

Medical ICU Teaching Service

The Medical Intensive Care Unit (MICU) is a 14-bed unit that admits critically ill patients with medical, surgical, neurologic, neurosurgical, and obstetric conditions requiring intensive monitoring and treatment. The MICU Teaching Service is the primary critical care training experience for residents in Internal Medicine.

The MICU, contrary to popular belief, is not a closed unit. By this, it means that the attending intensivist does not decide who will be admitted to the unit. Any physician with privileges can admit patients to the MICU. **Every patient, however, receives a consultation from the PCCM attending physician.** At least 90% of the time, the patients are either admitted directly to the MICU service or the MICU team is asked to assume primary responsibility while the patient is critically ill. For the others, the team will generally follow along and make recommendations to the admitting service.

Who Covers Where?

MICU Team

MICU

STICU (MICU overflow)

ED Holds

IP Phone 434-1853

Pager 352-0288

CCU Team

CCU

CVICU

IP Phone 434-1855

The attending and fellow call schedule is on **MyPal>>Richland>>USC PCCM Call Schedule**. It can also be found on www.medicalicu.com. This is the most up-to-date schedule out there.

Education

Your education is what you make of it. The *least* effective way to teach adults is by the traditional didactic lecture. The *most* effective way to teach adults is by immersion and active participation—in other words, learn by doing.

The MICU is one giant applied physiology lab where you have as much opportunity as you want to learn about the extremes of illness, injury, pathophysiology, and pharmacology. It's also a great training environment for time management, delegation, and to see how well you function under stress. Here are the best ways for you to make this a fruitful educational experience:

- Most of the basic information you need about critical care is on our website at www.medicalicu.com. Seriously. Check it out. There's plenty there.
- Pay attention on rounds. Ask lots of questions. Try to get a feel for why the attending practices the way he does.
- Read one article a day when you're at work. It can be a review article or a clinical trial, but try to find one that's pertinent to a patient you're seeing.
- DON'T kid yourself and think that you'll read a textbook chapter a day.
- DON'T kid yourself and think that you'll do all your reading at home. You won't, and then you'll feel guilty about it. Plus, home is the place you go to get away from work!
- If there's something you feel you need to go over in depth, ask your attending. It's not a problem to carve out 30 minutes in the afternoon to go over ultrasound, shock, ventilators, acid-base, etc.
- Teach others. If you can teach something, you know the material.
- We'll try to do fun* things on rounds like discuss physiology, have journal article presentations, pro-con debates, etc. Just remember that rounds are for getting things done, and we won't have time to get too far off the path.

* Not everyone's idea of fun

Know Your Role

Attending Physician: This is a faculty member of the Division of Pulmonary, Critical Care, and Sleep Medicine. The attending is responsible for everything that happens in the MICU. He or she will oversee daily rounds, approve the plan of care for each patient, and either supervise or perform necessary procedures. An MICU attending is either physically present or available by phone 24 hours a day.

Fellow: Fellows in Pulmonary-Critical Care Medicine are responsible for the function of the MICU team. Put another way, the job of the fellow is to make the trains run on time. The fellow doesn't have to know every bit of lab data or hemodynamic perturbation—that's the job of the residents, and he doesn't have the time for it anyway. He does need to know what's going on with every patient in the MICU, plus all the outliers in the ED, STICU, etc. The fellow needs to know who's staying on a vent, who can be extubated, and who can be transferred out of the ICU. Part of his responsibilities include meeting with the respiratory, speech, and physical therapists each morning in the MICU to discuss the plan of care. The pulmonary fellow also needs to make sure that all of the day's activities get done, and this requires a lot of delegation and changing plans on the fly.

First-year fellows should be given authority at the discretion of the attending. This can include running rounds, supervising procedures and new admissions, and dealing with consultants. As the fellow gains experience and confidence, he will be allowed more autonomy.

Second-year fellows are expected to be able to lead the MICU team. The role of the attending is to provide guidance and make recommendations based on his or her clinical experience, but the fellow should be allowed to make the majority of decisions and to "see the plan through."

Third-year fellows should be capable of independent leadership of the MICU, with consultation with the attending as needed. The attending will be present on rounds and during the day, and is ultimately responsible for the patients. The fellow, however, will have the delegated authority to supervise the MICU team.

Resident: PGY-2/3 residents in Internal Medicine and Emergency Medicine alternate between days and nights during the rotation. Residents are responsible for the day-to-day care of patients in the MICU. They are also expected to admit new patients, transfer patients out of the unit, and to perform procedures. An upper-level resident should be

responsible for at least five patients. He should also be able to advise and assist interns with their duties.

The degree of autonomy granted to a resident depends on both his stage of training and his abilities. A PGY-2 will be expected to present a comprehensive plan of care but will most likely still need a lot of guidance from the fellow or attending. A PGY-3 should be able to present a thorough assessment and plan of care without much input from the fellow or attending (although it is still subject to oversight!). This graduated level of responsibility will prepare the resident for independent practice by the time he completes his training.

Intern: There are three PGY-1 residents in Internal Medicine, Emergency Medicine, and Family Medicine on the MICU team. Interns should be able to care for 4-5 patients each. Of course, certain individuals may not be ready for this kind of patient load, and it's up to the fellow and attending to determine how many patients each intern should be responsible for. It's better to start off with fewer patients, increasing to the goal of 4-5 by the end of the month, than to get overwhelmed early in the rotation. Interns are expected to present an assessment of the patient's condition and propose a plan of care on rounds. Simply reciting the data and the physical exam is unacceptable.

Medical Student: M-4 students doing an acting internship (AI) in the MICU are expected to function at (or at least near) the level of a PGY-1 resident. An AI should initially be assigned two patients, increasing to four as the rotation progresses. One of the upper-level residents should supervise the AI and write a daily progress note on each patient as well—in the eyes of the Law and Medicare, a student's notes count for nothing. AIs will be expected to deliver a formal presentation on a clinical topic of their choosing to the team at some point during the rotation. AIs are also expected to work at least one week of night call during the month. Just like the interns, the AI gets one day off a week. AIs are permitted to do invasive procedures, if the attending feels that it's safe.

M-3 students may rotate through the MICU during their clerkship in Internal Medicine. This may be for a two-week period. During this time, the students are expected to observe rounds and participate in discussions. They may be assigned one or two patients at the discretion of the fellow or attending, but M-3 students will obviously need to be supervised closely. M-3 students can place IVs, NG tubes, do ABGs, etc. They are not allowed to do central lines, intubations, or other more invasive procedures. Sign up for an AI if you want the experience!

All In A Day's Work

- 0600-0900 Night resident should check out to the day team
Night fellow should check out to the day fellow about major events, new patients, tasks to be completed, etc.
See patients, talk to nursing and respiratory staff
Extubate patients who pass a spontaneous breathing trial
Put in transfer orders
- 0900-1200 Daily Rounds (see below for the details)
Put in orders
Learn something new on every patient!
- 1200-1300 Eat lunch
- 1300-1630 Take care of transfers, new admissions, etc.
Some attendings will carve out 30 minutes here or there for teaching
- 1630-1700 Walk-around with the fellow, attending, and charge nurse
Review the day's events and plan of care
Make a list of things for the night resident to follow up on
- 1800 Night resident and fellow arrive and takes checkout from the day team

Roundsmanship

Rounding in the MICU is the time to assess the patients, talk with the families, put in orders, and come up with the plan of the day[†]. Our rounds are multidisciplinary—the charge nurse, patient's nurse, respiratory therapist, and Critical Care Pharmacist are all present during rounds, and the fellow is responsible for discussing the plan of care with the speech and physical therapists beforehand. Maintaining this open communication and collaborative approach has been the key to success in the MICU. Here's the way rounds should generally be run:

[†] See the *MICU 101* section later in this document

1. The resident gives an overview of recent events, the patient's condition, and his or her assessment and plan. This presentation should be *concise* and should not include a lot of numbers, unless they are of great importance. The assessment can be either systems-based or problem-based, but it does need to be thorough. Since an assessment is worthless without a plan, the resident should state what is needed to make the patient better (or at least keep him from getting worse). "Will discuss with team" is not an acceptable plan.
2. The patient's nurse will go through the Daily Goal Sheet. This document covers a lot of the quality measures that all patients need (like DVT prophylaxis, nutrition, and glycemic control). ***Any problems identified on the Goal Sheet should be dealt with at that time***—for example, if glycemic control is suboptimal, go ahead and change the patient's insulin dose when it's brought up.
3. The fellow should lead the discussion, including providing some teaching. The attending should also participate by examining the patient, going over the medications and ventilator settings, and contributing to the discussion of the day's plan. Teaching on rounds is always appreciated, but make sure that it's brief and focused on the patient at hand. The "One Minute Lesson" is a good model for bedside teaching.
4. Input from the nurses, respiratory therapists, and pharmacists is invaluable. Make sure that they are contributing to the discussion (and that you listen to what they have to say).
5. Family members are often present during rounds and make an effort to be there when you are. Please make sure that you explain what's going on to them. Most will not interfere with the clinical discussion, but you can be certain that they are listening. If you give them a chance, many will also be able to answer questions about symptoms, a patient's medical history, and provide other useful information. This is also the time to get consent for procedures and to have brief "family meetings" about goals and expectations. If you think a longer discussion will be needed, schedule it for after rounds.
6. It is crucial that all orders are put in the computer before the team moves on to the next patient. This includes the transfer order Powerplan ("Transfer From Critical Care"). Make sure that labs, medications, and imaging are put in properly.
7. Lastly, the fellow should sum up the day's plan for the rest of the team. Mention the one or two things that are most important.

MICU 101

[a.k.a. the things the MICU nurses really want you to know!]

Unit-Specific Information

- Assignment board is located in the corridor by the medication room.

Room #	Patient's last name	Attending	Day shift nurse	Night shift nurse
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This board will let you know which nurse is assigned to your patients, so you don't have to ask, "Who has [insert room number here]?" over and over.

- The Intubation and Difficult Airway boxes are located above the travel monitors.
- Code Carts and the Glidescope are located between rooms 540 and 541.
- The unit ultrasound is kept in the anteroom to 542.
 - This machine does not leave the 5th floor. Not even if your best friend wants to use it "just for a minute" somewhere else in the hospital.
 - It is the user's responsibility to clean the probes, make sure the cables are off the ground, and plug in the machine when finished.
- Please plug "Workstation On Wheels" into an outlet in the locked position, lock your screen when not in use, and clean all supplies/personal items when finished with rounds.
Hallways must be clear and organized for patient travels. This is a Joint Commission rule!

Daily Orders

- Routine AM labs should be ordered during rounds. Waiting until the next day to order necessary labs is a huge imposition on the daytime nursing staff, who are just coming on duty and now have to draw blood for labs that should have been ordered the day before.
 - Not every patient needs a full battery of labs, but if you're not sure either ask the fellow or just put in the "routine" stuff.
 - Resist the temptation to modify the details on the labs. Find the one that's labeled "AM labs" in the appropriate folder on Cerner. Click it. Don't mess with the time or the date. If it's labeled "AM labs" it will be done the next morning. Changing the details messes things up. Point and click, point and click....
 - Lactic Acid and Ammonia cannot be ordered as an ADD-ON (these have to be sent down separately on ice)
- The same goes for ABGs. If you want a morning ABG, click the one that is labeled as an AM lab. Leaving all the blood gases for the daytime RRT is a good way to make enemies in the MICU. Use your common sense as to who needs an ABG. Patients on >50% FiO₂, >8 cm PEEP, APRV, on pressors, the oscillator, etc. will all likely need a morning ABG.
- The same goes for morning CXRs. Put them in the day before and click the one for "CXR in AM."
- For other diagnostic tests and medications, pay attention to the details:

- It's hard for a ventilated patient to walk to his echocardiogram. Change it to "Portable" and make it "ASAP" or "STAT."
- Just about anything ordered in the ICU should be put in as ASAP or STAT. Very little is "Routine."
- If you want a patient to get a medication right away, change the Pharmacy Priority to "Now" or "STAT." Leaving it as "Routine" may delay the medication for hours.
- Please make sure to modify the medication route in the order: e.g. PO, IV, or TUBE (if via NG, OG, PEG, etc.)
- Capsules, extended release, and enteric coated medications cannot be crushed and flushed through NG or feeding tubes. Please modify these.

Consents and Procedures

- Consents for blood products, procedures, and anesthesia are located in a navy blue binder above travel monitors. There is also the Universal Consent form. This is the best consent to use when a patient is admitted to the ICU—go over it with the family member authorized to sign consent, and that way you don't have to call them at 0300 to get consent for a procedure. We still notify the family whenever a procedure is done, but this takes some of the headache out of it.
- Two nurses must be present to witness phone consents.
- Emergent consent must be signed by two physicians.
- If you are not signed off on a particular procedure, make sure someone is there to supervise you.
- If you are leaving something in the patient at the conclusion of the procedure, you must use full barrier precautions and sterile technique.
 - This includes central lines, chest tubes, arterial lines, and dialysis lines. If you use the ultrasound during these procedures, it must be in a sterile sheath. The only exception is endotracheal intubation.
 - Procedures where nothing is left in the patient (lumbar puncture, thoracentesis, paracentesis) can be done with aseptic precautions. When in doubt, however, gown and drape!
 - If you haven't gotten the procedure by the third attempt, you're unlikely to be successful on the fourth or fifth. Call the fellow or attending for help.
 - The nursing staff are empowered to stop the procedure if there is a breach in sterile technique or a potential safety hazard.
- A CXR must be ordered after internal jugular or subclavian central lines and endotracheal intubation to confirm placement and exclude complications (even if the attempt was unsuccessful).
- A KUB must be ordered after NGT or OGT placement.
- An "OK" order to use the central line or tube must be entered once confirmed by the MD.

Nursing and Ancillary Staff Issues

Use the Daily Goal Sheets on rounds. These are the Five Ds:

- Devices (what does the patient still need, vs. what can be removed)
- DVT prophylaxis
- Diet
- Disposition (stay vs. transfer; what's keeping the patient in the ICU)
- Discussion of other issues

Restraint Orders

- Must be ordered by a PGY-2 or higher
- Critical Airway Restraint Guidelines are an OT order for intubated or trach/ventilated patients
- Non-violent restraints must be renewed at 0000 daily

Foley Orders

- Please make sure you check the FOLEY box in the order set
- Select either "MD to manage" or "Nurse to manage." "Nurse to manage" is the usual option.

Extubation Orders

- Please place an "Extubation" order
- Order a Speech Therapy consult for post-extubation swallow study

Mobility Therapy

- Order a PT/OT consult for all patients in the MICU who are able to mobilize:
 - Not in a coma
 - Not in shock
 - Not in severe respiratory failure ($FiO_2 > 60\%$, $PEEP > 10$)

Who Requires MICU Admission?

Patients diagnosed with the following should almost always be admitted to the MICU:

- Acute respiratory failure requiring mechanical ventilation or continuous BiPAP
- Hemodynamic instability
- Status asthmaticus
- Intracerebral hemorrhage of any significance (a very small hemorrhage without associated deficits may not need MICU admission)
- Acute subdural hematoma
- Subacute/chronic subdural hematoma with midline shift or if the patient is coagulopathic (INR > 1.5, Platelets < 80K)
- Acute stroke after thrombolysis or mechanical clot retrieval
- Acute stroke with significant edema or midline shift
- Status epilepticus
- Malignant hypertension associated with
 - aortic dissection
 - cardiac ischemia
 - acute pulmonary edema (not just venous congestion)
 - acute renal failure, or an increase in baseline creatinine by 50% if the baseline creatinine is > 2
 - hypertensive encephalopathy
- Hyponatremia with seizures, coma, stupor, or cerebral edema
- Diabetic ketoacidosis with a pH < 7.20
- Hyperglycemic hyperosmolar state with stupor or coma
- Acute GI bleeding with resting tachycardia or orthostatic hypotension
- Variceal hemorrhage
- Drug overdose with hemodynamic instability, respiratory compromise, stupor, or coma

Grey Zones

There will be times when a patient does not easily fit into the aforementioned criteria. In that case, there should be discussion between the hospitalist and the MICU service. If the patient is being accepted in transfer, the best course of action is to bring the him to the ED.

These conditions do not normally require MICU admission:

- A small intracerebral hemorrhage without significant neurologic deficits or alteration of consciousness
- Subacute/chronic subdural hematoma without midline shift if the patient is not coagulopathic
- Acute stroke that isn't treated with thrombolysis or clot retrieval
- Seizures that have stopped, with a postictal state
- Hypertension (it doesn't matter what the numbers are) that is not causing end-organ damage as listed in the other column. Headache is not end-organ damage. Neither is nausea. Patients who are asymptomatic after being treated in the ED do not require admission to the MICU.
- Hyponatremia (it doesn't matter what the number is) without seizures, stupor, coma, or cerebral edema
- Diabetic ketoacidosis with a pH \geq 7.20
- Subacute GI bleeding (melena, etc.) with stable vital signs
- Drug overdose with intact mentation and stable hemodynamics
- Sepsis without signs of end-organ hypoperfusion
- Patients with advance directives stating that they are not to be intubated, placed on vasopressors, be resuscitated, or receive other forms of intensive care—**the ICU is a place for intensive treatment, not to observe the inevitable without intervening.**

Once he arrives, he can be evaluated by whomever accepted him and then appropriately dispositioned. This avoids two problems—first, it ensures that the patient will be admitted to the appropriate bed after evaluation in the “staging area” of the ED. Second, it speeds the transfer process and does not require the sending physician to speak to numerous people and tell the same story several times. *Even if the receiving physician (intensivist or hospitalist) is sure that the patient will need the other’s service*, he should go ahead and accept the patient for evaluation in the ED.

Example 1: A patient is transferred for neurosurgical evaluation of a subdural hemorrhage. The sending physician tells the intensivist that the patient has a headache and left arm weakness, but he is alert and his vital signs are stable. The intensivist asks that the patient be brought to the ED instead of the MICU. On arrival, the patient is found to be stable. His subdural hemorrhage is chronic, and the consulting neurosurgeon recommends burr holes in several days (but no urgent evacuation). The MICU team contacts the hospitalist, who admits the patient to the medical wards.

Example 2: The HIM physician is asked to accept a patient from an outlying ED with a sodium of 110. The sending physician says the patient is alert and has not been seizing. Recognizing that the patient may in fact be worse than described, the hospitalist asks that he be brought to the ED. When he arrives, the hospitalist notes that the patient is stuporous. A CT scan shows cerebral edema. The hospitalist contacts the MICU team, who admits the patient to MICU for hypertonic saline and close observation.

Transfers From MICU

1. Put in the orders:
 - a. "Transfer From Critical Care" Powerplan
 - b. "Remove From List" 80182, unless you want the Pulmonary or CCU/MSU team to keep seeing the patient. Call 434-1854 if you want the Pulmonary team to see the patient in the stepdown unit or on the floor (lung mass, respiratory reasons, tracheostomy, etc.)
 - c. "Change Attending" to whomever is appropriate
 - d. Transfer Medication Reconciliation

2. Do a transfer summary if the patient has been in the MICU for more than 24 hours, or if there's been a significant change in his condition

3. **For patients going to the HIM service:**
 - a. In the patient's EMR, go to 'Patient Information'>>'PPR Summary'>>right click to 'Add Visit Relationship'>>put HIM-A in the last name box
 - b. When the patient gets a bed assigned, use the electronic paging system in myPal to contact the hospitalist who is going to be receiving the patient
 - c. Put in the "Change Attending" order with the appropriate name
 - d. Be sure to make a note in the chart (either on the transfer summary, or as a separate note) saying which hospitalist you spoke with and the time. This will save you many headaches!

Rapid Response Team Calls

The MICU resident is the designated physician backup for the Rapid Response Team when they are called to see an unstable patient. The resident doesn't go to all the RRT calls, but if you are contacted by the RRT:

- Go see the patient
- Stabilize the patient
- Get the patient to the ICU, if necessary, and notify the MICU or CCU fellow
- Contact the patient's attending physician to relay the news and discuss the plan

An Incomplete Glossary of MICU Terminology

Anemia: a condition seen almost universally in the MICU; brought on by unnecessary phlebotomy, inflammation, and excessive fluids. Anemia rarely needs treatment unless the hemoglobin is less than 7 g/dL.

Arterial Line: a catheter placed to monitor the blood pressure directly in sick patients. Most people who are on vasopressor drips should have one. The femoral site is preferred for those who are in shock. A-lines should be placed using the same sterile precautions you use for central lines.

Central Line: a 2, 3, or 4-lumen catheter that is useful for infusing caustic medications like vasopressors or TPN. Internal jugular or subclavian lines are preferred, but femoral lines aren't terribly bad. Sterile technique should be used for insertion. Ultrasound should be used if at all possible. Central lines are notorious for infections and DVTs, so get them out as soon as they aren't needed!

Daily Goals Sheet: an invaluable tool to make sure that the team isn't missing anything. The goals sheet is presented by the nurse during daily rounds. Be sure to act on it—if a problem is identified, fix it then and there.

DVT: deep venous thrombosis, and preventable most of the time. Every patient in the MICU is at high risk and should have some sort of prophylaxis, and this should be reviewed daily. See also "Daily Goals Sheet."

Extubation: removal of the endotracheal tube. A noble goal, and one where a failure rate of up to 20% is accepted.

Family Members: relatives of your patients who are understandably anxious, and sometimes downright scared, about everything that's happening in the ICU. Please talk with them on rounds and as needed throughout the day.

Glycemic Control: defined as adequate when the blood sugar is between 80 and 180 mg/dL.

Hands: the deadliest vector of disease in the hospital. Wash them before and after every patient contact. You're never more than 10 feet away from gel, soap, or foam, so no excuses!

Labs: diagnostic blood tests that should be ordered based on a patient's clinical condition and not simply on a routine basis.

Mobility: another noble goal for pretty much every patient in the MICU. This can range from sitting up in the bed to walking, and is not precluded by the presence of an endotracheal tube. See also "PT/OT."

Nutrition: the sustenance of life. Should be provided to pretty much every patient via the enteral route, even those on vasopressor infusions. Even 10 mL/hour of elemental tube feeding is better than nothing!

Orders: the way you put in what care you want the patient to receive. If it's not ordered, it won't get done. Even if it is ordered, 10% won't get done, so stay on top of things. Orders should be placed during rounds to maximize efficiency and accuracy. See "Daily Goals Sheet."

PT/OT: actually two disciplines (Physical Therapy and Occupational Therapy), but often lumped into one. All patients in MICU should receive a PT/OT consult—we'll use common sense to decide which ones aren't quite ready for exercise, but PT/OT should be aware of every patient in the MICU.

Salt-water Drowning: the result of excessive administration of (ab)normal saline. Signs include renal failure, puffiness, pulmonary edema, and hyperchloremic acidosis. Readily avoided by judicious fluid administration and by using Lactated Ringer's or Plasmalyte instead of 0.9% saline.

Sedation: when used properly, an effective way of keeping patients comfortable while intubated. The Richmond Agitation-Sedation Score is a way to quantify it, and most patients should be kept at a RASS of 0 to -1. In the wrong hands, sedation causes iatrogenic coma, hypotension, delirium, long-term cognitive decline, and unnecessary CTs/MRIs/EEGs/Neurology consults. See also "Versed."

Spontaneous Breathing Trial: a test to see if a patient can separate from the ventilator. Usually performed by the respiratory therapist first thing in the morning; ignored to varying degrees by inexperienced residents. The SBT should last 30-60 minutes and *if the patient meets criteria, he should be extubated.*

Stress Ulcer: gastric ulceration precipitated by physiologic stress like shock, mechanical ventilation, or anticoagulation. The best prevention is nutrition and adequate perfusion. PPIs or H2 blockers also help, but aren't as effective.

TPN: a poor substitute for nutrition that often causes more harm than good. Use only in rare circumstances.

Ultrasound: a device that allows the user to place invasive lines and tubes, assess lung function, assess cardiac function, and to guide fluid resuscitation. It's also a device that is easily broken, so be careful with the probes! The ultrasound machine lives in the MICU and should not be loaned out or otherwise disappear from its home.

Versed: an archaic form of intravenous sedation, especially when used as a continuous infusion. Responsible for all sorts of adverse events, especially in patients with renal or hepatic dysfunction. This should be avoided in favor of better sedative infusions like fentanyl, propofol, or dexmetomidine. See also "Sedation."

RULES OF THE HOUSE

- Your first priority is the patient. Period. Tell everyone else to stuff it.
- There's no such thing as a secured airway. Have a healthy degree of paranoia.
- Your hands are vectors of countless teeming, pus-producing, malevolent bacteria, and pose the single greatest health threat in the entire hospital. Wash them.
- Fingernails should be trimmed to less than ¼ inch. Wait until you're on another rotation to get your nails sculpted at the mall.
- Primum non nocere.
- The nurses know more about the patient and his family than you do. Talk to them and ask their advice.
- Ten percent of what you order will get neglected, misplaced, or forgotten. Stay on top of things.
- Be fanatical about your sterile technique. Drape widely.
- Be nice. It sounds strange to have to tell adults to be nice to each other, but a kind word and a smile will do wonders for your reputation.
- The relief of pain and suffering is the oldest charge to the physician, and the most important.
- Never...NEVER...**NEVER** make changes to the ventilator without the respiratory therapist's direct involvement. They are always happy to help you, but please call them first.
- Chronic diseases develop over time—don't try to fix them acutely.
- Just because it's in the urine bag doesn't make it good—resist the temptation to give diuretics just to see urine. Reserve them for patients with volume overload.
- In a resuscitation, remember the first commandment—"Thou shalt not spazz."
- Not all fever is due to infection. However, a fever should prompt a search for infection. If none is found, look again before you consider another cause.
- Dyspnea in the hospital is never due to anxiety. If a physician says a dyspneic patient is just anxious, then it means one of two things—the physician has performed an exhaustive history, physical, and evaluation and found no cause, or he is a fool. Usually the latter.
- Any therapy should be Safe, Effective, and Cheap. In that order.
- If it isn't written down, it wasn't done.
- Resist the temptation to copy and paste yesterday's note onto today's. Too many things happen for this to stay accurate.
- Lab tests, CT scans, etc, are only useful if you know what to do with the results. Don't order tests if you don't have a plan.
- Plastic tubes, lines, and catheters are unnatural. Remove them as soon as the patient doesn't need their help.
- Oxygen is a drug. Dose it to the patient's needs.
- Teach your students. That's what they're there for. Remember how badly it sucked when you were a student and no one ever taught you anything?
- Blood draws for lab tests use up to 50cc of the patient's blood every day. Resist the temptation to order "routine" lab tests and blood gasses.
- When in doubt, repeat your physical examination. Look everywhere.
- **We are all on the same team, working for the same person. We all have a job to do. Treat those who perform their jobs well with respect.**