Family Medicine: FAP-FAP461a – Inpatient Family Medicine

Elective/Selective/Non-clinical	Primary Care Selective
Prerequisites:	
Restriction days:	14
Course Title	FAP 461a Inpatient Family Medicine
Director	Eugene J. Barone, M.D.
Contact person	Debbie Badura (dbadura@creighton.edu) Phone: 280-4542 Fax 280-5165
Length of Course	2 weeks
Frequency of Presentation	Continuously
Maximum Number of Students	2
Course Description	FAP 461a Inpatient Family Medicine is an elective in which the student participates in the care of hospitalized Family Medicine patients. Students are assigned patients on a rotational basis and will follow their patients throughout their hospital stay. Patients are from the practices of family physicians on the staff, or are patients admitted from the Family Medicine outpatient offices. The patient's population provides a wide range of experience including Surgery, Pediatrics, Ob-Gyn, and Geriatrics. The number of patients admitted to the service varies from 20-30 per week, with an age range from birth to 99 years. This is a busy service with a wide variety of diagnoses. There are daily teaching rounds taught by Family Medicine faculty. The student will aid in the management of the assigned hospitalized patient under the supervision of the resident and the attending physician. The student will also attend the weekly Core Content Lecture series.
Course Objectives	To integrate the clinical data gained from each inpatient into a diagnosis and comprehensive treatment plan that demonstrates the student's knowledge and skills for compassionate care, health promotion through patient education, effective interpersonal communication, humanistic and ethical care, and an awareness and effective use of all available health care resources in a family medicine hospital setting. 1. Improve "hands-on" patient management skills necessary for post-graduate training. 2. Accurately diagnose and treat common inpatient illnesses. 3. Improve problem-solving skills in an inpatient setting. 4. Conduct inpatient care in a compassionate and professional manner with adherence to ethical principles and a sensitivity to a diverse patient population. 5. Recognize the bio-psychosocial factors affecting patient care. 6. Integrate various sources of medical evidence to accurately make a diagnosis and improve patient outcomes. 7. Effectively utilize all healthcare resources including other healthcare professionals to optimize patient care.
Evaluation	1. The attending staff physician and supervising resident will complete a combined Elective Evaluation Report on the student. 2. The student's admission history and physical examination and SOAP notes will be evaluated by the attending physician or supervisory resident. 3. An Honors grade will be given to the student who receives a grade of 5 (Superior) in each category evaluated and substantiated by the written comments of the preceptor.

Schedule	The student will 1. conduct rounds on all inpatients assigned to him/her before the attending rounds. 2. be assigned to a Family Medicine resident for supervision, direction, and approval of all orders. 3. exam his/her assigned patients on a daily basis, gathering new historical and physical information, obtaining new diagnostic and laboratory data, and integrating this information into a treatment plan. New orders and progress notes will be expected daily under resident or staff supervision. 4. be assigned new admits then conduct and dictate a history/physical examination, write and admission note, and write admission orders under the supervision of the resident on these patients. 5. present his/her patient information verbally to the residents and faculty preceptor during formal rounds. It is expected the presentation will reflect the new patient information gathered that day be the student (history, physical examination, laboratory, and diagnostic data) and should be delivered in a concise manner. The student is also expected to detail his/her treatment recommendations. 6. communicate with the patient daily regarding his/her condition and treatment. The student also will communicated to anyone designated by the patient to receive information regarding the patient's condition and treatment. 7. obtain co-signatures from the Family Medicine resident or preceptor for all orders and written chart communication. 8. be expected to effectively, and with respect, work with the other health care professionals caring for the student's patients, which includes calling on their expertise to optimize the care of their assigned patient. 9. be expected t discharge his/her assigned patients under the supervision of the resident. 10. complete the history and physical examination, and SOAP noted according to the guidelines enclosed. Students will be evaluated regarding these items according to these guidelines. 11. attend all formal rounds, conferences, and didactic sessions. 12. be expected to conduct his/herself in a professional, ethical, and courteous manner with sensitivity to our diverse patient population. 13. be expected to be on-time during all rotation components. 14. cannot be granted time off during this two-week rotation except for illness or immediate family member emergency. 15. complete one night call until 10:00pm (weekend rounds are optional) **Work Rounds:** M-F, 7:30-9am, Sa-Sun, 7:30 – Noon **Rounds:** M-F, 9am-12pm **Preceptor Conference:** Mon-Thu, 1-2pm, Fri 12-4pm **New Admits:** Mon/Thu 2-5pm, Tue/Wed 1-5pm **Documentation and Requirements** 1. History and Physical Outline for Dictating (indicate the staff physician for whom you are dictating) and include the following in your dictation. a. Chief complaint b. History of present illness c. Past History (include allergies and current

	medications) d. Relevant family history and social history e. Review of systems f. Physical examination g. Impression h. Treatment Plan 2. SOAP Notes (daily progress note) **Subjective** – Chief complaint in patients own words and elaboration of any related symptoms. **Objectives** – Documentation of all physical findings including vital signs, laboratory, and diagnostic tests. **Assessment** – Clinical impression of patient’s problem. **Plan** – Treatment Plan.
added to course catalogue	
revised/modified/updated	