LAC+USC Medical Center
Medical ICU Orientation
2021-2022

Faculty in Charge of Rotation:
May Lee, MD
323-409-7184
maymlee@med.usc.edu

First Day of Rotation:
Report to MICU 4A low or 4B low depending on your team assignment for sign-out at 6:30 AM.

GOALS

The Medicine ICU rotation is the core intensive care unit experience. The overarching goal of the LAC MICU service is to create a supportive, well supervised and dynamic environment where interns and residents of varying training and skill levels rotating with the Division of Pulmonary Critical Care Sleep Medicine (PCCSM), can acquire knowledge, skills and expertise in the management of critically ill medical and surgical patients. The critical care environment challenges trainees to develop skills for recognizing the acuity of life threatening illness in a predominately urban, medically underserved cohort of socioeconomically, culturally and ethnically diverse patients. Interns and residents work with PCCSM fellows in a collaborative, multidisciplinary critical care team to provide timely, appropriate interventions and participate in a culture of continuous quality improvement and safety based on sound evidence-based practices, broadly accepted quality care measures and institutional initiatives.

In addition to fostering competence in the areas of patient care and medical knowledge, the service provides critical experience in collaborating with other members of the healthcare team, including care coordinators, social workers, and pharmacists, as well as students and fellow residents, which builds skill in interpersonal communication and professionalism. Exposure to the intricacies of daily hospital care, including discharge planning and triage to higher or lower levels of care, builds competency in systems-based practice, provides opportunities to learn from mistakes, and builds patterns of practice-based learning.

ROTATION STRUCTURE

STARTING THE ROTATION

Before the first day on service, sign-out should occur from the outgoing member to the appropriate oncoming team member (resident to resident, intern to intern).

WEEKLY SCHEDULE

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
2PM – 3PM	Resident Lecture	Resident Lecture		Resident Lecture	Resident Lecture

DAILY SCHEDULE

6:30 AM – 8:30 AM	Sign-out, Pre-rounds, and Fellow Rounds
8:30 AM – 10:00 AM	Work Rounds
10:00 AM – 12:00 PM	Multidisciplinary Bedside Rounds
12:00 PM – 1:00 PM	Lunch/Conference (Grand Rounds, M&M, CPC)
1:00 PM – 5:30 PM	Patient Care and Management / Afternoon Didactics/Attending afternoon rounds
5:30 PM – 6:00 PM	Sign-out to Night Float resident

Fellow Rounds

Fellow Rounds on all of the team's established patients must be conducted with all the team members present every morning from 7AM – 8AM. All team members, therefore, will become familiar with all of the patients on the team. These rounds are led by the fellow without the attending. The goal is to ensure that a management plan for the day as well as the overarching plan for each patient is established daily. The team should strive to see all patients during this hour, but should prioritize sick/unstable patients, patients pending discharge, and new patients.

Multidisciplinary Bedside Rounds

The ICU is a highly dynamic environment and team-based care are essential for improving ICU performance. The ICU team is comprised of physicians, clinical pharmacists, respiratory therapists, dieticians, bedside nurses, and social workers. Bedside Rounds are performed from 10:00 AM – 12:00 PM every Monday through Friday. The attending should review and discuss with the team, all of the team's new admissions from the previous twenty-four hours and determine plans of care. Any new patient must be seen by and discussed with the attending with the team at the bedside. Faculty are expected to perform bedside teaching, discussion of pathophysiology, and should use current available studies to aid in diagnostic and therapeutic decisions. Faculty must perform discharge planning and management rounds daily. Faculty must evaluate all of their team's patients each day and must co-sign all necessary notes. All documentation, including the initial history and physical must be signed within 24 hours. Each faculty attending is available for their team at all times when they are on service.

TEAM STRUCTURE

There are two teams that make up the MICU service. Each team is comprised of one faculty attending, one fellow, 3-4 senior residents, and 4 interns. Additionally, depending on the time of year there can be up to 2 fourth year medical student (sub-intern).

An attending will be available to the house officers at all times of the day. Each attending will perform teaching rounds five days per week with their individual teams and will cover the weekends within each firm. The housestaff are expected to use this attending as the primary resource for issues regarding patient care.

Additionally, during the weekdays, one additional senior PCCSM fellow will oversee admissions, procedures, and serve as a resource to the two MICU teams as needed. One PCCSM fellow is assigned to cover the MICU and emergency pulmonary consults in house overnight as a night-float.

ADMISSION SCHEDULE

The MICU accepts new admissions daily and are distributed between the two MICU teams by patient location. MICU Team A will be responsible for all patients assigned in 4A and MICU Team B will be responsible for all patients assigned in 4B. Patients admitted outside 4A or 4B will be assigned by the senior fellow. The fellow and resident must see and evaluate all admissions assigned to the intern and medical students who they supervise. The team's attending is always responsible for all activities no matter the time of day.

SIGN-OUT

Each MICU night float resident and intern team are responsible for cross-covering and admitting for one MICU teams overnight. Each MICU team signing out to the night float should provide a written handoff ("Physician Handoff") in addition to preparing for a verbal sign-out. Sign-out should take place in a protected, quiet space, and follow the I-PASS format. It is the responsibility of the team member signing out patients to update the Physician Handoff. The MICU team should arrive promptly to receive sign-out on their patients at 6:30 AM and the night float should arrive promptly to receive sign-out at 5:30 PM.

CALL

Interns
There is no overnight call for interns. The interns on service will alternate service coverage for each of the weekends during the rotation. Overnight coverage of the MICU is managed by a MICU Night Float intern in conjunction with the MICU Night Float resident for one week at a time.

Residents
There is no overnight call for residents. The residents on service will alternate service coverage for each of the weekends during the rotation. Overnight coverage of the MICU is managed by a MICU Night Float resident in conjunction with the MICU Night Float intern for one week at a time.

DAYS OFF

All house officers on MICU will get an average of one day off per week across the duration of the rotation. Days off will be designated by the Chief Residents and is available on AMION. Predetermining everyone's days off will ensure that days off are distributed fairly and that the appropriate complement of residents and interns are in the hospital at all times.

EXPECTED OR UNEXPECTED ABSENCES

Any planned absences, including for fellowship interviews, must be reported to the Medicine Chief Residents. You should also let the Pulm Consult fellow and other team members know if you will be absent from service so that patient care responsibilities can be redistributed accordingly.

CURRICULUM

EDUCATIONAL PLAN

The purpose of this rotation is to train residents to competently care for patients with a broad range of medical problems who require hospital admission to the intensive care unit. The rotation is designed to increase diagnostic skills, reasoning ability, therapeutic acumen, objective knowledge, overall patient care skills and team management skills.

CONFERENCES

Resident Lectures

Resident lectures are given by MICU fellows in 4A or 4B at 2PM as clinical work allows. Topics may include:

1. Ventilator basics
2. Ventilator weaning assessment, sedation, analgesia
3. MICU pharmacology and antibiotic usage
4. Vasoactive drugs: vasopressors and anti-hypertensives
5. Shock/ hemodynamics/ use of the pulmonary artery catheter
6. Acid base disorders/arterial blood gas interpretation
7. Surviving sepsis guidelines
8. Ventilator management of severe hypoxemia/ARDS
9. End of life issues and brain death
10. ACLS review
11. DKA/HHS
12. ICU Ultrasound basics
13. Hypertensive Emergencies
14. Post- Cardiac Arrest Care
15. Liberation from Mechanical Ventilation

Interdisciplinary Rounds

Interdisciplinary rounds occur as part of bedside rounds daily. Monday through Friday, Social Work, nursing, respiratory, pharmacy and dietary services will be on rounds. On the weekends, nursing an respiratory will be on rounds. Interns and residents should be inclusive of these other services when rounding, and make an effort to work closely with these important ICU ancillary services. Use of a daily checklist will include discussion of nutrition, DVT prophylaxis, central line, arterial line and foley catheter necessity, PT/OT, vent management, and skin issues.

EDUCATIONAL METHODS

Direct observation of patient care and bedside teaching occur in the setting of daily inpatient rounds with the attending. Residents evaluate and treat patients both in the capacity of follow-up as well as initial evaluation. The supervising attending reviews and critiques the resident's interpretation of diagnostic studies and formulation of assessments and plans. Residents additionally attend didactic conferences as indicated above.

EDUCATIONAL RESOURCES

- http://www.thoracic.org/
- http://www.chestnet.org
- http://www.sccm.org
- http://www.ardsnet.org/files/ventilator_protocol_2008-07.pdf
- http://www.ardsnet.org/files/pbwtables_2005-02-02.pdf
- http://www.survivingsepsis.org/Guidelines/Pages/default.aspx
- https://www.thoracic.org/statements/cc.php

EVALUATION TOOLS

The attending physician is responsible for providing verbal feedback and must submit evaluations of the resident physicians in MyEvaluations. The attending must meet face-to-face to provide mid-point and end-of-rotation feedback with all of the house officers they evaluate and indicate that discussion on the evaluation form. Evaluations must be completed within one week of completing a rotation. Peer evaluations for other trainees on the team should be completed in a timely manner.

PATIENT CARE

LOCATION & PATIENT CHARACTERISTICS

The ICU and CCU are separate services and closed units. Patients on the ICU service will be cohorted to primarily 4A or 4B depending on the MICU team.

- 4A/4B: Medical ICU (MICU)
- 4C: Neuro ICU
- 4D: CCU
- 5A/5B: Surgical ICU (SICU)
- 5C: Cardiothoracic ICU (CTICU)
- 5M: Burns ICU

The patient population at LAC+USC Medical Center is very diverse, with multiple ethnic and socioeconomic groups represented. The spectrum of these encounters will be from primary presentation of new disease processes to the tertiary care for the patient who is referred for subspecialty care. We also receive transfers from outside hospitals needing acute hospitalization for higher levels of care. Once the patient is stabilized and can be transitioned out of the ICU or CCU, the care for this patient can be reassumed by the general medicine ward service.

ADMISSIONS

All potential patient admissions are screened using Interqual criteria, and some undergo a secondary physician review regarding medical necessity for admission. Bed control is first informed of the admission, and once an assignment to a team is made, this is communicated to the MICU team. If the patient is in the ED or med/surg floor, physician sign-out to the accepting team will occur. Transfers from outside hospitals are arranged through the Call Center and are accepted by the MICU fellow directly.

Day Team Admissions: 6:00 AM – 5:00 PM
Night Team Admissions: 5:00 PM – 6:00 AM

TRANSFERS

If a patient is stabilized and no longer needs to be in the ICU, the patient can be moved from the ICU to the Telemetry Unit (8A), to a PCU (4M, 5F, or 8B), or to the med/surg floors.

Transfers from the ICU

When the ICU team deems a patient stable for transfer to a lower level of care, the medicine team will be notified by Bed Control that a patient has been assigned to the medicine team. The medicine team should call the ICU team to receive sign-out. A Transfer Summary will accompany all patients being transferred out of the ICU. The medicine team should addend the Transfer Summary upon transfer of care.

Transfers to the ICU

Patients that a medicine team deems to require a transfer to a higher level of care will have the care of the patient assumed by the ICU team. To initiate an ICU transfer, first notify Med Consult that there is a patient who necessitates transfer. Med Consult will then evaluate the patient and discuss the case with the ICU Fellow. If determined to be an appropriate ICU transfer, Med Consult will notify the team to place orders and to give sign-out to the ICU team. All transfers to the ICU must be

accompanied by a Transfer Summary from the ward team. The ICU team is expected to write transfer orders and reconcile all prior active orders.

DISCHARGES

The decision to discharge a patient and the discharge plan must be discussed with the attending each day. This discharge plan should also be discussed with the patients. All hospital discharges require Discharge Instructions and educational material for the patient, appropriate medication reconciliation and prescriptions, appropriate follow-up referrals or appointments, an electronic discharge order, and a Discharge Summary (please see below).

Transfers to other healthcare facilities (another hospital, long-term acute care (LTAC), skilled nursing facility (SNF), rehab, etc.) require a Discharge Summary (please see below). Additionally, a triplicate form, which can be obtained at each nursing station, will need to be filled out and signed by a licensed physician prior to transfer.

RAPID RESPONSE & CODE BLUES

If a patient appears acutely unstable, do not hesitate to call the fellow on your team or the supervising float fellow. Always document goals of care discussions, even if the decision is to remain full code. Keep in mind that the code status obtained during the hospitalization is dynamic and only relevant to the current hospitalization. It does not necessarily hold true for the next hospitalization unless the patient has a signed a POLST or on discussion with your patient, he/she reiterates his/her desired code status. Upon discharge, a POLST form should be completed in an effort document goals of care. The pink original goes with the patient and a copy should be placed in the chart for scanning into ORCHID.

PLACING CONSULTS

Decisions to consult a different service should always be discussed with the attending of the team. The consultant can be reached either through the operator (dial "0" from any hospital phone) or through AMION. Remember to be courteous when calling the consult and have a well-defined question for your consultants. Please give your consults enough time to see your patients, so try placing consults as early in the day as possible.

PROCEDURES

Prior to performing any procedure, an informed consent must be obtained and placed in the patient chart. If a translator is used to obtain consent, this must be documented. For any procedure, residents must be supervised by an attending physician or a senior resident until they have logged 5 instances of performing said procedure in MyEvaluations. Procedures that require attending supervision regardless of the number of times the resident has performed the procedure include central line placement and thoracenteses. Interns and residents will have the opportunity to perform basic procedures including but not limited to: lumbar puncture, thoracentesis, paracentesis, arterial blood gas, and venipuncture. In addition, interns and residents may have the opportunity to perform arterial and central venous line placement under supervision of a procedurally credentialed physician.

DEATH

Deaths must be pronounced by a licensed provider on the primary team. All in-hospital deaths require a Death Summary to be written by the primary team. If a death is pronounced by the overnight cross-covering resident, he/she may write a brief Death Note to document the circumstances and death exam; however, a Death Summary still needs to be completed by the primary team.

Deaths in the hospital are not uncommon and may be an emotionally challenging experience. Housestaff are encouraged to discuss the experience of caring for a patient who has died with the team and/or chief residents.

DOCUMENTATION

All documentation must be completed electronically in ORCHID. Each note needs to end with "Discussed with Attending Dr. [Name]" and be forwarded to the attending on service for the day for review.

History & Physical

H&Ps must be written and signed by the attending within 24 hours of admission. The assessment and plan of each note should be systems and problem based. Be sure that these problems include detailed descriptions (ie. acute vs chronic hypercapneic vs hypoxemic respiratory failure). In ORCHID, the note type, "History and Physical" should be used.

Daily Progress Note

A daily progress note must be completed for each patient unless an H&P or Discharge Summary will be written for the day of admission or day of discharge. The assessment and plan of each note should be systems and problem based. Be sure that these problems include detailed descriptions (ie. acute vs chronic hypercapneic vs hypoxemic respiratory failure). Daily progress notes must be forwarded for evaluation to the attending of the team. In ORCHID, the note type, "Adult ICU Progress Note" should be used. In addition, daily ad hoc charting of "Adult ICU progress note required details" should be completed.

Central Line Necessity

It is important to document Central Line Necessity and restraint need daily in ORCHID through the Ad Hoc template. This is part of the Adult ICU progress note required details"

Discharge Summary

Discharge Summaries are required for any discharge from the hospital and should be completed within 24-48 hours of discharge. This includes discharges against medical advice or elopements. In ORCHID, the note type, "Discharge summary" should be used. Discharge summaries should include the following:

- Admission date
- Discharge date
- Procedures or surgeries
- Consulting services
- Summary of hospital course
- Discharge diagnoses and medication
- Follow-up plan

Transfer Summary
A Transfer Summary is required when the patient is being transferred to another service (medicine wards, surgical service) or to another facility. The transfer summary should follow the format of the Discharge Summary above. In ORCHID, the note type, "Transfer Summary" should be used.

Death Summary
A Death Summary is required when a patient expires in the hospital. The Death Summary should follow the format of the Discharge Summary above. In ORCHID, the note type, "Death Summary" should be used.

MEDICAL RECORD DOCUMENTATION QUERIES

You may receive a message in your ORCHID inbox from Medical Records inquiring about specific diagnoses. Please make sure to respond to all messages in a timely fashion as it affects hospital funding.

ACGME MILESTONES 2.0

LEARNING OBJECTIVES

	PGY 1	PGY 2	PGY 3
Patient Care	• Resident will obtain a detailed history of the illness, emphasizing chronology of the events with good review of systems. • Resident's presentation will include pertinent positive and negatives findings • Resident will use nonpatient sources of data if cannot give a history for example calling the nursing home, the EMT, or the family. • Resident will be able to tailor the physical examination to patient's complaints. • Resident will be able to accurately identify and characterize the signs and stages of SHOCK (septic, cardiovascular, and hypovolemic). • Resident will be able to identify and characterize cardiac murmurs and sounds • Resident will be able to identify and characterized pulmonary auscultatory findings. • Residents should be proficient identifying and interpreting the following elements of the physical examination: blood pressure – orthostatics, pulsus paradoxus; cardiopulmonary – pulse examination – venous pulsations – JVD, hepatojugular reflux, v waves and arterial – carotid, femoral, and pulse character; palpation and auscultation – LV impulse (location and characterize) thrill, RV heave, regurgitant murmurs (AL, MR, TR), Stenotic murmurs (AS, MS), Pericardial Rub, S3 and S4, abnormal pulmonary findings – crackles, wheezing, egophony, bronchophony, dullness to percussion, abdominal findings – bowel sounds, fluid wave, shifting illness, neurologic – cold - calorics, asymmetric reflexes, strength and sensory	• Obtain a detailed HPI emphasizing chronology of presentation and containing good descriptions of systems • Resident's presentation will include appropriate pertinent positive and negatives • Resident will use appropriate nonpatient sources of data cannot give a history • Resident will tailor the physical examination to patient's complaints • Resident will be able to accurately identify and characterize the signs and stages of septic, cardiovascular, and hypovolemic shock.	• Resident will obtain a detailed HPI emphasizing chronology of presentation and containing good descriptions of systems. • Resident's presentation will include appropriate pertinent positive and negatives. • Resident will use appropriate nonpatient sources of data cannot give a history. • Resident will tailor the physical examination to patient's complaints. • Resident will be able to accurately identify and characterize the signs and stages of septic, cardiovascular, and hypovolemic shock. • Resident will be able to identify and characterize cardiac murmurs and sounds. • Resident will be able to identify and characterized pulmonary auscultatory findings.
Medical Knowledge	• Able to apply pathophysiology and perform focused, cost - effective evaluations of the following complaints/ disorders: • Approach to respiratory failure, acute and progressive dyspnea, pulmonary embolism, COPD, asthma, acute respiratory distress syndrome, Basic ventilator management. • Approach to patient with shock (septic, cardiogenic, hypovolemic), chest pain, cardiopulmonary arrest, hypertensive emergency, aortic dissection	• Be proficient in the diagnosis and therapeutic management including monitoring for the adverse effects of specific therapeutic management, including monitoring for the adverse effects of specific therapeutic interventions, for the following medical conditions/complaints: Cardiology - Shock (septic, cardiogenic, hypovolemic) chest pain, cardiopulmonary arrest, hypertensive emergency, artic dissection; Pulmonary - Respiratory failure, Acute and	• Resident understands the epidemiology, pathophysiology, and pharmacology of common critical illness including ARDS, multiple organ system failure, pulmonary embolus, shock, vegetative state and brain death, ketoacidosis and hyperosmolar coma, asthma and COPD, and psychosis/delirium in the ICU setting. • Resident will develop experience in the use of vasoactive drug.

	• Approach to GI bleed, acute liver failure, complications of liver failure • Altered mental status, seizures, stroke, intracranial hemorrhage. • Bleeding diathesis, DI, anticoagulation, VET treatment, HIT diagnosis and treatment, DVT prophylaxis in the ICU setting • Diabetic ketoacidosis, hyper/hypo -kalemia, hyper/hypo -natremia, hypo/hyper -calcemia, renal insufficiency • Nutrition fundamentals • Fever in ICU setting, line infections, meningitis, complications from HIV, community and health care associated pneumonia, fungal diseases, severe sepsis. • Drug overdose and poisoning • Begin to develop interpretative skills of: Oximetry and blood gases, Serum electrolytes, Chest X - rays, Results from thoracentesis, paracentesis, spinal fluid, Pulmonary artery pressure reading, EKG's (see cardiology ward objectives) • Know the indications, limitations, and complications associated with the following test/procedures: Mechanical Ventilation, Lung VQ scan, High -resolution CT, lower extremity Doppler, CT and MRI imaging of the head, chest and abdomen, Bronchoscopy and bronchoalveolar lavage, Endoscopy, Stress test - chemical or exercise stress testing, stress echo, stress thallium (also addressed in Cardiology ward), Transthoracic echocardiogram, transesophageal echocardiogram	progressive dyspnea, pulmonary embolism, COPD, asthma, acute respiratory distress syndrome - Basic ventilator management; GI/hepatology - GI bleed, acute liver failure, complications of liver failure; Neurology - Altered mental status, seizures, stroke, intercranial hemorrhage; Hematology - Bleeding diathesis, DI, anticoagulation, VET treatment, HIT diagnosis and treatment, DVT prophylaxis in the ICU setting; Metabolic & Electrolyte disorders • Diabetic ketoacidosis, hyper/hypo - kalemia, hyper/hypo - natremia, hypo/hyper - calcemia, renal insufficiency • Develop proficiency in the interpretation of: Oximetry and blood gases, Serum electrolytes, Chest X-rays, Results from thoracentesis, paracentesis, spinal fluid, Pulmonary artery pressure readings • EKG's (see cardiology ward objectives) • Appropriately order and understand the indications and contraindications as well as complications associated with the following tests/procedures: Mechanical Ventilation, Gastrointestinal endoscopy, CT and MRI imaging of the head, chest, and abdomen, Bronchoscopy and bronchoalveolar lavage, Lung VQ scan, High - resolution CT, lower extremity Doppler	• Resident will Resident will achieve or demonstrate competency in all ABIM required procedures as patient case mix allows. • Resident will demonstrate developing competency in the use ventilatory support.
Practice Based Learning and Improvement	• Attend all ICU conferences • Resident will present a minimum of one evidence based medicine review of a topic. • Patient will develop clinical judgment in the strategies used to match treatment protocols with critical illness. • Attend all autopsies preformed on patients expiring in the ICU.	• Resident prioritizes diagnosis and treatment decisions based on patient's severity of illness • Develop clinical judgment in the strategies used to match treatment protocols with critical illness • Present a minimum of one EBM review at topic review and presentation conference. • Attend all ICU conferences • Attend all autopsies preformed on patients expiring in the ICU	• Resident prioritizes diagnosis and treatment decisions based on patient's severity of illness. • Resident will develop clinical judgment in the strategies used to match treatment protocols with critical illness. • Resident will present a minimum of one EBM review at topic review and presentation conference.
Interpersonal and Communication Skills	• Resident communicates regularly with patients and his/her family. • Resident is respectful to patient. • Resident is concerned about the patient's comfort. • Resident communicates effectively with other members of the health care team.	• Resident communicates regularly with patients and his/her family. • Resident is respectful to patient. • Resident is concerned about the patient's comfort.	• Resident communicates regularly with patients and his/her family. • Resident is respectful to patient. • Resident is concerned about the patient's comfort. • Effectively coordinates team to optimize patient care. • Able to deal with challenging patients and families. • Functions as an effective team leader.

		• Resident addresses patient care issues such as end of life decisions with moderate faculty input. • Resident provides feedback to junior team members. • Resident functions as an effective team leader. • Resident communicates effectively with other members of the health care team.	
Professionalism	• Resident completes the H&P/consultation within 24 hours of contact, and writes a daily progress note. • Resident will follow through with scholarly assignments promptly. • Resident completes medical records on time. • Resident recognized and takes steps to correct his/her deficiencies. • Resident treats team members with respect, including nurses and other health care providers. • Resident acknowledges personal reaction to morbidity and mortality associated with infectious disease • Adheres to all ACGME mandated duty hour restrictions.	• Resident completes the H&P/consultation within 24 hours of contact, and writes a daily progress note. • Resident will follow through with scholarly assignments promptly. • Resident completes medical records on time. • Resident recognized and takes steps to correct his/her deficiencies. • Resident treats team members with respect, including nurses and other health care providers. • Counsel's junior team members on issues of professionalism including personal reactions to the morbidity and mortality associated with the care of patients requiring intensive medical management. • Resident adheres to all ACGME mandated duty hour restrictions. requiring intensive medical management. • Resident adheres to all ACGME mandated duty hour restrictions.	• Resident completes the H&P/consultation within 24 hours of contact, and writes a daily progress note. • Resident will follow through with scholarly assignments promptly. • Resident completes medical records on time. • Resident recognized and takes steps to correct his/her deficiencies. • Resident treats team members with respect, including nurses and other health care providers. • Resident adheres to all ACGME mandated duty hour restrictions • Counsel's junior team members on issues of professionalism including personal reactions to the morbidity and mortality associated with the care of patients requiring intensive medical management • Sets a tone of respect and collegiality for the team • Resident adheres to all ACGME mandated duty hour restrictions
Systems Based Practice	• Resident can effectively initiate the appropriate clinical pathways. • Resident can effectively initiate the appropriate consultative services • Resident develops a multidisciplinary approach to medical intensive care	• Resident can effectively initiate the appropriate clinical pathways. • Resident can effectively initiate the appropriate consultative services • Resident develops a multidisciplinary approach to medical intensive care • Resident serves as a consultant to other services with moderate faculty input.	• Resident can effectively initiate the appropriate clinical pathways. • Resident can effectively initiate the appropriate consultative services • Resident develops a multidisciplinary approach to medical intensive care • Resident serves as a consultant to other services with moderate faculty input. • Resident critically evaluates all consultant evaluations including conflicting recommendation to develop an effective patient care plan.