Expectations of Attending Performance
Inpatient Rotations Medicine Residency Program
Georgia Health Sciences University and VA Medical Center

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I. Clinical Competence

Attendings are expected to achieve and maintain the competency of a general internist sufficient to provide excellent care and serve as a role model and mentor to the resident and students.

II. Leadership

Attendings are the ultimate responsible leader of the patient care and teaching team. It is his responsibility to set standards and expectations of patient care and learning, orient the team to policies and procedures and ensure that the missions of excellent patient care and education/training are accomplished. Attendings do this by empowering residents and students to make decisions, supervising their activities, anticipating problems, correcting mistakes, giving immediate feedback, evaluating performance of individual residents and students face-to-face at least bi-weekly, counseling, encouraging, and assigning and following up on tasks. A good attending makes things go smoothly, facilitates prompt discharge planning, is efficient in the use of resources, and most importantly, has a clear idea of what is to be accomplished with each case and how to expeditiously accomplish it. The good attending leads by example, endows a sense of esprit de corps, facilitates team building by showing, then assisting the resident to be a team leader.

III. Time

The greatest single determinant of high quality attendings is the amount of time and effort expended. A minimum of 25 hours per week of direct patient care, teaching, resident/student evaluation and preparation are expected in order to do a satisfactory job. Free your schedule to accomplish this.

IV. Teaching

The attending is the primary teacher for the inpatient experience. The attending must educate and train the residents and students in the following manner:

A. Teaching Rounds

The purpose of teaching rounds is to ensure that the competencies to be achieved through the inpatient experience are actually met. This is accomplished through interactive discussion with residents and students to
To impart and assess their level of competence, specifically with the patients at hand. As dictated in the RRC requirements:

Teaching or attending rounds must be patient-based sessions in which current cases are presented as a basis for discussion of such points as interpretation of clinical data, pathophysiology, differential diagnosis, specific management of the patient, the appropriate use of technology, the incorporation of evidence and patient values in clinical decision making, and disease preventions.

i) On all inpatient and consultative teaching services, teaching rounds must be regularly scheduled and formally conducted.

ii) Teaching rounds must include direct resident and attending interaction with the patient, and must include bedside teaching and the demonstration of interview and physical examination techniques.

iii) Teaching rounds must occur at least 3 days of the week for a minimum of 4.5 hours per week.

Inpatient teaching rounds and management rounds may be functionally combined when:

i) There is a single physician of record for most or all patients on the teaching service, and

ii) That attending physician of record is also the teaching physician conducting teaching for those same patients, and

iii) The total time spent in combined inpatient rounds must exceed by a minimum of 4.5 hours per week the time required to supervise the care of patients, with this time dedicated to fulfill the requirements outlined above for teaching rounds.

At least 50% of the teaching should be done at the bedside with residents directly demonstrating interviewing and physical diagnostic skills, problem solving, and decision making. Residents should present evidence for their decisions based on evidenced based literature searches. They should be teaching students, themselves, and each other. “Canned” talks in the conference room by the attending are to be discouraged.

B. Review and Critique of Charts and Orders

1. Attendings are expected to review all notes and orders written by housestaff and students. Prompt correction and feedback is essential for them to improve their notes.

2. Attendings should review drug orders and laboratory orders daily.

3. Attendings are expected to review and formally grade at least one admission note and one discharge summary from each resident each month, discuss the performance with the resident and submit the critique to the program office after signed by the resident. This critique will become part of the resident portfolio.

4. Attendings should encourage cost containment and efficiency of orders.

5. Attendings should ensure use of “contemplated discharge” orders the evening before pending discharges, and that discharge orders, including CHF and pneumonia review orders are completed and
applied to all patients prior to discharge. Attendings should ensure that most if not all discharge orders are written before 0900.

6. Attendings must review and complete yellow death reviews of all patient deaths on their service. These reviews will be forwarded from the Medical Center QI Program.

C. Procedures

Attendings should be physically present for all invasive procedures, and insure that appropriate informed consent is in the progress notes. This should include full disclosure of indications and risks of the procedure. If the attending is not credentialed for the procedure, she or she should observe the procedure with a resident who is credentialed. The attending should assist or get assistance in supervising and critiquing the procedure if necessary. The procedure, if performed properly, should be documented and attested in the One45 system.

D. Discharge Planning Meetings and Discharges

Supervise the residents’ participation in discharge planning meeting with nursing, physical therapy, and social work staff. Assist in streamlining the discharge. Encourage resident dictations the night before anticipated discharge and encourage early morning discharge.

E. Teachable Moments

Use times of reviewing x-rays, lab results, pathology slides, and autopsies as premiere teaching moments. Try your best to get an autopsy on every case and attend it with the residents.

F. Conferences

1. Attendings are expected to complete work and teaching rounds in sufficient time to allow residents to write orders and attend noon conference. Rounds should be completed by 1130 each morning for this purpose.
2. Attendings must attend 0800 morning conference on days their team is presenting a case. This is to clarify the case, encourage the resident, and critique performance.
3. Attendings must attend morbidity/mortality conference the last Monday of the months of and following the attending duty in order to discuss morbidity (current month) and mortality (previous month).

V. Attending Notes

Attending notes should be sufficiently detailed to meet payer guidelines.
More importantly, they should demonstrate the pertinent aspects of the case to meet any legal claim, and demonstrate to other care-givers the decision-making process for that patient. It is still best practice that attending notes be capable of “standing on their own” if all resident and student notes were absent from the chart. Notes should be dated and legibly signed with printed or stamped names. You should insist that not only your note but resident notes meet this standard.

VI. Evaluation of Residents and Students

A. Feedback
Feedback should be given nearly daily to each member of the team. Feedback should be usually private (especially if negative), include first positive statements, then statements of specific items needing improvement. Examples include a more concise history that is chronological, a more accurate and detailed cardiac examination, consideration of psycho-social-economic-patient preferences in care, etc.

B. Mid-rotation Summary Evaluation
The attending should use a copy of the monthly evaluation to direct the resident to those areas needing improvement before the end of the month. Be specific within each of the six competencies. Incorporate your chart review and chart critique. Give a tentative score and tell them what would increase their score. Have them sign the copy, and each of you keep it until the end of the month. (Expect 15-30 minutes per resident to do this, and use it instead of teaching time)

C. End of Rotation Summary Evaluation
At the end of the month review the mid-month evaluation form along with a copy of your One45 end of month evaluation. You should complete the One45 evaluation prior to the last day of the month, save the draft on the computer and use a printed copy to discuss with the resident. Determine whether improvement was made. Discuss the mid-month and final evaluation form with the resident. Obtain the resident’s perspective on how he or she might have improved performance. Have them understand their weaknesses and strengths, and how to improve. Document this discussion on the final version of the One45 milestone evaluation and submit it no later than 4 days after the end of the rotation.

VII. Expectations Checklist for Attendings

<table>
<thead>
<tr>
<th>Item</th>
<th>Date Expected</th>
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<tbody>
<tr>
<td>Orientation of Team</td>
<td>First Day of Rotation</td>
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<tr>
<td>Feedback</td>
<td>Daily to each resident and student</td>
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<tr>
<td>Teaching rounds</td>
<td>4.5 hours per week/ 50% bedside, learner directed</td>
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Conferences
- Discharge planning: weekly
- AM report: when team presents
- M&M: last Thursday of month and month following

Evaluations (face-to-face)
- Inpatient record review: one blue sheet per resident/intern
- Mid-month evaluation: each resident before end of 2nd week
- End-month evaluation: each resident before end of rotation
- Submission of One45 eval: by 4 days after end of rotation

VIII. Attending Accountability

Attendings will be evaluated by the residents regarding both their teaching and clinical performance on One45. Attendings will be informed by the 10th of the following month if they are delinquent in their One45 evaluation of residents. If attending persist in tardy evaluations or deficiencies in teaching or patient care, they will be discussed with the appropriate Department Chairs and barred from future attending opportunity and/or financially penalized according to Department Policy.

Further Tips on Inpatient Attending

7 February 2011

The Medical College of Georgia is committed to providing excellent patient care and educating Resident Physicians in an efficient manner. The following model has been adopted to assist the Attending Physician in achieving this goal:

Education and Attending Rounds
1. The role of the Attending is to facilitate patient care of and education of Residents and students.
2. Formal Attending rounds should be no longer than 1.5 hours and should not occur more than once a day with the exception of short evening rounds on overnight call days (soon to have no overnight call with new duty hour restrictions). To facilitate this, it is often prudent to only see new and very sick patients with the team and others independently on your own time. The house officers need time to get their work done to fall within the duty hour restrictions.
3. Post call rounds should begin between 6:30 and 7:30 AM to get the team out quickly. On Friday and Saturday overnight ward calls, consider rounding in the evening on recently admitted patients to get credit for the date of admission and to facilitate efficient patient care. Use morning rounds, with refreshments, to discuss new admissions and see them, as well as very sick patients, with the team. See the rest of the patients independently on your own.
4. Consider early afternoon rounds on Sunday by yourself if no admissions on Saturday (i.e. no new patients). The team can see patients on their own in the morning and page you if needed. Discharges for that day would already be planned. You can then round on your own in the afternoon. This facilitates autonomy for the house officers and helps them have a short day and go home.
5. Let the residents and students do their work. Attendings should follow behind, seeing what they have done and written and how it relates to his/her view of the situation. The attending reads the notes, corrects, and gives feedback on what should be done or written better with concentration on errors of omission, failure to write out the big picture, what progress or lack of progress is actually occurring, and especially concern the residents with safety issues, simplification of management, cost issues, ethical issues, and prognosis.

6. Be aware of the interests, strengths, and weaknesses of each team member. Spend at least 20-30 min with each one during the rotation doing something together, preferably seeing a problem patient.

7. The work up and therapeutic interventions should be limited to the reason for admission – not a total tune-up of every broken part.

8. Try to encourage the use of published guidelines available online.

9. Involve the palliative care team early for chronic pain patients and for patients with uncontrolled symptoms as well as those with hospice needs. Encourage family meetings and involvement of the chaplains frequently and early in the hospital course.

10. Use consultative services appropriately. Use IR for most timely surgical interventions if possible.

11. Ask psychiatry to see patients who are obviously psychotic and need to be transferred to inpatient psychiatry.

12. Time and date all notes. Use ICD9/10 codes for diagnosis.

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**Discharge Planning**

1. Plan ahead if patients are to be discharged the morning after an overnight call. Making the decision post-call and expecting the house officers to do all of the necessary work to discharge patients is not compatible with the duty hour rules as it prolongs the time house officers are in house post-call. If the decision is made after an overnight call to discharge patients, it is the responsibility of the Attending physician to do the necessary discharge work and counseling to assist the house officers in leaving the hospital in compliance with ACGME duty hour provisions.

2. Develop an overall care plan on admission. When appropriate, PT, home health services, follow-up, etc. should begin at time of admission. A formal weekly discharge planning meeting with the discharge planning team plus nurses is critical.

3. All diagnoses should be on the discharge form and dictation. If a patient has ever had a diagnosis of CHF of any kind, they will forever need written instructions on diet, weight, etc. documented as this data is monitored for quality assurance purposes.

4. Be willing to pitch in by writing some orders or discharging and dictating a patient or two yourself. The latest ACGME guidelines regarding duty hour restrictions place more restraints on the Residents.

5. Give printed materials to patients and families on how to care for themselves prior to discharge.

6. Make and publicize to nurses and patients (the bed white board) the target date of discharge. This allows family and ancillary staff to plan (i.e. Family can pick patient up at 0730 and then go to work). Plan and make sure everything happens that is supposed to happen before the time of discharge.
7. Use Christ Community Clinic and other resources for indigent care. Keep a list of these patients for the Program Director to review for a compliance measure.
8. Try to avoid drawing labs the morning of anticipated discharge. Most labs should be drawn the day before discharge so that appropriate discharge planning measures can be instituted.
9. In planning for discharge, remove unnecessary monitors, foleys, extra lines, restraints, etc. and switch to discharge PO meds as early as possible as determined by medical necessity. Purge all “convenience” orders to make nursing life easier.

Please use this as a guide only. Every attending has personal style that can be beneficial to the team environment, and this is not meant to discourage that. In discussions with various attendings and house officers, the above model seems to be appreciated by all. Of note, MCG is currently in the process of having a specific ward designated per team to aid in efficiency as well. Thank you for all of the hard work that you do on a daily basis for our patients and our residents!