often be an emotionally draining month. However, you learn about palliative care, acute and chronic pain management and most importantly you learn how to discuss end of life issues with your patients. Below is the description provided through the Internal Medicine website.

WHERE: 11 Reisman; with typical overflow to 12 Reisman and 7 Feldberg
THE PATIENTS
1. Solid Oncology Patients:
Typical patients that are admitted are onc patients with oncology related issues (DVT, PE, febrile neutropenia, etc), initiation/continued chemotherapy, transitions of care (ie inpatient hospice) -- Not all oncology patients are admitted to OMED. A cancer diagnosis does not mean a mandatory OMED admission (though often it does). For example, if a woman with breast cancer comes to the hospital complaining of cardiac-type symptoms she may better be served on Zoll or the general wards.
2. Liquid malignancies--lymphomas and leukemias
Though these patients are usually admitted to BMT, BMT is an incredibly busy service and overflow typically goes to the OMED team. When this happens you will typically card flip/walk round with one ofBMT attendings later in the day (be sure to have your note ready as most like to take your note, sign it and throw it in the chart/give it back to you to place in the chart)
3. Biologic Patients.
These patients are usually on IL-2 for treatment of metastatic renal cell or melanoma. Though this service is run by NPs if patients become sick they are typically transferred to the OMED team for closer monitoring. ** Patients are admitted from the ED, directly from clinic, or home, i.e. for planned chemotherapy**

THE TEAM
The OMED team consists of 2 interns and a resident.
-- Team cap: 16 as each intern caps at 8 patients each; overflow now goes to the onc hospitalist who also caps at 8 - and when times get really tough to the medicine hospitalists (when this happens you have the potential to have these patients transferred to OMED once you are under cap)
On the weekend, one of the days is covered by the OMED rounder (a junior or senior resident) ensuring each member of the team gets one day off
** If interns so chose they can decide to pull golden and black weekends - just be sure to ask your resident and ensure you aren't violating work hours **
A TYPICAL WEEK DAY

You pick up the sign-out at 7 a.m. and sign out at 7 p.m.

PICK UP signout on 11 Reisman from the moonlighter - at this time you will receive any new overnight admission.
** You admit daily on OMED so expect occasional o/n admissions followed by several more thru out the course of the day **

ROUNDING
: The daily round schedule depends on the attending on service. Generally, you round on your patients and see overnight admits from 7 a.m. to 9-10 a.m. You may then have sit-down rounds with your resident and/or attending. The service is too busy to walk-round on all the patients; however your attending may want to see new patients or sick patients together as a team. In general, the intern who is not taking care of the patient is free to do other work. The time of rounds also depends on the attending. Some like to round in the late morning, some in the early afternoon.

AFTERNOON HOURS: Since there are many admissions directly from clinic, there is often a few hours of calm in the early afternoon followed by several new admits. If you know of patients waiting to be admitted from clinic and you have some spare time, you should consider seeing these patients or at least starting to skeletonize their notes (many of these patients have repeated admissions, so there are likely old discharge summaries and clinic notes that you can use to start outline their note even before they arrive).

EVENING: DROP signout on 11 Reisman; the moonlighter comes in at 6pm to gather signout from the onc hospitalist and if they're nice/not too busy and you are done with your work you have potential to sign out early! CONFERENCES/TEACHING
You will be emailed a list of lectures/conferences at the start of the rotation -- No formal attendings rounds unless scheduled by the attending on service -- Mondays: heme-path conference (analyzing slides in the context of different clinical cases) at 1pm with Dr Drews in the clinical lab on Finard 3; typically 45minutes long -- Tuesdays, Wednesday, Friday: noon conference in the GI conference room in the Rabb Building, 1st floor (lunch served - monday and thursday youre on your own food wise)

WEEKEND DAYS
Again day starts and ends at 7a and 7p; no conferences are scheduled. You and your co-intern decide who has what day off; typically the resident always has saturday off.
CODE PAGERS:
The OMED resident and one intern carry East campus code pagers, and respond to both Code Blue as well as the more common First-Aid Emergency pages, e.g. for things like falls, chest pain for the East campus.
**** Prepare your sign-out/order next day AM labs early in the day. The late-afternoon/evening can be busy with admissions for clinic and it's often helpful to have all your next-day labs and sign-out ready to go to avoid working later than necessary

CLINIC DAYS

For categorical interns you still have your mandatory clinic once/week - during this time your resident will cover your list and help with your admissions. Once your return from clinic you'll pick up where you left up and hopefully still get out on time

OMED H&P

An oncology HPI begins with the pertinent one liner which should include key information about diagnosis also includes date of diagnosis, method of diagnosis, histology and stage of disease at diagnosis.

IE: Mr G is a 54yo male with history of hormone refractory metastatic prostate diagnosed in 2000 now C2D10 of taxotere presenting with febrile neutropenia.

History: You should know the dates and details of the patient's treatment since diagnosis including surgeries, of radiation treatment, and courses of chemotherapy. Regarding current state of the patient's disease, you want to know symptoms, where the disease is, functional status (ECOG 0 = no impairment, ECOG 1 = can do light work, ECOG 2 = Can't do work, but 50% waking hours; ECOG 4 = confined to bed/chair; ECOG 5 = dead), and current plan of treatment. Finally, as with any other patient, you should learn why they are here now. *** Much of this info will be previously documented in previous OMR notes/fellow admit note if patients arrive from clinic.

Physical Exam

Oncology patients should have careful full body evaluation for LAD, HSM, and rashes. You should look carefully in every patient's mouth (especially when receiving chemotherapy).

Code status

Should be addressed with every patient on admission unless there is a reason not to (ie attending preference) but be sure to talk with primary oncologist about change of code status discussion as they often like to engage patient in this discussion. After code status solidified it should be clearly documented in the chart, and confirmed with the attending. In addition to code status, document patient's health care proxy (name, relation and contact info (be sure to include code status and HCP in your discharge summary to make it easier for the next team!)

How should my thinking be different on OMED than on other services?

You will gradually learn the answer to this question over your month, but here are a few thoughts to get you started:

1. When evaluating any problem or complaint, your pre-test probability of a horrible event is much higher in these patients than in the general population. Thus, have a lower threshold to obtain ABGs for SOB, EKGs for chest pain, stat labs, stat CTAs, and to call your resident. This is a very different subset of patients that on the general medicine floor, and be sure to always keep this in mind. Have a low threshold for kicking information up to your resident and attending. You will never be faulted for asking too many questions.
2. Pain Management. Treat pain especially aggressively—these people are not drug seekers and have much higher medication need than any other patients. Many know what dose and what med they want, not because they are abusers, but because they

have been unfortunate enough to have a lot of experience with these meds. Use opioids liberally, but also learn about other palliative approaches. Know that a pain and palliative care services is available to help with complicated palliative issues and that they are quite Start of deleted contentuseful. End of deleted content Start of added contentuseful (Julie Knopp, the NP on palliative care, is a tremendously valuable resource person). End of added content Morphine elixir is helpful as well for dyspnea, and for patients who have difficulty swallowing. As with any patient on opioids, make sure they have an aggressive bowel regimen and try to prevent constipation before it starts.

3. On pre-rounds, always look in the patient's mouth and always ask about symptoms of mucositis. Be sure to carry a strong pen-light with you.

4. Labs and imaging are more urgent on OMED than elsewhere—keep on top of them. .
Why OMED and BMT is special
No doubt the rotation is tough. Prognoses are poor on this services and each day can be an emotional (as well as physical!) challenge. Remember that every OMED patient represents an opportunity to improve the quality of life of a suffering person. Some patients will have their lives extended by your interventions, allowing them to enjoy more time with their friends, families and pleasures. For others, you will help ameliorate specific symptoms. You will listen the stories and provide reassurance to patients and families alike. Finally, some will die and you will help their death to be as painless and calm as it can be.
Other Helpful Tips for OMED
Logistics
-If you have patients on 7F, you will need your ID badge to get on the floor. You will need to have it activated in order to have access. Talk to the unit coordinator to access it. -There is a housestaff lounge located on the 2 nd floor in the Rabb building near the cafeteria (look for the corridor with the golden shovel) and walk to the end of the hall. You can bring a lock to use on the lockers, although most interns leave their things in the nurse conference room or on the floor itself
-Symptom management is key for this rotation. Opioids for pain, aggressive bowel regimens. Mucositis can be treated with Clotrimazole troches, Caphosol, Magic Mouthwash (Maalox/Lidocaine/Benadryl), and Fluconazole for thrush. Appetite stimulation with Megace, Dronabinol/Marinol, or Ritalin. Options for nausea include Compazine, Zofran (works best with chemo), Reglan, Ativan, Zyprexa, Haldol, Aprepitant (Emend). For patients who are CMO or actively dying, Scopolamine patches decrease secretions, Morphine gtt is better than Morphine boluses, and Ativan can be used for restlessness/anxiety. Sublingual morphine or ativan can be given to avoid IVs if necessary. -Use the Palliative Care Consult Service liberally, but be sure to confirm with the attending prior to consulting. It is often helpful to send the Palliative Care team a page in addition to putting the consult in POE to discuss the reason for consult. Consults can be helpful for symptom control with or without the need for end-of-life discussion. -Fellows often write their own admit notes on their patients when admitted. If you know of an admission, you should consider asking the fellow if and when they plan on making their note available in OMR so that you can have access to it when you write

your admit note. -Communication is vital this month. Communicate with your patients but also with the primary oncologist and fellow (likely different from the teaching or ward attending). Make it a habit to page the patient's fellow or send an email to the fellow and attending on a daily basis to update them on the patient's status. Discuss major decisions such as code status, end-of-life discussions, PEG tubes, and procedures with the primary oncologist, fellow and teaching attending. This can be very time-consuming but will help tremendously with overall patient care and satisfaction. Start of added content-Communicate with the nurses; many of them are experienced and they are spending much more time in the room with the patient than you are (especially when you have a census of 10), so trust them when they are worried about a symptom.

INPATIENT MEDICINE AT BI and VA: During these months, you will learn a lot of the 'bread and butter' topics in medicine (CHF exacerbations, ACS, alcohol withdrawal, etc). The patient population between the BI and VA are very different, but you get to see some incredible pathology.

Getting signout: You can figure out who your resident will be ahead of time using amion (see below); probably a good idea to send them a quick email within the week before going to a new rotation to introduce yourself and get a signout email for the patients your'll be picking up the following week.

Call: Never overnight! Go to www.amion.com, password "BIDMC" (in caps) to see your medicine call schedule. Click on "block", make sure the first drop down box is on "intern" and find yourself in the second drop down box.

Website: The internal medicine program has a very useful website for the medicine residents. Most of the answers to your questions about OMED and general inpatient medicine months at BI and the VA can be found on this website: http://www.bidwiki.org

BIDwiki is a great resource throughout the year. It provides the phone numbers, contact info, expectations during your medicine rotations, and relevant journal articles.