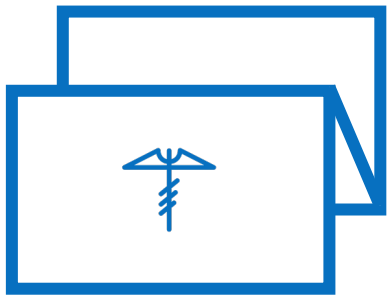
# Inpatient Pocket Cards



**tinyurl.com/InptPCS**

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Made with assistance from ChatGPT and OpenEvidence

For additional resources go to
tinyurl.com/InptPCSResources

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| Pre-Rounding Guide | |
|---|---|
| **Overnight Events** | Night float signout, nursing notes |
| **Interdisciplinary Notes** | Review original note and any addendum |
| **Vital Signs** | Trends and ranges (min and max) values |
| **I/O and Weights** | Input: Oral, IV, via feeding tube<br>Output: Urine, stool, drains, ostomy, hemodialysis<br>Weight trends |
| **Labs** | Include trends<br>Review pending/send-out labs<br>Consider which ones are truly needed on daily basis |
| **Radiology** | Review images yourself<br>Note if interpretation is preliminary or final |
| **Microbiology** | Bacterial culture not considered “negative” until at least 48 hours (does not finalize until day 5) |
| **Pathology** | Review initial stains and pending stains |
| **Medication Administration Record (MAR)** | IV fluids and drips |
| | Missed doses of medications (and reason for missed doses) |
| | Review medications that have expired/“fallen off” |
| | Review medications that need to be discontinued |
| | Overnight medications that were written by night float |
| | Pain medications |
| | Insulin requirements (and glucose ranges) |
| | Antibiotics received and start/end dates |
| | Review if held/modified home meds can be restarted/returned back to home dose |
| **Cardiac Monitoring/Pulse Oximetry** | Review telemetry<br>Consider if cardiac monitoring and/or pulse oximetry needs to be continued |
| **Tubes, Lines, Drains** | Review dates of when these were placed<br>Review indications for removal and/or replacement on daily basis |

## Daily Checklist

| | |
|---|---|
| **FEN/GI** | IV fluids (put end-time/total amount and review daily)<br>Indications for NPO<br>☐ Upcoming procedure<br>☐ PET scan (also avoid dextrose-containing IV fluids – review all IV meds)<br>☐ Concern for aspiration of all PO intake (including medications)<br>☐ Avoid caffeine prior to regadenoson stress testing[a] |
| **DVT prophylaxis[b]** | ☐ SCDs<br>☐ Enoxaparin subQ if CrCl >30 (hold 24 hours before most procedures)<br>☐ Heparin subQ if CrCl <30 (hold 12 hours before most procedures)<br>☐ Contraindications: active bleeding, low platelet count, |
| **Stress ulcer prophylaxis[c]** | Indications (for critically ill patients)<br>☐ On mechanical ventilator for ≥48 hours<br>☐ Coagulopathy (INR >1.5, plt <50)<br>☐ High-dose/chronic steroid or NSAID use<br>☐ Recent GI bleed |
| **Code status[d]** | Options include: Full, DNR/never intubate, DNR/okay to intubate, compressions okay/never intubate |

## Disposition Checklist

- ☐ Update family/DPOA on status of patient
- ☐ Fill out/update POLST form (if indicated)
- ☐ Post-hospitalization living situation
- ☐ Insurance for meds (prior authorization) and nursing homes
- ☐ Post-discharge transportation
- ☐ Equipment at home for safety/function
- ☐ Outpatient referrals and appointments
- ☐ Consider need for prescriptions (new medications, refills)
- ☐ Discharge medication education
- ☐ Discharge summary (include pending inpatient labs that require outpatient follow-up)
- ☐ Outpatient labs (if needed) and identify provider responsible for results
- ☐ Handoff communication to accepting provider (PCP, SNFist, etc.)

a. Some centers require patients to be NPO prior to stress test simply due to policy
b. The FDA has approved some DOACs and fondaparinux as options as well
c. If a patient is on long-standing PPI or $H_2$-blocker therapy which cannot be discontinued due to symptoms or specific medical indication, this will suffice as stress ulcer prophylaxis. Consider de-prescribing if no indication
d. At the VA, patients cannot legally have mixed code status (if pulseless, patients must be Full Code or DNR/never intubate)

Inpatient Pocket Cards

# Signing Out to Covering Services

| | | |
|---|---|---|
| **Context** | *"Patient being actively diuresed for volume overload, anticipate arrhythmias from electrolytes"* | |
| **Concrete steps** | <u>Patient-specific</u><br>How does my patient's care differ from typical management of common issues? | *"Patient had cardiac arrest after beta blocker use, so if patient goes into A-fib with RVR, consider amiodarone"*<br><br>*"Patient has an EF of 15% so be cautious with fluid administration"* |
| | <u>Accelerated management</u><br>What information can be related to save time and accelerate care for the patient? | *"Patient with QTc of 560, if nauseous, try trimethobenzamide or low-dose lorazepam"*<br><br>*"Patient prefers omeprazole over lansoprazole"* |
| **Contingencies** | Recent procedure and relevant complications | *"Patient s/p ERCP, pancreatitis can occur"* |
| | Logistical considerations | *"Patient may need urgent IR intervention overnight, here is the number for the on-call IR fellow"* |
| | Psychosocial challenges | *"Patient lacks capacity to make decisions surrounding discharge planning"* |

***Signouts are considered part of medical records***

# Conversing with a Consultant

| | |
|---|---|
| **Preparation** | Determine the consult question |
| | Obtain relevant information from the chart/patient |
| **Presentation** | Introduce yourself and your role clearly |
| | Deliver a concise relevant one-liner |
| | Always provide context |
| | Be honest |
| **Plan of Action** | Review steps that have been taken so far |
| | Formulate next steps with your consultant |

*"Hello, I am the resident on the inpatient medicine service, and I am here with my attending. We have a young patient with no past medical history who has been reporting melena for the past week and their Hgb is currently 10 g/dL (baseline of 14 g/dL based on chart review). We have not witnessed the melena and the patient just had a bowel movement, but we forgot to notify them to not flush it for us to examine it. We placed 2 large-bore peripheral IVs, completed a type and screen, are giving IV fluids, and started a PPI IV BID due to suspicion for upper GI bleed. Is an inpatient EGD appropriate? Are there additional steps that we should be taking right now? FYI the patient is expressing a desire to leave tomorrow as they are the sole caregiver for their children."*

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***Some institutions have auto-consults (e.g., all with Type 1 Diabetes Mellitus automatically get an inpatient endocrinology consult); even so, make sure to do your due diligence before reaching out to the consultant***

Inpatient Pocket Cards

# Anti-Emetic Regimen Guide

| Class | Medication | Route | Common Side Effects | QT-Prolongation |
|---|---|---|---|---|
| Serotonin antagonists | Ondansetron (Zofran) | PO, IVP, IM, sublingual | Headache, constipation, drowsiness, diarrhea | ✓ |
| | Granisetron (Kytril, Sancuso) | PO, IV, transdermal | | ✓ |
| Dopamine (DA) antagonists | Metoclopramide (Reglan) | PO, IVP, IM | Drowsiness, EPS, do not use if increased GI motility | ✓ |
| | Olanzapine (Zyprexa) | PO, IM, sublingual | EPS, hyperglycemia | ✓ |
| | Prochlorperazine (Compazine) | PO, IVP, PR | EPS, NMS | ✓ |
| | Haloperidol (Haldol) | PO, IM | EPS, constipation, dry mouth, blurred vision, somnolence | ✓ |
| | Chlorpromazine (Thorazine) | IM, IV | EPS, dry mouth | ✓ |
| Histamine antagonists | Diphenhydramine (Benadryl) | PO, IVPB, IVP | Dizziness, drowsiness, paradoxical excitation | ✓ |
| ACh antagonists | Scopolamine | PO, IVP, IM, transdermal | Bradycardia, flushing, thirst, xerostomia, urinary retention | ✓ |
| DA/Histamine/ACh antagonist | Promethazine (Phenergan) | PO, PR, IVP, IM | EPS, NMS, drowsiness, sedation, leukopenia, thrombocytopenia | ✓ |
| Neurokinin-1(NK-1) receptor antagonists | Aprepitant (Emend) | PO | Hiccups, bradycardia, neutropenia | |
| | Fosaprepitant (Ivemend) | IV | Angioedema, bradycardia, neutropenia | |
| Centrally acting | Dexamethasone | PO, IVP, IM | Leukocytosis, mood changes, adrenal suppression, hyperglycemia | |
| | Trimethobenzamide (Tigan) | PO, IM | EPS, disorientation, seizure | |
| | THC, dronabinol | PO | Hyperemesis, tachycardia, nystagmus, ataxia | |
| | Lorazepam (Ativan) | PO, IVP, IM | Respiratory depression | |

***When using multiple agents, avoid choosing from the same class***

| Bowel Regimen Guide | | |
|---|---|---|
| **Class (Mechanism)** | **Medication** | **Side Effects** |
| Osmotic agents (draws water into bowel, thereby loosening stool and promoting evacuation) | Polyethylene glycol | Nausea, bloating, cramping |
| | Lactulose | Abdominal bloating, flatulence |
| | Sorbitol | |
| | Glycerin | Rectal irritation |
| | Magnesium sulfate PO | Watery stools and urgency |
| | Magnesium citrate | |
| Stimulant laxatives | Bisacodyl | Rectal irritation |
| | Senna | Melanosis coli |
| Bulk-forming laxatives (fiber absorbs excess water and stimulates elimination) | Psyllium | Impaction above strictures, fluid overload, gas, and bloating |
| Rectal distension | Tap water enema<br>Fleet enema* | Discomfort during procedure |

***Avoid docusate as it does not help with constipation in hospitalized patients[a]***

*Fleet enemas contain phosphate and should be avoided in renal insufficiency

a. Robert J Fakheri, MD, Frank M Volpicelli, MD, Things We Do for No Reason: Prescribing Docusate for Constipation in Hospitalized Adults. *J. Hosp. Med* 2019;2;110-113. doi:10.12788/jhm.3124

# Pharmacologic Pain Management Options

| Class | Options |
|---|---|
| Anti-inflammatory | Acetaminophen (24 hours: <3-4g in healthy adults, <3g in CKD, <2g in liver disease or cirrhosis)<br>Oral NSAIDs or IV ketorolac (avoid NSAIDs if CKD or ≥2 of the following risk factors: history of GI ulcer, age >60, on steroids, on ASA/anticoagulation) |
| Opioid | Hydrocodone, morphine, oxycodone, hydromorphone, fentanyl, tramadol, codeine |
| Topical | Lidocaine patch, menthol cream, lidocaine/prilocaine cream, capsaicin cream |
| Neuropathic agents | Gabapentin, pregabalin, SNRIs, TCAs |
| Anti-spasmodic | Baclofen, cyclobenzaprine, tizanidine |

# Opioid Conversion Table[a,b,c]

| Opioid | Equianalgesic dosing (mg) | | Onset | Peak | $t_{1/2}$ | Considerations |
|---|---|---|---|---|---|---|
| | IV, SC, IM | PO | | | | |
| Morphine | 10 | 25 | IV: 5-10m<br>PO: 30m | IV: 15m<br>PO: 60m | 2-4h | Avoid in renal failure, active metabolites |
| Hydromorphone | 2 | 5 | IV: 5m<br>PO: 30m | IV: 10-20m<br>PO: 60m | 2-3h | Reduce dosing in hepatic dysfunction |
| Oxycodone | N/A | 20 | 10-30m | 1-2h | 3-4h | Caution in hepatic dysfunction |
| Hydrocodone | N/A | 25 | 10-30m | 1-2h | 4h | Caution in hepatic dysfunction |
| Fentanyl | 0.15 | n/a | 1.5m | IV: 5-10min | 2h | Preferred for hepatic/renal failure |
| Tramadol | N/A | 120 | 1h | 2h | 6-8h | Risk for serotonin syndrome<br>Can ↓ seizure threshold |
| Codeine | N/A | 200 | 30m-1h | 1-1.5h | 3h | Prodrug metabolized to morphine in liver, variable metabolism |

# Buprenorphine/Naloxone (Suboxone) Pearls[d]

**Always continue** in patients who have been taking prior to admission

If patient develops acute pain while on the medication, **split the same total daily** dose into q12h – q6h to utilize buprenorphine's analgesic window

If patient continues to have pain, **discuss ↑ total daily dose** OR **add a high-affinity full μ agonist** (such as hydromorphone or fentanyl) with assistance from pain medicine/ addiction medicine

**Continue this medication in the peri-operative setting**; doses >16mg/day may be decreased in discussion with pain medicine

**Discuss starting** this medication with **all hospitalized patients** with opioid use disorder

a. Different tables will reference different values. This table uses McPherson (Demystifying Opioid Conversion Calculations: A Guide for Effective Dosing, 2nd Edition by Dr. Mary Lynn McPherson PharmD, BCPS, CPE), while others utilize CDC guidance. Choose one and stick with it.
b. When rotating opioids, consider reducing equivalent dose by 25-50% to account for incomplete cross tolerance
c. If patients with renal failure, consider fentanyl, methadone or hydromorphone. Avoid morphine due to renally cleared metabolites
d. Kohan L, Potru S, Barreveld AM, Sprintz M, Lane O, Aryal A, Emerick T, Dopp A, Chhay S, Viscusi E. Buprenorphine management in the perioperative period: educational review and recommendations from a multisociety expert panel. Reg Anesth Pain Med. 2021 Oct;46(10):840-859. doi: 10.1136/rapm-2021-103007. Epub 2021 Aug 12. PMID: 34385292.

Inpatient Pocket Cards

# Inpatient Blood Pressure Management Guide

| Class | Route | | Frequently Used Agents | Relative/Absolute Contraindications | Effect on ICP |
|---|---|---|---|---|---|
| | PO | IV | | | |
| β-blockers | ✓ | ✓ | Metoprolol, Carvedilol, Labetalol | Bradycardia, heart block, ADHF, COPD exacerbation | ↔ |
| ACEI/ARBs | ✓ | ✓ | Captopril, Enalaprilat (IV), Lisinopril, Valsartan | AKI, hyperkalemia, angioedema | ↔ |
| α2 agonists[a] | ✓ | ✓ | Clonidine | Severe bradycardia | ↔ |
| Nitrates[a] | ✓ | ✓ | Isosorbide dinitrate | Severe AS, PDE inhibitor use | ↑ |
| CCBs[b] | ✓ | ✓ | Nifedipine ER, Diltiazem, Amlodipine | HFrEF<br>For non-dihydropyridines: Bradycardia, heart block | ↔ |
| Diuretics | ✓ | ✓ | Chlorthalidone, Hydrochlorothiazide, Spironolactone | AKI, hypovolemia, difficulty with transferring to urinate | ↓ |
| Vasodilators | ✓ | ✓ | Hydralazine | Can develop severe reflex tachycardia due to the unpredictable drop in SBP | ↑ |
| Non-selective α blockers | | ✓ | Phentolamine | | ↓ |
| Partial D1 agonists | | ✓ | Fenoldopam | Glaucoma | ↑ |

***Avoid acute treatment of asymptomatic severe hypertension (formerly known as hypertensive urgency)[c]***

a. Transdermal formulation is available
b. Amlodipine takes approximately 30 hours to become effective
c. Breu AC, Axon RN, Acute Treatment of Hypertensive Urgency. *J. Hosp. Med* 2018;12;860-862. Published online first October 31, 2018. doi:10.12788/jhm.3086

Inpatient Pocket Cards

## IV Fluid Timeout[a]

| Step 1: Indication | Step: 2 Approach | Step 3: Type of fluid[b] | Step 4: Amount of fluid |
|---|---|---|---|
| Low preload state leading to vital sign changes +/- symptoms | Resuscitation | Colloids are not superior to crystalloids<br>LR and Plasma-Lyte can be given in hyperkalemia<br>You cannot rely on serum lactate levels if you give LR to a patient with cirrhosis<br>If increased ICP, consider using Plasma-Lyte instead of LR | Give IV fluids (in 250-1000 mL increments) and re-assess volume status<br>In sepsis, consider 20-30 mL/kg (use extra caution with heart failure, renal failure and cirrhosis) |
| Disrupted oral intake | Maintenance | 0.45% NS with 5% dextrose | Calculate amount using “4-2-1” rule |

## Electrolyte Repletion Guide

| Electrolyte | Amount | Route | Details |
|---|---|---|---|
| Potassium (ref range 3.5-4.5) | $\frac{Goal\ K - Actual\ K}{Creatinine^{c}}$ x 100 = mEq of KCl | Oral, IV (10 mEq/hr peripherally, 20 mEq/hr centrally) KCl | >4 if acute MI, cardiac conditions<br>>4.5 if VT |
| Magnesium (ref range 1.3-1.7) | $\frac{Goal\ Mg - Actual\ Mg}{Creatinine^{c}}$ x 10 = gm of $MgSO_4$ | Oral (MgO causes diarrhea, Mg- protein complex does not cause diarrhea), IV $MgSO_4$ | >2 if CAD or active cardiac conditions<br>>2.5 for VT |
| Calcium (ref range 8-10) | 1 gm at a time | IV calcium carbonate | No need to replete unless symptomatic or if QT prolongation |
| Phosphate (ref range 2.5-4.5) | See table below | Oral, IV | Pay attention to K load |

## Phosphate Repletion Guide[d]

| Route | Formulation | Dose (based on phosphate level) | | | Amount of K |
|---|---|---|---|---|---|
| | | Phos <1.5 | Phos 1.5-1.9 | Phos 2-2.5 | |
| Oral | Neutra-Phos | 2 packets | 1-2 packets | 1 packet | 7.1 mEq per packet |
| | Neutra-Phos-K | 2 packets | 1-2 packets | 1 packet | 14.3 mEq per packet |
| | K-Phos Neutral (Na and K Phos) | 2 tablets q4h x4 doses | 2 tablets q4h x3 doses | 2 tablets q4h x2 doses | 1.1 mEq per tablet |
| IV | Potassium Phosphate | 18-21 mmol | 12-15 mmol | 9-12 mmol | 4.4 mEq per 3 mmol phos |
| | Sodium phosphate | 18-21 mmol | 15 mmol | 9-12 mmol | 0 mEq |

a. Consider aggressive IV fluids for nephroprotection in specific situations (e.g., tumor lysis, hypercalcemia, etc.)
b. For a table on options for considerations for crystalloids, go to bit.ly/crystalloids (case-sensitive)
c. If creatinine is <1, just divide by 1
d. If CrCl <30, divide dose by 50%

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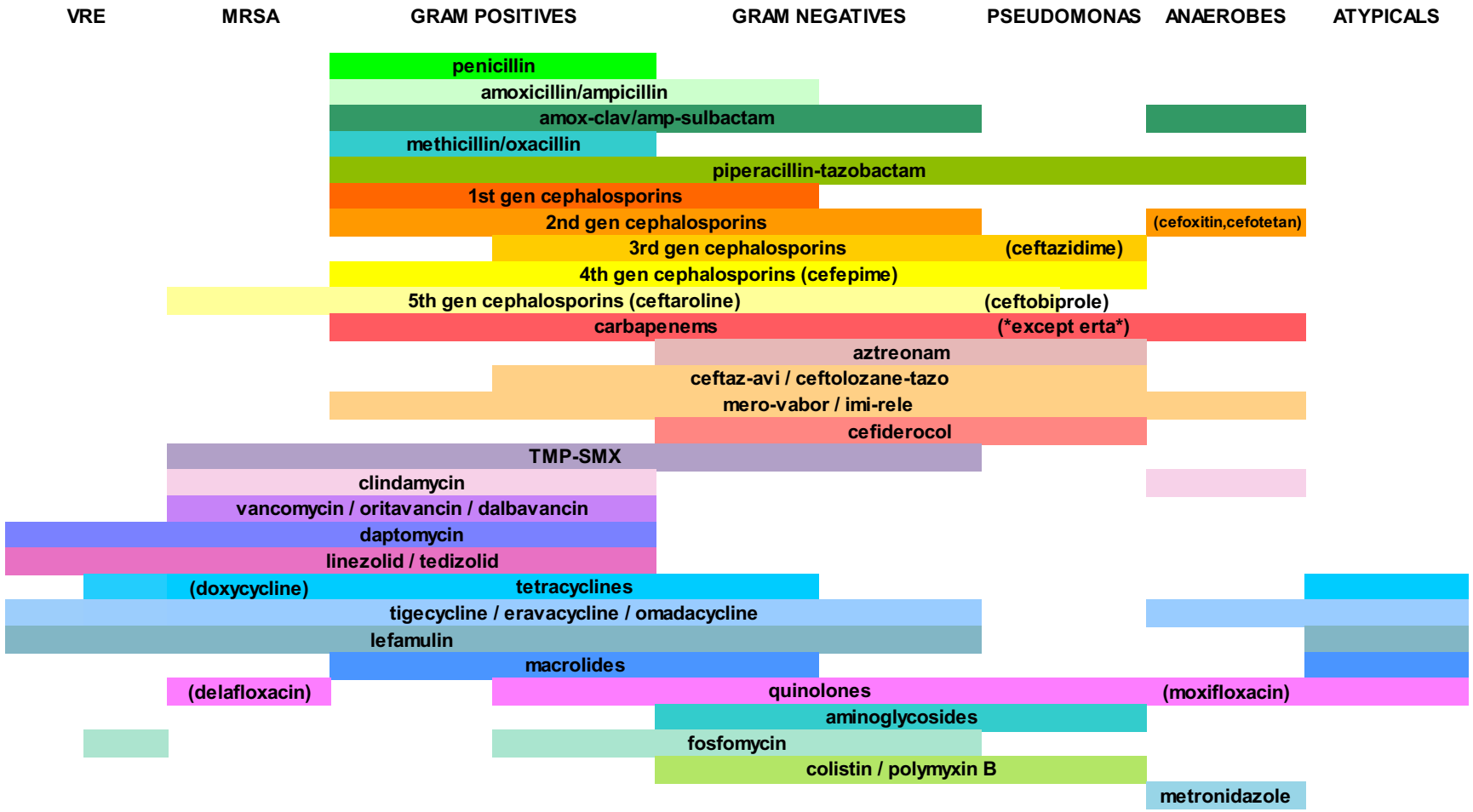
# Antimicrobial Stewardship

What syndrome? (e.g., UTI, bacteremia, etc.) What bug? (Use culture data. If none, what is most likely?) → What drug? (IV or PO?) Check local antibiogram Initial duration of therapy? → Can I de-escalate? If on IV, can I switch to PO? Can I stop? (Use clinical data like vitals, WBC count, and cultures to tailor therapy) → Discharge patient Confirm type of IV access (if indicated) and if frequency of medication and lab followup is feasible at discharge destination)

*Check the dose, frequency, and duration (renally dose when appropriate). For duration, be sure to account for any inpatient days of effective therapy.*

# Antibiotic Coverage

Jennifer Fulcher, MD, PhD | Last updated May 20th, 2024




Inpatient Pocket Cards

# Type 2 Diabetes Mellitus Inpatient Medication Guide[a]

| Class | Examples | When to hold? | If NPO, ↑ risk of hypoglycemia? |
|---|---|---|---|
| Biguanide | Metformin | Lactic acidosis<br>↑ risk of developing AKI<br>GFR <30 | No |
| Sulfonylurea | Glipizide | ↓ or variable oral intake<br>GFR <30 | Yes |
| TZD | Pioglitazone<br>Rosiglitazone | Risk of heart failure or MI<br>ALT >2.5x ULN | No |
| DPP-4 inhibitor | Alogliptin<br>Saxagliptin | Prior or current pancreatitis<br>Avoid saxagliptin in heart failure | No |
| GLP-1 receptor agonist | Dulaglutide<br>Liraglutide<br>Semaglutide | Hold pre-operatively for 1 day (if dosed daily) or for 1 week (if dosed weekly)<br>Prior or current pancreatitis<br>Nausea and/or vomiting<br>Ileus or gastric dysmotility | No |
| SGLT2i | Empagliflozin<br>Dapagliflozin | Hold pre-operatively for 72 hours<br>↓ or variable oral intake<br>Hypovolemia | No* |
| Meglitinide | Repaglinide | NPO | Yes |
| α-glucosidase inhibitor | Acarbose<br>Miglitol | Cirrhosis<br>Partial bowel obstruction<br>Cr >2 | No |

**Increased risk of euglycemic DKA*

## Insulin Pearls

Calculate total daily dose of insulin and adjust appropriately

Weight-based insulin
0.3-0.6 units/kg/day
~50% basal + ~50% mealtime

If NPO, stop mealtime insulin and reduce basal insulin by ~20%

Never completely discontinue basal insulin in Type 1 Diabetes Mellitus

Assess for presence of insulin pumps and continuous glucose monitors in Type 1 Diabetes Mellitus

If sliding scale insulin requirements are minimal, consider discontinuing it completely

Adjust insulin dose for renal dysfunction and older age

a. “Oral Diabetes Medications Inpatient: Mind the Gap Series.” coreimpodcast.com. Patel, S., Trivedi, S., Umpierrez, G., Troy, A., Larsen, T. October 13, 2021. https://www.coreimpodcast.com/2021/10/13/oral-diabetes-medications-in-hospitalization-mind-the-gap-segment/
b. Nice-Sugar Study Investigators. "Intensive versus conventional glucose control in critically ill patients." *New England Journal of Medicine* 360.13 (2009): 1283-1297.

***Inpatient blood glucose goal 140 – 180 mg/dL[b]***

Inpatient Pocket Cards

## Escalating Level of Care

| Setting | | | Details | Minimum functional status | Admission requires |
|---|---|---|---|---|---|
| Intensive Care Unit (ICU) | | | On mechanical ventilation, pressors, q1-2h checks/interventions | | |
| Intermediate Care/Step-Down Unit/ Progressive Care Unit (PCU) | | | On NIPPV, continuous drips | | |
| Long-Term Acute Care (LTAC) | | | Stable on ICU/PCU level of care | | Insurance |
| Med-surg ± telemetry | Inpatient status | | Hospitalized, needing cardiac monitoring and/or pulse oximetry, q4h checks/interventions | | |
| | Observation status | | Hospitalized, needing cardiac monitoring and/or pulse oximetry, q4h checks/interventions, anticipated discharge within 72h (or 2 midnights for Medicare) | | |
| Skilled Nursing Facility (SNF) | Short term | | Skilled need[a] | | Insurance |
| | Long term | Secured | Custodial care[b] with varying degrees of security based on ability to elope and safety risk if elopement occurs | | |
| | | Wanderguard | | | |
| | | Non-secured | | | |
| Acute Rehabilitation Unit (ARU) | | | ≥3h of PT/OT per day | Independent (or have someone available to assist) in iADLs | Insurance |
| Residential Care Facility for the Elderly (RCFE)[c] | Secured (Memory) | | Long-term housing, meals, and assistance with medication self-administration, but no skilled needs provided[d] | Independent in ADLs | Money |
| | Non-secured | | | Independent in ADLs/iADLs | |
| Substance rehabilitation | | | Facilities with daily group programs | Independent in ADLs/iADLs | Insurance or money |
| Recuperative care | | | For patients experiencing homelessness (services such as physical therapy, addiction therapy, and wound care can be done through home health) | Independent in ADLs/iADLs | |
| Section-8 Housing | | | Long-term subsidized housing | Independent in ADLs/iADLs | Money |
| Shelter | | | Conducts medical care by self | Independent in ADLs | |
| Home ± home health | | | Care by self ± help from family/friends/caregivers | | |

a. Medicare defines skilled need as IV antibiotics, daily complex wound care, speech therapy, PT/OT, first-time tube feeds comprising >26% of daily nutritional need
b. Medicare defines custodial care as care that helps you with usual daily activities, like getting in and out of bed, eating, bathing, dressing, and using the bathroom. It may also include care that most people do themselves, like using eye drops, oxygen, and taking care of colostomy or bladder catheters.
c. Includes Board & Care (B&C) and Assisted Living Facility (ALF)
d. Some RCFEs can accommodate ADL dependence for an additional fee

# Problem Representation

*An evolving summary of a patient's clinical presentation that strives to identify (1) Clinical syndrome (signs/symptoms), (2) Context (relevant history/demographics), and (3) Temporal pattern to maximize diagnostic signal.*

| Component | Detail | Examples |
|---|---|---|
| ***What*** are they experiencing? (clinical syndrome) | Chief concern forms the first clinical syndrome<br>Translate your patients' story into medical terminology<br>Highlight the relevant clinical findings | *Chest pressure and short of breath when I walk* → angina<br>*Fever, tachycardia, leukocytosis* → SIRS |
| ***Who*** is the patient? (context) | Use a patient's relevant epidemiology, medical, social, family, and exposure history as a framing tool | Age: 84-year-old with melena vs 24-year-old with melena<br>Biological sex: male with RLQ pain vs female with RLQ pain<br>Risk factors: patient with HTN and DM p/w chest pain vs patient on oral contraception p/w chest pain |
| ***When*** is this happening? (temporal pattern) | The temporal pattern of presentation is a key distinguishing feature that helps build and prioritize the differential diagnosis | Acute, subacute, chronic, sudden-onset<br>Episodic, progressive<br>Waxing, waning |

***Example problem representation***

*Middle-aged female with diabetes and GERD presents with acute progressive angina, elevated troponin x2, and inferior 2mm ST depressions.*

## Tips for making an effective problem representation

### Use semantic qualifiers

Use words to characterize signs and symptoms

*acute vs chronic*
*sharp vs dull*
*episodic vs constant*
*proximal vs distal*
*static vs progressive*
*painful vs painless*

### Keep it updated

Should evolve with new data

*An elderly male with acute hypoxic respiratory failure from community acquired pneumonia → An elderly male with improving community-acquired pneumonia now found to have acute diarrhea*

### Lower the cognitive load

Translate and abstract data into clinical syndrome

*Pain with inspiration → pleuritic*

*Fevers, cough, CXR infiltrate, hypoxia, tachycardia, hypotension, leukocytosis, positive sputum culture with S. aureus → Severe sepsis from MSSA pneumonia*

*Keep trying – if difficulty with arriving at a diagnosis, change the input to see if it changes the output*

## When to use?

| |
|---|
| One-liner at start of Assessment and Plan |
| Calling a consultant |
| Signing out a patient for cross coverage |
| Educating a team at a rapid response |

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For an effective conversation, you must **match** the type of conversation your patient is trying to have with you.

# Matching Communication Types[a]

| Type | Purpose | Clues to identify type of conversation | Sample phrases to engage | Risk if mismatched |
|---|---|---|---|---|
| **Emotional** | To express or process feelings and for others to see what they are experiencing | "Why is this happening to me?"<br>Same question is repeated after a clear answer<br>You feel stuck or unsure how to respond | "That sounds really hard"<br>"This feels like a lot to carry"<br>"Thanks for sharing that. I want to understand better" | They feel dismissed or unheard if given facts too soon |
| **Practical** | To understand, plan, or make a decision | Logistical questions<br>Patient is trying to make a decision | "Here's what we know so far…"<br>"We're still waiting on [test, consult, etc.]"<br>"What questions do you have? I want this to feel clear" | They feel frustrated if met only with empathy or vagueness |

# Communicating Uncertainty[b]

| *The **GAP** framework can help if clinical trajectory or next steps are unclear* | Scenarios | |
|---|---|---|
| | **Diagnostic**<br>(Patient with fevers despite extensive workup and is asking for a medical update.) | **Prognostic**<br>(Patient with recent brain bleed, family wants to know if he will return to baseline.) |
| **Given**<br>(what we know) | "You've had fevers, and your labs suggest inflammation, but common causes have been ruled out." | "We know the bleeding in their brain has stopped and they're stable right now." |
| **Ambiguous**<br>(what we don't know) | "We don't know yet what's causing your symptoms. Some test results are still pending." | "We're not sure how much of their thinking and strength will return over time." |
| **Plan**<br>(what we will do) | "We're reviewing more specialized labs and consulting rheumatology to help us figure this out." | "We'll monitor them closely and involve rehab specialists to guide the next steps." |

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# Communicating Code Status

| *The **CLEAR** framework can help guide code status conversations* | Scenarios | |
|---|---|---|
| | **Clinical Decompensation**<br>(Patient with end-stage HFrEF, now on BPAP and borderline hypotension, showing signs of rapid decline.) | **Discordant Goals or Wishes**<br>(Patient with metastatic cancer, with multi-organ failure, insists on being full code despite poor prognosis.) |
| **Curiosity**<br>(explore goals, concerns, and values) | "When you think about everything you've been through recently, what feels most important to you right now?" | "Can you help me understand what you're hoping for?" |
| **Language**<br>(use words that reflect values) | "We can use machines to support your breathing, but they may not help you recover." | "Some treatments might prolong life but not improve quality or function." |
| **Empathy**<br>(acknowledge emotional experience) | "This must be overwhelming, we're here with you." | "I can see how hard this is for you and your family." |
| **Assurance**<br>(provide comfort, normalize fears, and ensure continuity) | "Whatever you decide, we're going to make sure you're cared for and not in any discomfort." | "We'll stay with you and support you, even if we see things differently." |
| **Recommendation**<br>(align care recommendations with what matters most) | "Given what's happening and what's most important to you, I'd recommend comfort and time with loved ones." | "Considering your goals, I'd recommend avoiding treatments that won't help you recover." |