The Basics

For your intern year, all but one month is spent outside the OR and anesthesiology department. Even so, you are still a member of the department and are invited and encouraged to GO TO EVENTS when you can (e.g., Journal Club, Grand Rounds, Town Rounds, resident meetings, etc.).

Take advantage of all off-service rotations (e.g., learning about PFTs in Pulmonology) and do as many procedures as you can on Medicine and Surgery.

You have a mailbox in the residents’ area. Check it frequently—you get mail even as an intern, and some things that you need to sign and return to Susan Dawkins, the program coordinator, are time sensitive.

If there is a problem with scheduling, call, vacations, whatever, on off-service rotations, Susan Dawkins is your friend and can facilitate a solution—know her e-mail (sdawkins@gru.edu) and office extension (1-4544).

Dr. Mark Banks (pager 1096) and Dr. Sean Crane (pager 5826) are your new anesthesiology chief residents. If you have problems or questions, particularly those that are best addressed by a fellow resident, it is reasonable and acceptable to ask either Mark or Sean.

Paging system: Call 706-721-PAGE (7243) or 1-PAGE (1-7243), then type in Pager ID, # key, your return extension, Star key, Your Pager ID, and then # again. It is also helpful to learn how to change your page status over the phone (this will be especially important on Medicine). The Medicine residents know how to do this, so ask them.

For your Medicine and Surgery (floor) rotations, call one of the interns on the team that you’re starting with on the day before you start, to get checkout. For example, you will begin a new rotation on the 1st of every month. On the day before you begin (the 30th or 31st), call the intern on the rotation that you are about to start. This way, you will know which patients to see on the morning of the 1st.

Books

Important ones are in bold; you can go ahead and get these. Keep your receipts; you can be reimbursed, but not until your second year, when we can access your book money.

- **Pharmacopoeia or Epocrates**—this will be helpful with drugs and pharmacology.
- **Mini Maxwell’s Quick Med Reference**—great for ACLS algorithms, admit orders, and those other equations that you’ll always need to look up.
- **Pocket Medicine** by Sabatine—aka, “The Red/Green Book”—a great quick reference for Internal Medicine that will fit in your coat pocket. Lists all kinds of problems and diseases and gives concise differentials and recommendations for treatment. (If you don’t get any other books for your intern year, get this one.)
- **The Washington Manual**—like Pocket Medicine but difficult to fit into coat pocket. Not as concise, but very thorough.
• **The ICU Book** or **The “Little” ICU Book** by Marino—aka, The Blue Book—this is a good supplement to ICU months depending on how early in the year you have ICU rotations (good explanation of ventilators, weaning, shock, etc.).

• **Johns Hopkins ABX Guide for iPhone and iPad**—a little expensive but a quick and convenient guide for use on Green Medicine months if you need help with antibiotics.

To access **UpToDate** at the hospital, simply type [www.uptodate.com](http://www.uptodate.com), or Google search uptodate, on any networked hospital computer.

You have access to Citrix, PowerChart, UpToDate, Micromedex, Lexicomp and many other resources at home through GRU using the Citrix Portal: [https://citrix.gru.edu](https://citrix.gru.edu)

To get to UpToDate through the VA hospital: open the VA Augusta Home Page from the desktop and scroll down. Toward the bottom right of the screen, there should be a link to library resources and UpToDate.

For anesthesia books, log onto our intranet ([https://paws.gru.edu/pub/anesthesia/](https://paws.gru.edu/pub/anesthesia/)), and click on Resources for links to a number of anesthesia e-books including “Baby Miller” which you will need in June when you have your anesthesia intern rotation and in July, the first month of your CA-1 year.

**Step 3**

Crush Step 3, First Aid for Step 3, Boards and Wards, Kaplan Qbank and USMLE World. Your best bet is to pick a book and go through it, then do all of the questions from USMLE World or Kaplan.

Interns are expected to take Step 3 during their intern year. Take it after you complete your Medicine rotations. You should try to take Step 3 during a laid back rotation where the hours aren’t too long. (Pulmonary, Pain or Emergency Medicine rotations are easy months where you get off early and work less.)

Register through a state like Delaware which has no requirements for amount of residency completed (Georgia requires 9-12 months before you can be eligible). It makes no difference which state you register through; you can take it anywhere. When you take it, plan on signing up for it and scheduling a date and THEN asking for time off to take the test.

**Pulmonology**

**Schedule**

This is a Monday through Friday rotation, no weekends, no holidays!! This in an Inpatient CONSULT service. You should arrive at 8 am and generally be done by 3-4 pm. No weekends, no call. It is generally one intern, occasionally a Medicine resident, a Pulmonary fellow, and the attending. Workload is dependent on which fellow you get and whether or not there are medical students with you for that particular month. Also, sometimes Pulmonology will have to cover the overflow from the MICU, during which times you may have to cover a patient or two.
**Expectations**

See your patients when you get in, write the notes, and round with the team. There is usually a lot of downtime during the day. Rounds are variable and, depending on who the attending is, what day of the week it is, and how busy the service is, you might round in the late AM or sometime in the late afternoon. Pulmonary takes care of MICU overflow patients (any patients more than 18) on weekdays; sometimes the fellows ask for your help. Technically, you are on a consult service but you are a physician and this is your team, so it is appropriate to help that team and attend to patients (even if you don’t want to or it doesn’t make sense). Besides the patients that overflow to Pulmonary are the ones closest to d/c to floor so it’s usually pretty straightforward. Pulmonary does a lot of bronchoscopies and the suite is in the corridor that connects MICU A to MICU B—don’t expect to perform the bronchoscopy on many patients as this is the fellow’s domain. There is also a Pulmonary Consult “clinic” which can vary by month, based on the attending, but there are usually a few patients a week that you may be asked to see—these are outpatient issues (think COPD) that pulmonary has been asked to see by the ER or other primary care.

**Helpful Hints**

This is a month you are allowed to take vacation. Contact the Pulmonary Medicine office to put in a request for scheduling. You can get a vacation request form from Susan and take it to their office on the 5th floor back toward the elevator; they’ll most likely approve it. Submit requests early.

This is a great month to learn PFTs. The attendings are very knowledgeable and willing to teach. A lot of the patients are cystic fibrosis patients—know the disease well. Always check for PFTs and echos and print out their results because you will definitely be asked.

Dr. Gossage is rarely the consult attending, but if he is, his specialty is Pulmonary Hypertension. Read up on it. He is nice to work with but very thorough in his clinic and may not round until very late afternoon or evening. He is also very big on occupational and exposure histories on his patients.

More patients are presenting with HIV. Know some of the respiratory diseases associated with it. If you have the opportunity (and definitely mention it to the attending if you don’t want to ask for yourself) visit the PFT lab and ask the ladies that run it to have you do PFTs—it’s “fun” and a good learning experience (it isn’t as easy as it sounds).

**Emergency Medicine**

**Schedule**

This is a shift rotation. Day shift: 7 am-4 pm. Evening shift: 3 pm-12 am. Night shift: 11 pm-8 am

The ED chief resident will send you an email prior to your rotation with a YouTube link. Watch it! It walks you through everything you will need to know about the rotation.

ED morning report occurs at 7:30 am in a small conference room in the back right (as you walk in) of the EM department. You’ll have approximately 14-18 shifts during the month (which means you will only work 14-18 days out of the month).
You will sign up for patients via the computer (ED Track), see the patient, and then run the plan by an attending. This is a very self-motivated rotation. You can be as involved in traumas or level I/II as much or as little as you want though the EM residents tend to snap them up VERY quickly. You’ll end up having almost 2 weeks off over the course of the month and free time is valuable during residency so plan accordingly. We are scheduled as “back up,” meaning that we are essentially extra personnel. They can get by without us but since they have us they try to schedule us at times that they’re likely to need us most. The downside is that it makes it tough to switch shifts around. Depending on the EM chiefs, you might be able to swing it.

**Expectations**

Show up for your scheduled shifts. The ED residents are not going to give up intubations or procedures easily so get in there if you want them. You will have to be aggressive to get procedures. Be careful and respect the turf of the residents. You can easily dig yourself into a hole even if you steal something small like an A-line. Most of the time they will cover all of the trauma and critical patients. Sometimes the night shift can slow down—DO NOT SLEEP—especially in a public place! If you are deemed to be a hard worker, life is usually easier. If night shift slows down and the attending is cool, you might even go home several hours early.

**Helpful Hints**

This is a month that you can take vacation, but keep in mind that you may still be scheduled to work the same number of shifts. Contact EM Chief Resident for scheduling (same deal as the other vacation months—get vacation request from Susan and submit it to the service).

Medical students only work with EM residents. Residents will notice if you are not working and will see that you are not signed up for any patients on the board (this can be very important to certain residents). Generally, have your name signed up for 1-2 patients, that you are actively working on and you will be safe.

You may be asked to do an EM morning report.

**YOU NEED A CHAPERONE (i.e., nurse, attending) IN THE ROOM FOR ALL PELVIC EXAMS.**

**SICU/CTICU**

**Schedule**

The schedule on this rotation varies. As an intern you will be spending 2 months in SICU. You might be on the day or night shift. It depends on how many interns we have during that month. If you are the only intern, then you would be working all nights. If there are two interns, then you will rotate between the day and night shift.

The day shift is 6 am to 7 pm Monday through Friday. On weekends you get off in the early afternoon. You get two weekends off a month. The night shift is 9 pm to 10 am the next day. Arrive in time to see your patients and write your notes (usually arrive at 6 am to 6:30 am). Have a plan...ask the upper levels what the plan is if you are unsure. You will have up to two weekends off a month.
The time of rounds may be different each day, and often, you will have a different attending each day. (Anesthesiology Grand Rounds are 7 am to 8 am in the CHOG Conference room and you are encouraged to attend.)

Afternoon rounds usually occur around 2 pm to 3 pm and are usually just to go over what has happened during the morning. You typically will have 1-3 patients. The team consists of a SICU attending and CT Surgery attending, two upper level Anesthesia, and one or two Surgery/Anesthesia interns. There may also be medical students. SICU attendings sometimes give lectures at 11 am.

**Expectations**

SICU, especially CTICU, can be very overwhelming so it is important to remain ORGANIZED. **Print daily reports which have all the lab, vitals and medications. Use pre-printed progress note sheets (residents will show you where they are) and lab forms.** It is expected that you know what drips, labs (and trends), antibiotic day #, line day #, microbiology (check cultures EVERY DAY), etc. Especially if your SICU month is early on, you will not be expected to come up with plans and manage these critical patients, however, you better know everything about them!!

Definitely have their home meds and past medical histories readily available. It is a good idea (highly recommended!!) to **make a “to do” or check sheet during rounds.** Then check to make sure all orders are entered on the computer, lines placed, vent changes made, etc. In addition, rounds go more smoothly if you work as a team—someone should operate the computer (to check pending labs, results and to enter orders). Also someone should have the patient’s chart in front of them so if you need to check a consult note, recall a patient’s home meds, etc., it can be done right then. If a patient is being transferred out, the ADMITTING team (usually) writes the transfer orders other than CT patients—who usually have pre-printed orders that we select appropriately. Sometimes the CT attendings, but usually the PAs, will write orders for CT patients. Either way, let the primary team know early or often that transfer orders can be written so the patient can get a bed on the floor.

**CTICU**

The first few hours after an open heart case are very critical in maintaining blood pressure control (via drips), UOP, and CT output, and sinus rhythm. The attendings will call frequently requesting this information (if you are the only one there, grab the flow sheet and pull up their latest labs in Citrix—“that’s not my patient” is definitely “NOT” an excuse) and you MUST HAVE IT AVAILABLE DURING AFTERNOON ROUNDS if the case was finished before rounds. The CTICU is one rotation where calling because you are concerned about something will never get you in trouble, however, not calling and something happens is bad form! Particularly in your early months, let the upper levels take care of the hearts—learn the ropes, then take over. The CT Surgery attendings are sometimes less available and the patients often have more going on, particularly in the beginning.

**Helpful Hints**

**It is primarily the intern’s job to order AM labs (BMP, CBC, mag, phos, ionized calcium) and CXR (for intubated patients) for EVERY patient in the SICU.**
For Monday and Thursday labs, order a **CMP instead of BMP**, and prealbumin. If a NEW patient is on the vent or has an A-line, get an **ABG** and get **PT/PTT/INR**, especially if the patient is coagulopathic. Most attendings do not require progress notes to be finished prior to rounds.

Presenting your patient basically consists of reading your progress note. A SICU Admit note is similar to any other H&P but is more focused and concise. A brief HPI consists of procedure and reason or events leading up to it, then an Intra-Op course (fluids, EBL, UOP, anesthesia and surgery times, any complications—look at the anesthesia record for this. It is found in the patient’s Paper Chart!), then PMH, PSH, etc., followed by exam, labs, imaging. The assessment and plan are usually very brief and similar to those in daily notes.

Be nice to the nurses, clerks, and respiratory therapists; they can make your life easy or a living hell. **Also, they usually know more than you do!** Ask the RTs what they think about vent changes, ABG results, and any other questions you may have. Usually if they are not too busy, they can teach you a lot. Don’t forget to look in the Respiratory tab on PowerChart for secretions color, PIP, plateau pressure, static compliance and airway resistance.

Try to get access to CompuRecord via your Citrix account (it is the program we use for anesthesia records in the OR). Email Aubre Keenan in the anesthesia office for help. You can learn the program and “watch the board” and monitor cases that you know are or may be coming the ICU. If you know of planned admits to ICU early in the day, look them up on PowerChart. Usually there is an H&P on file and you can begin your admit note and have most of it done before the patient arrives!

Important things to follow closely and call upper level that might not otherwise be viewed as important:

- Low urine output
- Increased chest tube output

Always call:

- Before giving a blood product transfusion
- For all line placements
- For admission of all new patients, even if straight forward and relatively stable
- Ventilator changes

**CCU-MCG**

**Schedule**

This is a 7-day-a-week rotation, with one day off per week. Rounds are usually around 9 am. The team consists of two upper-level Medicine residents and 2-3 interns. Typically the census is 10-15 patients, but can be up to 25-30. This is a **very fast-paced rotation, admitting and discharging numerous patients a day**. You will be covering CCU and ward Cardiology patients. To stay within duty hours, they sometimes allow interns to alternate days leaving early. (This must be discussed and agreed upon with your fellow interns and residents.)
**Expectations**

Know your patient. Know when their last Echo, Cath, Stress test, clinic visit was (and have results and recommendations). Always have a new admit’s EKGs available during rounds. At some point during the month, you will be expected to present on a cardiology topic during rounds. It will not be terribly in-depth, and luckily it will be pertinent to one of your current patients. So definitely pay attention during rounds!

**Helpful Hints**

KEEP UP ON THE DICTATIONS—this rotation is worse than ward Medicine because patient turnover is so high; you’ll easily have 20 dictations in one week! Take some time to read some ECHOs with the attending/fellows. There is less time for teaching but you learn a great deal by admitting patients and repetition (many of these patients are rule-out MI and very similar).

**Medicine**

**Schedule**

This is a 7-day-a-week rotation with call q4. A typical day is from 7 am to 3-4 pm. Call days are 7 am to 7 pm (except Saturdays which are 7 am to 9 pm) every 4 days.

Teams consist of the attending, an upper level Medicine resident, 2-3 interns, a sub-I (who acts as an intern; you may not always have a sub-I), and 2-3 junior med students. Rounds are attending-dependent. There is **morning report every day at 7:30 am** (and as an off-service resident, you are not required to attend). **Grand Rounds are on Wednesdays** at 12 noon (not required to attend, but there is free food). There is **noon conference daily**, occasionally with food (not required for us but often informative).

On days when you are not on call, you can leave as early as 2 pm, however, you must check out your patients to the on-call team or the intern on call; and if you do so, you must leave your pager on until 5 pm.

**Useful Information**

We will ask the chief residents to include you on the emails when they make the schedule. If you’re smart you’ll email them a week or two before the month starts to get the call schedule. Verify that it is the correct schedule a day before you start—sometimes they change it and do not tell you.

**Expectations**

Nursing home patients must be out and to their respective place before 2 pm (preferably earlier) or they will be sent back (they also don’t accept patients on the weekends).

**Helpful Hints**

There must be an intern H&P on admission (sometimes residents will do it for you but don’t get your hopes up) and daily progress note for EVERY patient (sorry, med student note is not enough. Make sure you sign it though!) At the end of the month, transfer/off-service notes need to be written if patient has been in-house for longer than a few days (hospital course, studies,
microbiology, current issues, and discharge plan). The really nice ones dictate an interim summary also.

Always discuss code status with every patient when they are admitted! **START DISCHARGE PLANNING THE DAY THE PATIENT IS ADMITTED!!** Will they be going home or to a nursing home? Home health? Do they need any devices (walker, shower chair, bedside commode)? Each team has its own social worker who needs to be your best friend (they will not be!!) There is a weekly planning meeting with Social Work, Nutrition, and the team specifically for discharge planning—it’s annoying but very important to make time for. Don’t make this your only planning though—**talk to Social Work DAILY!!**

Renew fluids, restraints, non-attending DNR notes before leaving so night float doesn’t get called. If a patient has the possibility of needing blood and a CBC is pending, fill out the blood form and consent before you leave.

**DO NOT LET YOUR DICTATIONS PILE UP!** Nothing is worse than having to go back and do 20 dictations (and they will call, page, annoy, threaten to hold your paycheck, send nasty grams to Susan and who then send nasty grams to you, etc., if you don’t get them done).

Know your ACLS algorithms—you will use them for codes.

You get 4 days off per month. Plan wisely and try to space them out. You’ll be wise to take them on weekdays since weekends are usually a shorter workday. Unfortunately/luckily you do not have clinic during the month; your other team members do. Try to be a TEAM and not leave one person with all the patients for rounds. If you happen to get sick during the month, your attending, the Medicine GME office, as well as Susan Dawkins need to be notified (required). Probably should let your resident and other intern know too!

**General Surgery Rotations**

**Overview for Off-service Residents**

There are service-specific duties you will be asked to perform, but generally the primary responsibility of all interns is to manage the floor patients and assist in clinic. This will typically mean pre-rounding on all inpatients followed by rounds with the service chief resident. “To do” lists are generated during rounds for completion. Whenever there is clinic, the interns are expected to participate unless there are pressing floor matters to attend to or they are able to go to the operating room.

You are generally required to be there from 6 am to 6 pm Monday through Friday. On weekends, you get off in the early afternoon but you will still need to be there at 6 am or earlier. You are required to check out your patients with on call or night float interns. You normally get 2 weekends off a month.

Keep in mind that the progress note for patients on the day of surgery have to be completed before the patients are sent to the OR.
The contact person for any given rotation will be the chief resident of that service.

**Acute Care Surgery**

Average 8-12 floor patients. You will likely be the only intern on service. Busy clinic schedule, with clinic 3 days a week. **Responsibility is floor patient care.** You will, on occasion, be asked to assist with seeing new consults and to scrub in on OR cases. Operative experience is minimal, unless you request otherwise.

**GI Surgery**

Average 10-15 floor patients. There will be 2 interns on service for all but 5 months. Very busy clinic schedule with clinic 4 days a week. **Responsibility is floor patient care.** Interns will, on occasion, be asked to assist in seeing new consults, and to scrub in on OR cases. Operative experience will be minimal, unless you request otherwise.

**Surgical Oncology**

Average 5 floor patients. Clinic is 2-3 days weekly and interns are expected to participate. Be very aggressive to get OR time because the attendings will let interns place central lines during vascular access cases.

**Primary responsibility is floor patient care** but may be asked to assist in seeing new consults. Should have some operative experience, especially in central line placement.

**Trauma**

Average 15-25 patients. There will be 2 interns on service all but 5 months.

Minimal clinic duties—2 afternoons a week. Interns are expected to participate unless dismissed by the attending or chief resident.

**Primary responsibility is floor patient care.** You will rarely be asked to assist with new traumas, though you are always welcome to participate if available. Minimal operative experience.

Make friends with physical therapists, social workers, case managers, and the nurse practitioner. Many trauma patients will need PT, walking aids, home health, or LTACH/nursing home placement on discharge. Start planning early. PT will tell you what your patients will need for discharge. Social workers with be able to provide the equipment. Case managers can set up transfer to LTACH or NH. Cassie Alexander is the trauma nurse practitioner. She is very helpful if you are on your own on the service. She can discharge patients, print prescriptions and knows how the trauma service works. The more interns on the service the easier your life is. Sometimes there is a night intern who helps you with the morning rounds.

**Vascular/Transplant**

Average 5-15 patients. Attendings: Drs. Wynn, Merchen, and Agarwal.
Expected to participate in clinic, typically 2-3 days a week. **Primary responsibility is floor care** of Vascular and Transplant surgery patients. Not required to follow Transplant patients (the upper level resident usually follows these patients), but should have general idea of their condition and care as they may have to assist when PG3 is off or in the OR. Some operative experience with amputations and central lines.

**VA**

Average 10-15 patients. Should have 2 interns throughout the year.

Clinic is 3 days weekly and you are expected to attend. **Primary duty is again floor care** with occasional assistance in seeing new consults. Some operative experience, primarily on Vascular doing amputations.

**Call Duties**

Each intern rotating on any of the General Surgery rotations will participate in call (usually 2 per month—call is either on Saturday or Sunday, 7 am to 7 pm OR 7 pm to 7 am). Overall responsibility is to cover the floor patients for GI Surgery, Vascular, Surg-Onc and VA. Peds surgery and Trauma floor are covered by other residents (PG2).

Duties include:

- Getting appropriate detailed sign-out from each services you will be covering.
- Answering all pages promptly.
- Seeing all patients with any new complaints and those you’re asked to see by the primary team during check-out (e.g., post-op checks).
- Initial work-up of direct admissions to the floor. Notify the chief of the service soon after seeing the patient. You may also need to notify the PG3 or on-call chief resident to see the patient as well.
- Directing all questions or concerns regarding care of a floor patient as well as any significant new events or complications involving these patients to the service chief resident, regardless of who is on call that night.
- Calling the PG3 on call and notifying the service chief if you need emergent assistance from an upper level.

**Anesthesia Rotation**

**Books**

- **Baby Miller**—recommended read for Anesthesia rotation (will be textbook used in July of CA-1 year)
- **Clinical Anesthesiology** by Morgan and Mikhail (publisher is Lange)—similar in content to Baby Miller but with more detail about physiology
Handbook of Anesthesiology by Ezekiel—a pocket version (used to be green, now aqua blue). Includes tables on all major anesthesia drugs including half lives, intubating and maintenance doses, fluid replacement, etc. A great quick reference in the OR

Clinical Anesthesia Procedures of Mass Gen Hospital—slightly bigger, bulkier version of Handbook of Anesthesia—still fits into pocket and good OR resource

Anesthesia: Comprehensive Review by Hall—provides review questions for Anesthesia boards (helpful for the AKT, in-service, and beyond)

Schedule
This is a Monday through Friday rotation with no call, no weekends. Usually you’ll be assigned or just tag along with a resident daily. You should show up at 6:30 am every day to prepare your room for the day (set up the monitors, machine, and draw up medications). Grand Rounds are every Monday at 7 am; cases start at 8:30 am. All other days, cases start at 7:30 am. Each day’s case load will vary, but in general most cases are finished and you’ll be sent home or “to read” by 3:30 pm to 4 pm.

Resident lectures are Mondays at 6 am. Keywords are on Tuesdays at 6 am. Basic Lecture Series alternates with oral board review on Wednesdays at 6 am.

Expectations
The attendings understand that you have little anesthesia knowledge or experience, but they do expect you to show much more interest than an off-service person since this is what you’re going to be doing in a few short months. The rotation will be what you make of it. The more you ask to do, the more you’ll get to do. Jump in there and put the IV in, or place the OGT. Ask to intubate and extubate the patient. Goal for the rotation should be to come pretty close to running cases on your own (i.e., be able to take call July 1). Before leaving for the day, check the board for the next day’s cases—you might have a pre-op to do or might need to talk with the attending about the anesthetic plan. Most of the outpatients have been seen in the Pre-Op Clinic and pre-ops can be printed in the PACU. Knowing the patient when talking with the attending only makes you look better!

It is HIGHLY RECOMMENDED that you read Baby Miller before or during your month. Attendings will ask questions to see if you’ve been reading!

Helpful Hints
- This is a rotation you can take vacation—get form from Susan Dawkins
- Go to every lecture, meeting, journal club, function during the month
- Anesthesia office door code is 3871*, resident office code is 9879*