General Rotation Information

1. Duration of Rotation: One (1) month/four (4) weeks.

2. Eligibility: PGY-1, PGY-2, PGY-3, MS4 Sub-intern

3. Position: One PGY-1, One PGY-2, and One PGY-3 per rotation (Daytime) One PGY-1, One PGY-2 (nighttime)

4. Facilities Used:
   a. Pediatric Inpatient Ward 3-West and overflow to other wards as needed
   b. Emergency Room, WRNMMC
   c. Pediatric Intensive Care Unit (PICU)

5. Teaching Staff:
   a. Ward Attending Physician, rotating position in 1 (occasionally 2) week intervals
   b. Pediatric Heme-Onc Attending Physician +/- PHO Fellow
   c. Pediatric Sub-Specialist Attendings and Fellows
   d. PICU Attending and Midlevel

6. Ancillary Faculty:
   a. Pediatric Radiologist
   b. Pediatric Nutritionist
   c. Pediatric Social Worker
   d. Discharge Planner
   e. Pediatric Pharmacist
   f. Charge Nurse and Nursing Team
   g. Medical Secretary
   h. Subspecialty Consultants (Surgical)

7. Schedule Requests
   Routine leave, TAD/TDY are not authorized on this rotation (unless otherwise approved by PD)

8. Didactics
   a. Morning Report and Lecture
   b. PICU Simulation Scenario (1st and 3rd Wednesday of the calendar month)
   c. Informal lectures and presentations (chalk-talks)
House Officer Responsibilities by PGY Level

*Intern (PGY-1)*

- **Professionalism:**
  - Participate in hospital safety practices
  - Communicate status of patient and treatment plan to the patient and family on a daily basis
  - Communicate with the primary care provider or referring physician
  - Serve duty for in-house call as assigned

- **Reporter:**
  - Perform complete history and physical exam
  - Present patients during attending rounds
  - Present patient case at department morning report (0745 M-F)
  - Perform complete IPASS handover to next team (including read-back!)
  - Documentation of acute clinical changes causing significant alterations to the treatment plan (night team please add a “PEDS Interim Update” note into Essentris as warranted)

- **Interpreter:**
  - Formulate an age appropriate differential diagnosis and management plan from current knowledge, consultation, and medical literature
  - Complete daily progress notes, which should delineate management plans and thought processes
  - Prepare discharge summaries and off-service notes

- **Manager:**
  - Primary responsibility for all team patients admitted by the Pediatric Service
  - Write admission orders

- **Educator:**
  - Familiarize oneself with the inpatient pediatric goals and objectives for medical students
  - Educate medical students on the organization and execution of daily tasks of pediatric inpatient medicine
  - Attend all scheduled academic sessions and ward rounds unless patient care requires presence at the bedside
  - Participate in emergency room consults with senior resident
Senior Resident (PGY-2)

- **Professionalism:**
  - Demonstrate skills as a team participant and team manager
  - Provide appropriate information and support to patients and their families
  - Serve duty for in-house call as assigned
  - Participate in hospital safety practices

- **Reporter:**
  - Ensure admission note documents management plans, differential diagnoses, and an understanding of disease process
  - Ensure appropriate documentation of acute clinical changes overnight causing significant alterations to the treatment plan (night team please add a “PEDS Interim Update” note into Essentris as warranted)

- **Interpreter:**
  - Review intern and medical student notes and give feedback to students
  - Co-sign all intern and medical student notes (including DC summary) with addendum including a summary statement to indicate they have been reviewed and agreed upon
  - Review orders and test results (imaging, labs, etc.)

- **Manager:**
  - Evaluate all patients admitted to the pediatric inpatient service
  - Assign patients to interns and students upon admission
  - Oversee and direct the hospital care of all pediatric inpatients
  - Provide consultation for hospitalized children on other services
  - Direct supervision of all intern activities, including reviewing orders, laboratory results, radiology results, H&P, progress notes
  - Organize and carry out family-centered rounds and check-out rounds
    - Monitor IPASS handover and ensure complete exchange, including read-back!
  - Review discharge summaries on all patients prior to discharge if time permits
  - Assure continuity of care and appropriate follow-up for discharged patients
  - Ensure that ward intern is off service at least 24 hours (1 day) each week

- **Educator:**
  - Guide the interns, sub-interns, and third-year medical students in preparation for daily rounds and presentation at morning report
  - Assist with all procedures when possible
  - Familiarize oneself with the inpatient pediatric goals and objectives for medical students
  - Educate medical students on the organization and execution of daily tasks of pediatric inpatient medicine and on identification and initial management of common diagnoses requiring inpatient pediatric admission
Senior Resident (PGY-3)

- **Professionalism:**
  - Organize pediatric multi-disciplinary ward huddle with physician, nursing and support staff at 0915 M-F
  - Attend the weekly Safety Huddle (every Wednesday)
  - Participate in hospital safety practices (Safety Huddle every Tuesday)
  - Provide appropriate information and support to patients and their families
  - Serve duty for in-house call as assigned

- **Reporter:**
  - Direct supervision of all intern documentation including H&P, progress notes, discharge summaries
  - Co-sign all intern and medical student notes (including DC summary) with addendum including a summary statement to indicate they have been reviewed and agreed upon
  - Review discharge summaries on all patients prior to discharge if time permits

- **Interpreter:**
  - Review orders and test results (imaging, labs, etc.)

- **Manager:**
  - Manage ward team, including night team, regarding schedule, priorities, education, wellness, and execution of care plans
  - Evaluate all patients admitted to the pediatric inpatient service
  - Oversee and direct the hospital care of all pediatric inpatients
  - Brief attending physician on all admissions, discharges, transfers, and changes in status
  - Provide consultation for hospitalized children on other services
  - Keep the team informed on the status and current plans for all pediatric patients on other services regardless of whether formal consultation made
  - Organize and carry out family-centered rounds and check-out rounds
    - Monitor IPASS handover and ensure complete exchange, including read-back!
  - Assure continuity of care and appropriate follow-up for discharged patients
  - Ensure that ward interns and PGY-2s are off service at least 24 hours (1 day) each week

- **Educator:**
  - Organize and carry out morning report and case presentation
    - Prepare interns, sub-interns, and third-year medical students for morning report presentations
    - Discuss management of pediatric inpatients
    - Lead discussions on treatment decisions
- Review Orient to Service material with team on first day of rotation
- Set team and individual SMART Goals
- Develop educator strategies such as teaching on rounds, bedside teaching, chalk-talk or informal lectures
- Educate medical students on the identification and initial management of diagnoses requiring inpatient pediatric admission
- Assist with all procedures when possible

**Work Hours and Call**

1. According to the recommendations of the ACGME, residents will limit work hours to no more than 80 per week and will not care for new patients post-call. The residents will be dismissed from all ward duties and will not exceed 28 consecutive duty hours.
2. The senior resident on-call will be responsible for all telephone consults (overseas and other facilities in the area). The senior on-call resident will assume responsibility for all emergency department consults and will follow up any reported abnormal lab or positive culture reported after-hours (even those ordered through the clinic).
3. An intern’s primary responsibility while on call is the ward; he or she will attend emergency room consults with the in-house resident and assist with emergencies in the PICU.
4. While on the inpatient ward rotation each house officer assigned will have a 4-week average of 1 day in 7 free of all clinical responsibilities. This will be coordinated by the Chief Resident with ward team double-checking compliance.

**Method of Evaluation**

1. Monthly summative evaluations written and discussed with intern/resident prior to end of rotation
2. Evaluation tools include:
   a. Performance on rounds with attending/fellow (Medical Knowledge and Patient Care)
   b. Nursing evaluation and Patient Satisfaction Survey (Interpersonal skills and Professionalism)
   c. Presentation skills during morning report and on rounds (Communication)
   d. Procedural skills (Patient Care)
   e. Evidence of self-evaluation and use of medical literature (Practice-based learning)
   f. Input from supervised and supervisory resident(s) (Peer evaluation)
3. Resident evaluation will be documented on electronic evaluation forms
4. Formal one-on-one verbal feedback will be given weekly on the last day of the on-service attending’s shift. Residents will be asked to come prepared with feedback for their peers and attending to this meeting.

**Ward Objective**

As a general pediatrician, the practitioner will be faced with a wide variety of diseases and conditions that require in-hospital care of the pediatric patient. A comprehensive experience in pediatric care is essential in the education of the pediatric resident. Knowledge of the general principles of the care of the sick patient, as well as familiarity with specific disease states and their evolution, will teach the training pediatrician to develop practical and cost effective management plans for hospitalized children. Supervision with increasing level of autonomy, commensurate with ability, ensures appropriate and competent performance of
diagnostic procedures and therapeutic strategies that enable the resident to safely and effectively care for inpatients and plan for their care after discharge.

The house officer will learn through directed patient care, formal lectures (both on the ward and through the Department Educational Lecture Series), informal discussions on rounds, and with reading assignments (assigned & self-directed) on topics related to the individual objectives.

Competencies & Milestones

Entrustable Patient Activities (EPAs) are specified by the American Board of Pediatrics. During this rotation, these are assessed by 10 of the 21 competencies which fall into 6 domains. Each competency has milestones to guide your progress. The faculty have identified traits that are specific to this rotation which help identify responsibilities and attainment of higher-level milestones.

Entrustable Patient Activities

EPAs are activities that providers are trusted with being able to diagnose and manage independently at the end of their training. Ward rotation EPAs are the conditions which residents should gain competence in managing with each inpatient rotation in order to be trusted to manage independently by the end of their graduation from residency. Clinical practice guidelines are included to reference as baseline knowledge although care should be individualized to each patient.

1. Manage patients with acute, common, single system diagnoses in inpatient settings (EPA 4).
   - Urinary Tract Infection (2011 AAP Guideline on UTI)
   - Acute respiratory illness
     - Bronchiolitis (2014 AAP Practice Guideline)
     - Asthma exacerbation (guidelines)
     - Pneumonia (2011 IDSA Guidelines)
     - Respiratory distress
   - Kawasaki Disease (2004 AHA Scientific Statement)
   - Soft tissue infection (2014 IDSA Guidelines and IDSA audio podcast)
   - Febrile neonate (Seattle Children’s Febrile Neonate Pathway 2017)
   - Bone and joint infections (IDSA Guideline Spring 2018)
   - Diabetes Presentation and Post-Diabetic Ketoacidosis care (WRB DKA Protocol & Diabetes Ward SOP)
   - Complications in post-surgical patients
   - Fever & Neutropenia (2015 Children’s Oncology Group guidelines)
   - Complications of chemotherapy and antibody-based therapies (NEJM, 2016)

2. Evaluate and manage patients with undiagnosed chief complaints severe enough to require hospital admission.
   - Failure to thrive
   - Fever without a source
   - Musculoskeletal pain
   - Abdominal pain
   - Altered mental status
   - Seizure or similar unexplained event
   - BRUE (Brief Resolved Unexplained Event)

3. Identify, evaluate, and manage potential complications of medically complex and technology
dependent patients.
- Spasticity
- Feeding tubes
- Tracheostomy
- Ventricular shunts
- Indwelling venous catheters and ports
- Neuropathic bowel & bladder
- Ketogenic Dieting

4. Provide consultation to other health care providers caring for children (EPA 1). Senior residents on the inpatient ward provide consultation for pediatric patients admitted to the pediatric surgical and subspecialty surgical services.
   - Focusing the clinical question
   - Obtaining essential information from the primary physician, patient and family
   - Demonstrating content expertise in one’s area of pediatrics

5. Recognize, provide initial management and refer patients presenting with surgical problems (EPA 7). Residents may be required to initiate management and/or refer inpatients to pediatric surgery if their primary diagnosis requires surgery as treatment.
   - Recognizing conditions where surgery is indicated primarily or in conjunction with medical management, including knowledge of the limitations of one’s ability to manage problems medically.
   - Providing initial management and/or stabilization.
   - Making a referral and communicating directly to the Pediatric or Subspecialty Surgeon.

   - Establishing a shared vision, goals, expectations and outcome measures
   - Engaging other team members in a way that utilizes their specific roles and capabilities
   - Eliciting and valuing the perspective and contributions of others
   - Monitoring individual team member’s performance to enable oversight and management of current and evolving situations
   - Balancing autonomy and supervision of team members by assigning/delegating unsupervised work to team members that aligns with their KSA and supervising work of team members that is designed to expand their Knowledge, Skills & Attitudes
   - Monitoring team performance and providing feedback
   - Recognizing and managing the social cues, emotional responses as well as the personal and professional needs of team members
   - Role modeling
   - Teaching to the needs of the team members, including patients and families

**Identifiable Traits Corresponding to Higher Level Milestones**

**Gathering and Reporting Clinical Data**
- Morning report and rounds presentations are delivered clearly and at a volume that all can hear.
- Verbal presentations are in SOAP format with the HPI in chronologic order.
- Verbal report and written admission H&P includes vital signs and anthropometric percentiles.
- The assessment in oral and written presentations includes an illness script that uses multiple semantic qualifiers to describe severity, time course, and relative values of quantitative data.
  [http://pediatrics.aappublications.org/content/130/5/795](http://pediatrics.aappublications.org/content/130/5/795)
- The oral or written plan is organized by systems or problems and no major systems or problems are omitted.
Organizes and prioritizes patient care
- Senior Resident ensures rounds occur and finish on time.
- The resident actively enlists the ward secretary to accomplish administrative tasks.
- The resident delegates care tasks to other members of the team.
- Rounds occur first on the sickest patients and then those being discharged.

Transfers of Care
- The sickest patient is identified out-loud and discussed first.
- Hand-over includes specific contingency plan items in the format of ‘If X happens, then do Y’.
- Contingency plans reflect the most likely and most serious issues that could arise for a patient.

Developing and carrying out Management Plans
- Resident develops own plan before input from attending or consultant.
- Resident references & uses guideline, if available, to develop and carry out management plan.

Uses literature and Evidence-based Medicine for patient care
- Develops a PICO based question during rounds based on a patient issue without prompting.
- Enlists the skills of the medical librarian for assistance during rounds to help answer a PICO based question without prompting.
- Locates and uses ward Standard Operating Procedures to guide patient care

Self-Assessment
- Resident initiates need for formal feedback each week.
- Resident self-identifies weekly goals that follow the SMART format each week without prompting.
- Goals written by the resident include knowledge, skills, and attitudes.

Communication with Families
- Parent can identify resident by name and sight.
- Resident knows name of patient’s primary care manager.
- Parent switches PCM to resident based on inpatient experience.

Ownership
- Without prompting, resident begins corrective action for problems with communication, patient care, medications, documentation, care coordination and discharge planning.
- Submits a PSR to help with process improvement.

Coordination of Patient Care
- Ensures written plan is updated on white-board in patient room each day without prompting.
- Solicits opinion from parents without prompting.
- Actively assists parents and considers family needs in making post-discharge plans.
- Ensures discharge summary instructions written in lay terms, specifically mentioning how and when to take medicines (including need for fasting, refrigeration, and drug interactions), diet, activity restrictions, contingency plans, contact information, and follow-up appointments.

Work in Interprofessional Teams
- Can identify charge nurse at any given time by name and sight.
- Knows nurse caring for patient at any given time by name and sight.
- Solicits opinion from nurse, pharmacist, nutritionist, respiratory therapist, and other physician members of the team without prompting

**Specific Competencies and Milestones**

You will be assessed on 10 competencies during this rotation. Final assessments will be given on the end of rotation written evaluation.

1. Gather essential and accurate information about the patient (Patient Care 1)
   a. Level 1: Either gathers too little information or exhaustively gathers information following a template regardless of the patient’s chief complaint, with each piece of information gathered seeming as important as the next. Recalls clinical information in the order elicited, with the ability to gather, filter, prioritize, and connect pieces of information being limited by and dependent upon analytic reasoning through basic pathophysiology alone
   b. Level 2: Clinical experience allows linkage of signs and symptoms of a current patient to those encountered in previous patients. Still relies primarily on analytic reasoning through basic pathophysiology to gather information, but has the ability to link current findings to prior clinical encounters allows information to be filtered, prioritized, and synthesized into pertinent positives and negatives, as well as broad diagnostic categories
   c. Level 3: Demonstrates an advanced development of pattern recognition that leads to the creation of illness scripts, which allow information to be gathered while simultaneously filtered, prioritized, and synthesized into specific diagnostic considerations. Data gathering is driven by real-time development of a differential diagnosis early in the information-gathering process
   d. Level 4: Creates well-developed illness scripts that allow essential and accurate information to be gathered and precise diagnoses to be reached with ease and efficiency when presented with most pediatric problems, but still relies on analytic reasoning through basic pathophysiology to gather information when presented with complex or uncommon problems
   e. Level 5: Creates robust illness scripts and instance scripts (where the specific features of individual patients are remembered and used in future clinical reasoning) that lead to unconscious gathering of essential and accurate information in a targeted and efficient manner when presented with all but the most complex or rare clinical problems. These illness and instance scripts are robust enough to enable discrimination among diagnoses with subtle distinguishing features

2. Organize and prioritize responsibilities to provide patient care that is safe, effective, and efficient (Patient Care 2)
   a. Level 1: Struggles to organize patient care responsibilities, leading to focusing care on individual patients rather than multiple patients; responsibilities are prioritized as a reaction to unanticipated needs that arise (those responsibilities presenting the most significant crisis at the time are given the highest priority); even small interruptions in task often lead to a prolonged or permanent break in that task to attend to the interruption, making return to initial task difficult or unlikely
   b. Level 2: Organizes the simultaneous care of a few patients with efficiency; occasionally prioritizes patient care responsibilities to anticipate future needs; each additional patient or interruption in work leads to notable decreases in efficiency and ability to effectively prioritize; permanent breaks in task with interruptions are less common, but prolonged breaks in task are still common
   c. Level 3: Organizes the simultaneous care of many patients with efficiency; routinely prioritizes patient care responsibilities to proactively anticipate future needs; additional care responsibilities lead to decreases in efficiency and ability to effectively prioritize only when patient volume is quite large or there is a perception of competing priorities; interruptions in task are prioritized and only
lead to prolonged breaks in task when workload or cognitive load is high

d. Level 4: Organizes patient care responsibilities to optimize efficiency; provides care to a large
volume of patients with marked efficiency; patient care responsibilities are prioritized to
proactively prevent those urgent and emergent issues in patient care that can be anticipated;
interruptions in task lead to only brief breaks in task in most situations

e. Level 5: Serves as a role model of efficiency; patient care responsibilities are prioritized to
proactively prevent interruption by routine aspects of patient care that can be anticipated;
unavoidable interruptions are prioritized to maximize safe and effective multitasking of
responsibilities in essentially all situations

3. Provide transfer of care that ensures seamless transitions (Patient Care 3)
   a. Level 1: Demonstrates variability in transfer of information (content, accuracy, efficiency, and
      synthesis) from one patient to the next; makes frequent errors of both omission and commission
      in the hand-off
   b. Level 2: Uses a standard template for the information provided during the handoff; is unable to
deviate from that template to adapt to more complex situations; may have errors of omission or
commission, particularly when clinical information is not synthesized; neither anticipates nor
attends to the needs of the receiver of information
   c. Level 3: Adapts and applies a standardized template, relevant to individual contexts, reliably and
reproducibly, with minimal errors of omission or commission; allows ample opportunity for
clarification and questions; is beginning to anticipate potential issues for the transferee
   d. Level 4: Adapts and applies a standard template to increasingly complex situations in a broad
variety of settings and disciplines; ensures open communication, whether in the receiver- or the
provider-of-information role, through deliberative inquiry, including read-backs, repeat-backs
(provider), and clarifying questions (receivers)
   e. Level 5: Adapts and applies the template without error and regardless of setting or complexity;
internalizes the professional responsibility aspect of hand-off communication, as evidenced by
formal and explicit sharing of the conditions of transfer (e.g., time and place) and communication
of those conditions to patients, families, and other members of the health care team

4. Develop and carry out management plans (Patient Care 5)
   a. Level 1: Develops and carries out management plans based on directives from others, either
from the health care organization or the supervising physician; is unable to adjust plans based on
individual patient differences or preferences; communication about the plan is unidirectional from
the practitioner to the patient and family
   b. Level 2: Develops and carries out management plans based on one’s theoretical knowledge
and/or directives from others; can adapt plans to the individual patient, but only within the
framework of one’s own theoretical knowledge; is unable to focus on key information, so
conclusions are often from arbitrary, poorly prioritized, and time limited information gathering;
develops management plans based on the framework of one’s own assumptions and values
   c. Level 3: Develops and carries out management plans based on both theoretical knowledge and
some experience, especially in managing common problems; follows health care institution
directives as a matter of habit and good practice rather than as an externally imposed sanction;
is able to more effectively and efficiently focus on key information, but still may be limited by time
and convenience; begins to incorporate patients’ assumptions and values into plans through
more bidirectional communication
   d. Level 4: Develops and carries out management plans based most often on experience;
effectively and efficiently focuses on key information to arrive at a plan; incorporates patients’
assumptions and values through bidirectional communication with little interference from
personal biases
   e. Level 5: Develops and carries out management plans, even for complicated or rare situations,
based primarily on experience that puts theoretical knowledge into context; rapidly focuses on
key information to arrive at the plan and augments that with available information or seeks new
information as needed; has insight into one’s own assumptions and values that allow one to filter them out and focus on the patient/family values in a bidirectional conversation about the management plan.

5. Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems (Medical Knowledge 1)
   a. Level 1: Explains basic principles of Evidence-based Medicine (EBM), but relevance is limited by lack of clinical exposure. Example: The senior resident asks each member of the inpatient team to answer a clinical question that he raised during rounds and to be prepared to discuss it the next morning. The learner goes to a more senior colleague for help, since he cannot work through a case or article using the critical appraisal approach, mainly due to lack of clinical context from which to work.
   b. Level 2: Recognizes the importance of using current information to care for patients and responds to external prompts to do so; is able to formulate questions with some difficulty, but is not yet efficient with online searching; is starting to learn critical appraisal skills. Example: In response to a clinical question raised during rounds and the senior resident’s request that everyone answer the question, the learner is able, with some difficulty, to frame the question in a Population-Intervention-Comparison-Outcome (PICO) format. He has searching capability, but the search and the steps of analyzing and applying the evidence are time intensive, so he is not prepared to discuss his findings on rounds the next morning.
   c. Level 3: Able to identify knowledge gaps as learning opportunities; makes an effort to ask answerable questions on a regular basis and is becoming increasingly able to do so; understands varying levels of evidence and can utilize advanced search methods; is able to critically appraise a topic by analyzing the major outcomes, however, may need guidance in understanding the subtleties of the evidence; begins to seek and apply evidence when needed, not just when assigned to do so. Example: In response to the clinical question raised during rounds, the learner develops an answerable clinical question in PICO format and efficiently searches for best evidence. He volunteers to present on rounds the next day and demonstrates effective analytic skills and the ability to apply his findings to the current patient. He has a bit of difficulty interpreting and applying some of the secondary outcomes and, in the context of this discussion, another question is raised, which he volunteers to search and answer.
   d. Level 4: Is increasingly self-motivated to learn more, as exhibited by regularly formulating answerable questions; incorporates use of clinical evidence in rounds and teaches fellow learners; is quite capable with advanced searching; is able to critically appraise topics and does so regularly; shares findings with others to try to improve their abilities; practices EBM because of the benefit to the patient and the desire to learn more rather than in response to external prompts. Examples: In response to the clinical question raised during rounds, presents a second question that he has already researched in a PICO format as well as a critique of the evidence and its applicability to the current patient. He was motivated to be proactive by his interest in learning, as well as the needs of his patient. He shares his tactics with team members by teaching them the steps he engaged in to learn and apply this information.
   e. Level 5: Teaches critical appraisal of topics to others; strives for change at the organizational level as dictated by best current information; is able to easily formulate answerable clinical questions and does so with majority of patients as a habit; is able to effectively and efficiently search and access the literature; is seen by others as a role model for practicing EBM.

6. Identify strengths, deficiencies, and limits in one’s knowledge and expertise (Practice-based Learning & Improvement 1)
   a. Level 1: The learner acknowledges external assessments, but understanding of his performance is superficial and limited to the overall grade or bottom line; has little understanding of how the performance measure relates in a meaningful way to his specific level of Knowledge, Skills and Attitudes (KSA). Example: During a semiannual review, a learner is unable to describe in any specific terms how he has performed when asked to do so by his mentor. In response, the
mentor reviews and interprets the learner’s evaluations and then asks the learner to reflect on the discussion. The learner repeats the language used and recites the overall score/grade without interpretation of further meaning or inference regarding the reported performance assessment.

b. Level 2: Assessment of performance is seen as being able to do or not do the task at hand without appreciation for how well it is done and whether there is a need to improve the outcome. Example: The learner seeks external assessment of performance as ability “to do” or “not able to do” with little understanding of what the assessment means. “Are these orders written correctly?” “Did I do that correctly?” “Are these orders written correctly?” “Does that therapy work for this patient?” “Did I do that correctly?” “Are these orders written correctly?” Does not seek “How?” or “Why?” as part of request for feedback to assist identification of KSA.

c. Level 3: Prompts for understanding specifics of level of performance are internal and may be identified in response to uncertainty, discomfort, or tension in completing clinical duties; evidence of this stage is demonstrated by active questioning and application of knowledge in developing a rationale for care plans or in teaching activities. Example: Learner requests elaboration, clarification, or expansion on patient care related task. “Why would we use this antibiotic for this condition?” or “The patient has underlying condition x. Does that alter therapy y for this patient?” or “I think we should order study w for this patient, since sometimes this disease presents with underlying condition z.”

d. Level 4: Prompted by anticipation or contemplation of potential clinical problems, the learner self-identifies gaps in KSA through reflection that assesses current KSA versus understanding of underlying basic science or pathophysiologic principles to generate new questions about limitations or mastery of KSA; evidence of this stage can be determined by the advanced nature and level of questioning or resource seeking. Example: In caring for a patient with an illness not previously encountered, this practitioner says, “I have experience taking care of patients with this acute illness but have never had a patient with this acute illness who also had this particular underlying condition and wonder if the chronic condition might alter his clinical course?”

e. Level 5: Prompted by a self-directed goal of improving the professional self, the practitioner anticipates hypothetical clinical scenarios that build on current experience and systematically addresses identified gaps to enhance the level of KSA; elaborate questioning occurs to further explore gaps and strengths. Example: In caring for a patient, a practitioner becomes aware of a gap in KSA, and in response (with or without consultation from a mentor) seeks to understand more about the identified KSA gap. A PICO formatted question (P = Patient, I = Intervention, C = Comparison, O = Outcome) is constructed, followed by a process of identification of learning needed.

7. Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds (Interpersonal Communication 1)

a. Level 1: Uses standard medical interview template to prompt all questions; does not vary the approach based on a patient’s unique physical, cultural, socioeconomic, or situational needs; may feel intimidated or uncomfortable asking personal questions of patients

b. Level 2: Uses the medical interview to establish rapport and focus on information exchange relevant to a patient’s or family’s primary concerns; identifies physical, cultural, psychological, and social barriers to communication, but often has difficulty managing them; begins to use non-judgmental questioning scripts in response to sensitive situations

c. Level 3: Uses the interview to effectively establish rapport; is able to mitigate physical, cultural, psychological, and social barriers in most situations; verbal and non-verbal communication skills promote trust, respect, and understanding; develops scripts to approach most difficult communication scenarios

d. Level 4: Uses communication to establish and maintain a therapeutic alliance; sees beyond stereotypes and works to tailor communication to the individual; a wealth of experience has led to development of scripts for the gamut of difficult communication scenarios; is able to adjust scripts ad hoc for specific encounters
e. Level 5: Connects with patients and families in an authentic manner that fosters a trusting and loyal relationship; effectively educates patients, families, and the public as part of all communication; intuitively handles the gamut of difficult communication scenarios with grace and humility

8. Professionalization: A sense of duty and accountability to patients, society, and the profession (Professionalism 2)
   a. Level 1: Appears to be interested in learning pediatrics but not fully engaged and involved as a professional, which results in an observational or passive role
   b. Level 2: Although the learner appreciates her role in providing care and being a professional, at times has difficulty in seeing self as a professional, which may result in not taking appropriate primary responsibility
   c. Level 3: Demonstrates understanding and appreciation of the professional role and the gravity of being the “doctor” by becoming fully engaged in patient care activities; has a sense of duty; has rare lapses into behaviors that do not reflect a professional self-view
   d. Level 4: Has internalized and accepts full responsibility of the professional role and develops fluency with patient care and professional relationships in caring for a broad range of patients and team members
   e. Level 5: Extends professional role beyond the care of patients and sees self as a professional who is contributing to something larger (e.g., a community, a specialty, or the medical profession)

9. Coordinate patient care within the health care system relevant to their clinical specialty (Systems based practice 1)
   a. Level 1: Performs the role of medical decision-maker, developing care plans and setting goals of care independently; informs patient/family of the plan, but no written care plan is provided; makes referrals, and requests consultations and testing with little or no communication with team members or consultants; is not involved in the transition of care between settings (e.g., outpatient and inpatient, pediatric and adult); shows little or no recognition of social/educational/cultural issues affecting the patient/family
   b. Level 2: Begins to involve the patient/family in setting care goals and some of the decisions involved in the care plan; a written care plan is occasionally made available to the patient/family; care plan does not address key issues; has variable communication with team members and consultants regarding referrals, consultations, and testing; answers patient/family questions regarding results and recommendations; may inconsistently be involved in the transition of care between settings (e.g., outpatient and inpatient, pediatric and adult); makes some assessment of social/educational/cultural issues affecting the patient/family and applies this in interactions
   c. Level 3: Recognizes the responsibility to assist families in navigation of the complex health care system; frequently involves patient/family in decisions at all levels of care, setting goals, and defining care plans; frequently makes a written care plan available to the patient/family and to appropriately authorized members of the care team; care plan omits few key issues; has good communication with team members and consultants; consistently discusses results and recommendations with patient/family; is routinely involved in the transition of care between settings (e.g., outpatient and inpatient, pediatric and adult); considers social, educational and cultural issues in most care interactions
   d. Level 4: Actively assists families in navigating the complex health care system; has open communication, facilitating trust in the patient-physician interaction; develops goals and makes decisions jointly with the patient/family (shared-decision-making); routinely makes a written care plan available to the patient/family and to appropriately authorized members of the care team; makes a thorough care plan, addressing all key issues; facilitates care through consultation, referral, testing, monitoring, and follow-up, helping the family to interpret and act on results/recommendations; coordinates seamless transitions of care between settings (e.g.,
outpatient and inpatient, pediatric and adult; mental and dental health; education; housing; food security; family-to-family support); builds partnerships that foster family-centered, culturally effective care, ensuring communication and collaboration along the continuum of care.

e. Level 5: Current literature does not distinguish between behaviors of proficient and expert practitioners. Expertise is not an expectation of GME training, as it requires deliberate practice over time.

10. Work in interprofessional teams to enhance patient safety and improve patient care quality (Systems based practice 3)

a. Level 1: Seeks answers and responds to authority from only intra-professional colleagues; does not recognize other members of the interdisciplinary team as being important or making significant contributions to the team; tends to dismiss input from other professionals aside from other physicians.

b. Level 2: Is beginning to have an understanding of the other professionals on the team, especially their unique knowledge base, and is open to their input, however, still acquiesces to physician authorities to resolve conflict and provide answers in the face of ambiguity; is not dismissive of other health care professionals, but is unlikely to seek out those individuals when confronted with ambiguous situations.

c. Level 3: Aware of the unique contributions (knowledge, skills, and attitudes) of other health care professionals, and seeks their input for appropriate issues, and as a result, is an excellent team player.

d. Level 4: Same as Level 3, but an individual at this stage understands the broader connectivity of the professions and their complementary nature; recognizes that quality patient care only occurs in the context of the inter-professional team; serves as a role model for others in interdisciplinary work and is an excellent team leader.

e. Level 5: Current literature does not distinguish between behaviors of proficient and expert practitioners. Expertise is not an expectation of GME training, as it requires deliberate practice over time.