Norris Comprehensive Cancer Center
Oncology Orientation
2021-2022

Faculty in Charge of Rotation:
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First Day of Rotation:
Report to 3rd or 4th floor nursing station for sign-out at 7:00 AM.

GOALS

Medical Oncology, a subspecialty of Internal Medicine, involves the understanding, diagnosis and management of solid tumors. In contrast, the leukemias, lymphomas, and plasma cell dyscrasias such as multiple myeloma, are part of Hematologic Oncology. Medical Oncology is built on a firm foundation of basic internal medicine principles, and requires the acquisition of a detailed understanding of the biology of normal and abnormal cellular growth and growth regulation, invasion and metastasis. Experience in medical oncology brings a familiarity with clinical trial design, biochemical pharmacology and molecular biology, as well as the clinical diagnosis and management of all forms of cancer as well as management of oncologic complications. Many oncology patients have associated histories of cigarette smoking, alcohol intake and industrial toxin exposure, so they frequently suffer from a variety of intercurrent medical disorders, resulting in a significant level of experience in general clinical medicine during Medical Oncology rotations. The emotional and social problems associated with advanced cancer require multidisciplinary management and a team approach, in addition to a detailed understanding of a range of psychosocial issues.

Medical Oncology is a unique subspecialty that integrates traditional approaches to clinical medicine with biochemistry, molecular biology and clinical trial methodology. Part of the practice of oncology includes participation in clinical protocols during which novel anticancer treatments move from the laboratory to the bedside, and involvement in the discovery of the mechanisms by which newly discovered genes control the growth and spread of cancer.

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.

WEEKLY SCHEDULE

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
12PM – 1PM		Grand Rounds			
1:00 PM – 2:00 PM		MKSAP review		MKSAP review	

DAILY SCHEDULE

7:00 AM – 7:30 AM	Sign-out
7:30 AM – 9:30 AM	Work Rounds
9:30 AM – 12:00 AM	Attending 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
6:00 PM – 6:30 PM	Sign-out to Night Float resident

Work Rounds

The Fellow Work Rounds are an opportunity for the consult team to discuss and evaluate the consults from the night before and the difficult management cases with the fellow prior to rounding with the attending. A preliminary plan on each patient should be made at this time. Priorities for work rounds include addressing patients for discharge (as well as placing discharge orders), addressing sick/unstable patients, entering orders for diagnostic testing early, and calling in consultations early in the day.

Attending Bedside Rounds

Attending Bedside Rounds are performed from 9:30 AM – 12:00 AM every Monday through Friday. The attending should review all of the team's new admissions from the previous twenty-four hours and discuss all of the team's established patients with new, significant developments. 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

The team is made up of 2-3 PGY2 residents, 1 fellow, 1 attending, and 1 NP. The 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 team. The housestaff are expected to use this attending as the primary resource for issues regarding patient care.

ADMISSION SCHEDULE

The team is available to admit patients daily. All admissions will have been approved by the fellow or attending on service. The team's attending is always responsible for all activities no matter the time of day.

SIGN-OUT

Each medicine night float resident is responsible for cross-covering and admitting for both the Norris Oncology and Hematology teams overnight. Each 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 medicine team should arrive promptly to receive sign-out on their patients at 7:00 AM and the night float should arrive promptly to receive sign-out at 6:00 PM.

TRAINEE CAPS

Residents on this service will cover up to 8 patients per day. Caps will be maintained on the weekdays and weekends. This is to ensure that the environment on this service is optimal for your learning.

DAYS OFF

All house officers on the Norris Oncology Service will get an average of one day off per week across the duration of the rotation. Days off will be determined amongst the team members.

EXPECTED OR UNEXPECTED ABSENCES

Any planned absences, including for fellowship interviews, must be reported to the Medicine Chief Residents. You should also let the Oncology 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 acute and chronic oncologic diseases. The rotation is designed to increase diagnostic skills, reasoning ability, therapeutic acumen, objective knowledge, overall patient care skills and team management skills.

The curriculum is organized into three components:
1. inpatient oncology services
2. didactic lectures and conferences

CONFERENCES

MKSAP Review
Tuesdays and Thursdays MKSAP reviews with Dr. Spicer at 1 PM for all oncology residents on service. Please check with the service to see if these will be held via Zoom or in person.

Grand Rounds
A formal presentation every Tuesday at 12:00 PM in Norris Research Tower – LG Aresty Auditorium covering recent developments in tumor biology, molecular biology, clinical trial design, or new techniques in diagnosis and management. Speakers are drawn from the USC Medical Campus or from other cancer centers.

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 METHODS & RESOURCES

- DeVita et al. Cancer: Principles and Practice of Oncology
- New England Journal www.nejm.org
- Journal of Clinical Oncology www.jco.org
- National Comprehensive Cancer Network www.nccn.org (for each cancer type, goes through work-up and treatment for various stages. Text & Reference list at the end of each section)
- Adjuvant! www.adjuvantonline.com (gives statistical approximation of the risk reduction an individual may receive from adjuvant chemotherapy for breast & colon cancer, using age/stage/pathologic features).

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 Norris Oncology Service is entirely at the Norris Comprehensive Cancer Center and comprises of floor and ICU patients.

The patient population at Norris Cancer Center Hospital is very diverse, with multiple ethnic and age groups represented. The spectrum of these encounters will range from primary presentation of oncologic disease processes to the tertiary care. Patients receiving inpatient care are generally here for complicated acute or chronic oncologic disease. We also receive transfers from outside hospitals needing acute hospitalization for higher levels of care. The care for these patients will occur on either general medicine floors or ICU.

ADMISSIONS

All patient admissions are approved by the fellow and attending on service. Patients may be admitted for scheduled chemotherapy or if they have a complication from their oncologic disease. Residents will be made aware of any admissions by either the Oncology fellow on service or the attending physician. Once the patient arrives to an inpatient bed, the resident will be notified for admission orders.

Day Team Admissions: 6:30 AM – 5:30 PM
Night Team Admissions: 5:30 PM – 6:30 AM

TRANSFERS

If a patient is sick or unstable, the patient can be moved from a Med/Surg floor to the ICU on the 4th floor. If there is a change in patient status (i.e. death, transfer to ICU, change in code status/goals of care) please inform your fellow and attending promptly.

DISCHARGES

The decision to discharge a patient and the discharge plan must be discussed with the fellow and 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).

RAPID RESPONSE & CODE BLUES

If a patient appears acutely unstable, do not hesitate to call the Rapid Response Team. If your patient is decompensating rapidly and requires intubation or resuscitation, call a Code Blue. If there is a change in patient status (i.e. death, transfer to ICU, change in code status/goals of care) please inform your fellow and attending promptly.

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 PowerChart.

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 QGenda. 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.

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. All deaths must be communicated with the attending on service at the time of occurrence.

Deaths in the hospital are not uncommon, but 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 PowerChart. 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. In PowerChart, 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. Daily progress notes must be forwarded for evaluation to the attending of the team and must include a reason for hospitalization. In PowerChart, the note type, "Oncology Inpatient Progress Note" should be used.

Discharge Summary
Discharge Summaries are required for any discharge from the hospital and should be completed within 24 hours of discharge. This includes discharges against medical advice or elopements. In PowerChart, 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
- Follow-up appointments

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 PowerChart, the note type, "Death Summary" should be used.

ACGME MILESTONES 2.0

LEARNING OBJECTIVES

Patient Care	• Obtain an accurate and relevant focused history. • Perform an accurate physical examination and present information concisely with an initial assessment plan demonstrating clinical reasoning. • Follow the patient's disease course during the patient's hospital stay. • With attending consultation, formulate and execute a differential diagnosis, impression, and plan. • Appropriately document clinical encounters in the EMR • Learn to provide inpatient care that is safe and compassionate and to develop the ability to thoroughly and clearly educate the inpatient in the relevant areas of disease prevention, detection, progression and therapy to promote oncologic health.
Medical Knowledge	• Residents will have formal instruction and clinical experience and demonstrate competence in: o The systemic effects of oncologic conditions o the epidemiology, pathophysiology, and treatment of common malignancies, especially breast, lung, and colon cancer o Impact of cancer on other major organ systems o Side effects of most common chemotherapy drugs o Management of chemotherapy side effects
Practice Based Learning and Improvement	• Identify and acknowledge gaps in personal knowledge and skills in the care of inpatient and ambulatory patients • Demonstrate independent initiative in commitment to identify and follow through with learning issues. • Develop real-time strategies for filling knowledge gaps that will benefit patients in a busy practice setting • Seek feedback from attending physicians.
Interpersonal and Communication Skills	• Consistently establish rapport with patients and staff. • Present cases in a logical, focused manner and outline impressions that can be justified based on the clinical data. • Work as an effective team member with staff, dietitians, nurses, diabetes educators, and attending physicians. • Write appropriately thorough clinical record entry in standard form. • Communicate consultative recommendations to primary services in a respectful, timely manner. • Communicate productively with challenging patients and families • Addresses end of life decisions with patient and family • Skillful employment of techniques for palliative care and symptom management for end of life issues.
Professionalism	• Arrive at the hospital promptly, well-prepared with identified learning issues. • Assume responsibility for patient welfare in a timely manner • Performs administrative tasks and patient care responsibilities in a time and professional manner • Model effective teaching skills to students and peers. • Comply with Residency dress code
Systems Based Practice	• Understand and utilize the multidisciplinary resources necessary to care optimally for patients • Use evidence-based, cost-conscious strategies in the care of patients

	• Demonstrates collaboration with other members of the health care team, including residents at all levels, fellows, attendings, medical students, nurses, pharmacists, occupational/physical therapists, nutritional specialists, patient educators, social workers, case managers, and providers of home health services • Effectively utilizes of medical consultants, including knowing when and how to request consultation, and how best to utilize the advice provided • Develops competency navigating a different health system.