

# *Success on the Wards*

*A Student-to-Student Guide to Getting the Most Out  
of your Third-Year*



# NORTHWESTERN UNIVERSITY

**NORTHWESTERN UNIVERSITY  
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## INTRODUCTION

Welcome to the nineteenth edition of the Ward Survival  
Guide. We can't promise that the upcoming year will be easy (because  
it certainly won't) but we hope to ease a bit of the confusion and worry  
with this little booklet.

You spent your first two years in the library and in the  
classroom (or neither), so you all must be very excited to finally enter  
the clinical phase of your training. But with that excitement comes a  
sinking feeling in the pit of your stomach that you have no clue what  
you are doing. Rest assured, generations of medical students before you  
have experienced that same feeling at one point in time. But much like  
learning how to swim, you will learn the most by simply jumping in.  
This booklet will keep you afloat only temporarily, with time and  
experience you will gain the confidence to swim without it.

The upcoming clinical years of medical school will provide  
some of the most influential and rewarding experiences of your life.  
You will learn from and work alongside your peers, mentors, future  
colleagues, and, most importantly your patients. Your experiences in  
these two years will guide your decisions about the rest of your medical  
career including choosing the specialty that is right for you. So make  
sure to study hard, pay attention, have fun and, of course, keep this  
book close at hand.

Bati Myles '08  
Nafis Ahmed '08

*If you have any suggestions for ICC or this guide, please  
contact Dr. Amy Kontrick or Melissa Truong so future classes may  
benefit.*

## THE WARD TEAM

The members of the team are described below. Students are an integral member and may be most knowledgeable about a patient.

Attending Physician has completed a residency and possibly a fellowship and is a member of the Northwestern faculty. He or she is ultimately responsible for the patient's care and will thus make or approve all major decisions.

Fellow has completed a residency program and is now in subspecialty training, e.g. cardiology, vascular surgery, high-risk obstetrics, etc. As a junior student, your contact with these individuals will occur in the setting of a subspecialty consult clinic. Fellows are, in general, exceptionally knowledgeable about their specialty, and as such, are excellent teachers.

Resident is anyone with more than one year of postgraduate training (PGY-2+). Since attendings typically round once a day, the resident is in charge of the daily work of the team. Besides helping the intern in managing the team's patients, he or she is also primarily responsible for the education of students. Clerkship evaluations are often solicited from residents.

Intern is anyone in the first year of postgraduate training (PGY-1). The intern is primarily responsible for the moment-to-moment patient care. You may be paired with an intern who will work with you on the patients you are assigned. The intern usually has many tasks to be completed through the day, so any work you can do to help out will be greatly appreciated. In return, they can show you the ropes around the hospital, teach you about your patients, and offer a good evaluation of your performance to the resident. Each minute of work you do for your intern is an extra minute with which they can teach you about clinical medicine.

Senior Student is a fourth year medical student who is taking an elective or a sub-internship (Sub-I). He or she has the responsibilities of an intern and is supervised by the resident.

Junior Student is described fully on the next page.

## WHAT IS JUNIOR YEAR?

The goal of the junior clerkships is to continue to teach you the clinical skills of a physician. During the M1 and M2 years, you learned pathophysiology, problem solving, and patient interaction skills. During the ward years you will learn how to integrate and apply these skills towards actual patient care. This is a challenging endeavor, but you will slowly improve as the year progresses.

You will frequently find that you lack knowledge of a particular disease process or the skills to perform a certain procedure. Remember, you are there to learn, and nobody expects you to know everything already. In time, your clinical judgment, problem solving skills, ability to manage patient issues, and self-confidence will develop.

### Your Role

Your first priority is to learn as much as possible. People learn in different ways and at different speeds, so you need to find what is best for you. Reading is highly encouraged and may be difficult during busy rotations. You should carry something to read at all times since you never know when you might have spare time!

Also, your presence during patient rounds, on the floor, in the operating room, and at conferences exposes you to clinical faculty. These individuals will serve as your mentors and have an obligation to teach you over the course of your clinical rotations. Always remember that you are a student who is paying tuition in exchange for the privilege of learning.

Your second priority is to help the team. You should write the daily progress note and orders on your patients (some hospitals with computer based ordering will not allow you to write orders—so try to write them whenever you can). These steps will help organize your thoughts about your patients as well as keeping you up-to-date on the plan. Student orders and notes always need to be cosigned, so an occasional error is OK, but you should learn from each error and avoid them in the future.

You should also help your intern in his or her daily duties. Taking a history and physical (H&P), following up laboratory results, getting films from radiology, or drawing blood provides you with an opportunity to refine your clinical skills, gain more patient care responsibilities, and help the whole team to finish their day's work earlier so that everyone can go home or have more time to teach you.

### Daily Schedule

The routine varies with every rotation. On your first day, you should ask about a typical schedule. Often, the day begins with work rounds. You are responsible for pre-rounding on all of your individual patients. This involves seeing the patient and finding about all relevant new information including vitals, lab results, etc. Afterwards, you will round with your team and see your patients a second time. The team of housestaff and students goes from patient to patient talking about each patient's medical problems, present condition, and plan for the day in regards to tests, therapies, procedures, etc.

After rounds, you may go into the operating room, see your patients individually, or arrange for tests to be done. The rest of the day is spent in attending rounds, conferences, lectures, writing SOAP notes, and following up results. Efficiency is a good skill to learn and refine. You must fit all of the unscheduled business around scheduled meetings and conferences. At the end of the day, sign-out rounds are usually done to update the team members and to let the on-call person know about each patient.

### What to Keep in Your White Coat

What to carry in your white coat will also vary slightly with every rotation. At a minimum, you should carry a stethoscope, penlight, and reflex hammer. For OB/GYN it's nice to have a pregnancy wheel, but you can often pick one up during the first days of the rotation. On Pediatrics, a developmental stage guide can be helpful (found in Maxwell's), and on Psych, bring the mini-mental plaque that you were given during physical exam courses.

### How You're Evaluated

The specifics of how you are evaluated are different on each rotation and should be explicitly explained to you on your first day. If it's not explained, feel free to ask. But in general, your evaluation will be based on some combination of how you perform on the wards (your clinical evaluation) and how you perform on the test at the end of the rotation (the "shelf exam" and in Surgery, OB/GYN, and Peds, a practical exam called an OSCE). The "shelf" is a multiple-choice, nation-wide test that will have clinical-vignette questions similar to those you saw on Step 1, although with even more of a clinical focus.

## **RULES TO LIVE BY (THE TEN COMMANDMENTS)**

There are many unwritten laws in medicine, so here are some rules that many students have found useful.

1. ***Remember that there is a person on the other end.*** During your clerkship, you may begin to forget that the only reason we are here is because there are patients. They deserve our time, help, and most importantly our respect. It is an obligation to inform the patient of a new procedure or test and to explain it as much as possible. Regardless of how exhausted or frustrated you may become, it is important to remember these priorities.
2. ***Enthusiasm.*** Be a happy worker. Residents and interns have a hard life as it is, and behaving in a reluctant or uninterested manner will make them enjoy their situation even less. Try to have a positive attitude. Generally, you should learn something from the tasks that you do, but occasionally, that may not be the case. One piece of advice you should keep in mind throughout your medical education is that any task that must be done for *your* patient should not be considered "scut."
3. ***Assertiveness.*** Patients appreciate it if you say or do something with certainty. Likewise, your residents and attendings will appreciate a medical student who exhibits confidence. You can be assertive without being aggressive or rude. Talk clearly and enunciate. Explain what you are doing and why you are doing it. Actively volunteer to take a patient or to present your patient. Every once in a while, ask yourself, "Am I getting out of this rotation what I want? Am I being taught enough? What should I be doing differently?" During rounds or pimp sessions, volunteer your answers if you know them, and do so with confidence. (But **always** give the person to whom the question is directed a chance to answer first!)
4. ***Reading.*** Assertiveness comes with knowledge. By reading, you learn more and prepare yourself for when you become an official MD. Although the wards experience can teach you a lot that you can never learn from books, reading never hurts. You will also obtain more details from books than from your residents.
5. ***Have a good time.*** Despite the fact that medical students are "lowest on the totem pole," you do not have to suffer. This is two years of your life, and you have a right to learn as much as you can and to be respected as a human being. Try to enjoy yourself, but not too much; after all, work is work. Take care of your health. Eat whenever you can. Sleep whenever you can. Although losing weight may not sound so bad, losing energy will just make you less attentive, less eager, and more irritable. Carry around a

granola or candy bar in your pocket. You may be able to sneak in a snack during lecture.

6. Respect your fellow classmates. Never put down or show up your colleagues. Residents and attending can spot "brown-nosing" and back-stabbing behavior easily. Remember: your classmates are your colleagues. Like you, your peers are trying their best to do well and learn as much as they can. Try to show mutual respect. This will allow for a more pleasant rather than painful experience. Residents and attendings have been where you are now and know who the boot-licker is.
7. Be friendly with support staff, especially the nurses. Being nice to them makes life much easier for you. At this point in your education, they know a lot more than you do when it comes to the daily routine of patient care. As proper etiquette teaches you, say "good morning" or "hello" every day. It is also a good idea to talk to the nurse caring for your patients. Not only can he or she tell you about your patient's condition, you can let him or her know about any changes in the treatment plan. Your patients will receive better care, and you will save time and impress your residents.
8. Be on time. It may seem that no one will notice if you are late by a few seconds or minutes, but punctuality and promptness are always evaluated. Being late can only hurt you. Once again, this is very resident-dependent. Your resident may consistently arrive late for morning rounds; do not assume that you are allowed to do the same.
9. Ask questions. Asking many questions will demonstrate interest and an eagerness to learn. You will also be making the most of your experience. There is a limit, though. You may find that your knowledge of the physiology and biochemical mechanism of a particular disease exceeds that of your resident. If your resident gives you a round-about answer, do not proceed to continually ask that question. The questions you ask will reflect how much you know. Make sure that the questions you ask show that you have been doing your reading. Try to avoid questions that could be answered simply by reading a textbook. Instead, focus on clinical decision making skills and questions that can only be answered by someone with experience.

10. Seek feedback. It is your responsibility to find out how your residents and attendings regard you. You should not rely upon subtle hints and body language. Rather, directly ask for feedback approximately halfway in the rotation. Do not just ask how you are doing (you will probably receive a vague, "You're doing all right."). Ask if there are any things upon which you can improve, and in the remaining time, improve on those things. Also, contrary to what SEGUE teaches you with patients, when asking for feedback, the more focused your questions, the more constructive the feedback will be. (i.e. "Did I present that patient in a concise and focused manner?" or "Can you comment on my H&Ps?")

#### ADDITIONAL RULES TO LIVE BY:

- Let your intern/resident know where you are at all times. Post a schedule of your lectures and give them your pager number. This is a good idea for a couple of reasons. First, part of your role is to give your intern a hand with his/her work. Second, if they can't find you, they might assume you are goofing off, or you may miss the chance to do a procedure. Use your discretion to avoid annoying your intern and resident, but check-in occasionally to give them an idea of what you have been doing and what you are going to do.
- Work hard. Any boss you have had or will have appreciates hard workers. Being a medical student, it is almost a given that you are a hard worker. But the trick is to *show* that you are a hard worker. Volunteer to take on an extra patient. Offer to stay a little longer at the end of the day to help out. Always ask if there is anything else you can do before you leave for the day.
- Take initiative. You can probably pass all of your rotations by doing the minimum requirements. But if you are in the OR or on the floor anyway, why not make the most of the situation? Take an active role in all aspects of your education. Volunteer to answer a pimp question if you know the answer. Offer any good ideas or plans that you have in your patients' care. Occasionally bring in articles relevant to your patients' treatment plan or disease.
- Know your patients better than anyone else. Know the most and be the first one to know. Know the history of your patients the best and, by reading on a case-basis, know everything about their diseases, even the ones that are not currently active. Be the first to know the latest word on your patient, which includes pre-rounding, checking labs, and getting imaging studies when they are performed. Your residents will appreciate you telling them the latest developments on your patient and it makes you look like you are "on top of things".

- Appropriate humility. There is a time for everything. As a medical student, you should show the appropriate due respect to the residents and attendings who were once in your position. Do not try to outsmart, embarrass, or correct them in the middle of conference. Do not talk back; arrogance is the biggest turnoff. Say “I don’t know” if you really don’t know the answer. Be a team player and don’t make other students look bad.
- Understand responsibilities and expectations. Your duties are usually well explained in the clerkship syllabus at the beginning of each rotation, but because each resident runs his or her team differently, clarification is usually needed. It is to your advantage to ask early in the rotation. Miscommunication concerning student responsibilities can be a source of unnecessary conflict.
- Be prepared to be on-call the first night. This is a possibility.
- Appearance and demeanor are important. Students are considered part of the patient care team and are therefore expected to dress and act in a manner suitable to a professional medical environment. Men are expected to wear dress slacks and ties; women are expected to wear dresses, skirts, or slacks. Socks or pantyhose should always be worn, and open-toe shoes are not acceptable. Shorts, extremely high cut skirts, and sleeveless shirts are also unacceptable. Scrubs may be acceptable if you are on-call. However, if in doubt, ask your resident. Keep in mind that some attendings expect students to be dressed nicely and clean shaven (men) even if you’re post-call. You’d rather not find out the hard way. Also, keep in mind that how you dress may depend upon which clerkship you are on. For some rotations, you may wear scrubs every day, whereas during others, they are never permitted. Even when on surgery, business attire in the clinic is expected. Note that most hospitals’ infection control regulations forbid you from wearing scrubs outside the hospital.
- Prepare/practice for oral presentations. You will definitely be asked to present for attending rounds, and you may be lucky to present in conference as well. Usually, you will be warned ahead of time when you will be presenting, but sometimes you will be told at the last minute. Your oral presentation is your time to show what and how much you know about your patient. This may be the only way for your attending to evaluate you, in addition to what he or she hears about you secondhand from your resident. It will not hurt at all to have your whole presentation memorized word for word, although it may not be worth your time. You should be prepared to answer any questions such as why a certain study was ordered, etc.

- Efficiency is key. An attending/resident/intern appreciates an efficient, organized medical student. Do not spend hours trying to determine the liver span of your patient. Try to keep progress notes as concise as possible. As an MD, your time will be limited.
- Remember Patient Confidentiality. Be careful about where you talk about patients. Corridors, elevators, stairwells, Au Bon Pain, and other public locations are inappropriate areas. There have been incidents in which patients’ families have complained to the hospital.

## BASIC CHARTING INFORMATION & TIPS

One of your duties will be writing the progress note and orders for the patients you are following. The key issue to remember is that the patient's chart is a legal document. Thus, if you make a mistake, you should cross out the mistake once, write "error" or "err" and initial it (if you are using paper charts; on the computer, write an addendum). Also, you must sign your notes and orders and have them cosigned by an intern or resident.

At the beginning of all written notes, remember to indicate which service you represent and your individual status, e.g. Neurology/ MS3. At the end of all notes and orders that you write, sign your name, print your name, indicate your status and pager number.

In the Assessment/Plan section of your notes, you are encouraged to give your impression of patient management and recommendations. However, always state them as considerations unless you have discussed them already with your team. For example, "consider Celexa 20mg po qd to treat major depressive symptoms." Also, never make statements that directly question a caregiver's recommendations or judgment.

Remember that the purpose of notes is to communicate. Write clearly. It's ok to use standard abbreviations that everybody understands but avoid using abbreviations that are ambiguous, likely to be confusing to others, or that only you and three other people understand.

### Documenting Laboratory Values

One of the most commonly ordered tests is the basic chemistry panel, previously referred to as the 'SMA-7' or 'Chem-7', since it provides a quick assessment of electrolytes, renal function, and serum glucose. The following skeleton is used:

$$\frac{\text{Na} / \text{Cl} / \text{BUN} / \text{Glucose}}{\text{K} \setminus \text{HCO}_3 \setminus \text{Cr} \setminus}$$

Another common test is the complete blood count, which can be reported in the following format:

$$\text{WBC} \setminus \frac{\text{Hb}}{\text{Hct}} / \text{Platelets}$$

It is also recommended that you include the MCV and RDW to rule out or help evaluate anemia as well as the differential if it was ordered.

The traditional method to report arterial blood gas results is:

$$\text{FiO}_2 / \text{pH} / \text{pCO}_2 / \text{pO}_2 / \text{HCO}_3 / \text{BE} / \text{O}_2 \text{ saturation}$$

Frequently, the  $\text{FiO}_2$  is left out if the patient is on room air, and the bicarbonate is appended to the end to help evaluate acid/base disturbances.

Electrocardiographic results can also be presented in the following manner:

Rhythm, rate, P-R interval / QRS interval / QT interval,  
QRS and T wave axes, ST and T wave abnormalities,  
Interpretation.

However, this format is the most variable, and the amount of information is dependent upon your own and your housestaff's level of confidence in interpreting EKG's. Formal EKG readings are typically available the next working day.

### History and Physical (H&P)

One of the goals of your medical education is to become proficient at writing H&P's. You should periodically ask for feedback regarding your write ups from both your attendings and residents. Initially, your H&P's will be long and detailed in order to show your superiors how much you know and understand about your patient. Gradually, with your growing knowledge, confidence and experience, your H&P's will become concise and efficient.

## The SOAP Note

The purpose of the daily progress note is to document any significant patient events, the patient's current condition, and the current therapeutic reasoning and plan. It improves communication between everyone involved in the care of your patient. The most common method of writing this note is using the **SOAP** format.

- S - Subjective:** This section documents the patients' own assessment and description of their condition. Also included here are significant events which have occurred since the last note. You should consider recording the details of any significant conversations (informed consent, pt refusing treatment, etc) with the patient and family here.
- O - Objective:** Under this heading are the vitals signs, input & output, an abbreviated physical examination, and new laboratory and test results. While the vitals signs may seem straight forward, it should be tailored to the service you are on and the patients you are following.
- A - Assessment:** This is the most important part of your note. Here you provide a brief summary of the patient and analysis of his or her pertinent medical problems. Your team's, and eventually your own, reasoning should be explained as to how the patient's signs and symptoms are consistent with a particular diagnosis and how your current test results support or refute your reasoning. A differential diagnosis may also be useful.
- P - Plan:** Your current management and diagnostic plan should be listed. With the current emphasis on shortening hospital stays, it is useful to consider the issue of hospital discharge. Frequently, the Assessment and Plan are written together.

The basic format of a SOAP note is consistent between rotations however there are subtle differences that you'll need to keep in mind as you tailor the SOAP note to each rotation. We've attempted to point out the major differences in the examples that follow.

## THE CASE PRESENTATION

For as long as you practice medicine, you will be presenting patients to your colleagues. To do this, you need to formulate and convey a well ordered, concise summary of the pertinent clinical information. Additionally, the case presentation is the basis upon which your peers form their first impression of your clinical abilities.

### Structure

Think of the presentation as a story. The presentation should begin with the patient's name, age, race, and sex followed by a statement of the chief complaint. If this person has a complicated medical history, you may also include relevant past medical conditions. Your goal is to give the audience a general overview of the patient. Continue with an abbreviated history of present illness, including description of symptoms, chronologic development of symptoms, and pertinent positive or negative review of systems. For the past medical history, list all medical conditions which the patient carries and elaborate on those with special relevance. When you reach medications, only list the names, either generic or brand; if your audience is interested in specific dosages, they will ask. The social and family medical history can be condensed to relevant details; however, some attendings place special emphasis on these areas in order to learn more about the patient. At this point, the audience has constructed and narrowed down a differential diagnosis.

The physical exam should always begin with a description of the patient and vital signs. Then, list the pertinent positives and negatives in the order of systems. The lungs, heart, and abdomen are covered in every presentation due to their importance. Next, the pertinent laboratory values and results from tests or procedures are mentioned. By now, you should have hopefully led the audience to a single diagnosis, so you can finish with a summary statement that mentions the obvious and describes your management plan.

The following is provided as a very brief example which should be tailored to the clerkship and attending preferences:

Mr. Foley, a 53 year old, white male with a history of stage III prostate cancer diagnosed 2 years ago s/p radical prostatectomy with adjuvant radiation therapy, presents with lower back pain x 2 months. Pain began gradually 2 months ago without radiation and has a severity of 8/10. Pain is on and off, and is worse at night but independent of position. Pt. has been taking Advil but without relief. Denies history of trauma to area, change in urination, change in bowel habits, weakness of proximal muscles, fevers, and chills.

Past medical history is as described above. No known drug allergies. Medications include bethanecol. Denies ethanol and tobacco usage. Family history is noncontributory.

On physical exam, the patient is a cachectic male in no acute distress. Vital signs are stable. HEENT: wnl. Lungs: CTAB. CV: RRR, normal S1S2. ABD: (+) BS, soft, NTND, liver edge 2 cm below costal margin. Rectal: hemoccult negative. BACK: point tenderness over L4-L5. EXTREMITIES: Ø c/c/e. NEURO: A+Ox3, motor 5/5 throughout, sensation intact to light touch bilaterally, (-) straight leg raising test. Basic chemistry panel and CBC were within normal limits; however, calcium = 11.5; alkaline phosphatase = 150; PSA=10 a month ago with baseline of 5.

In summary, the patient is a 53 year old male with history of prostate cancer and now presents with back pain. Given the focal nature of the pain with elevated PSA, calcium, and alkaline phosphatase, it is likely this represents metastasis to the lumbar vertebrae. The enlarged liver may represent liver metastasis. Our plan is to start Vicodin for the pain, obtain a bone scan to evaluate for bone metastasis, and obtain abdominal CT to evaluate liver metastasis.

### Helpful Advice

The most common problem with case presentations is that they are too long and detailed. Many people will read directly from their history and physical. This is a mistake. The written history and physical summarizes all the medical information regarding a patient, while the case presentation is concerned with only that information relevant to the current problem (or your diagnosis for the current problem). Remember the following:

- 1) Present only the important facts.
- 2) Start with descriptive information (e.g. name, age).
- 3) Clearly state the chief complaint.
- 4) Offer an assessment and plan.
- 5) Know current vitals and laboratory values.
- 6) Practice makes perfect.

One last critical aspect of giving oral presentations is following the appropriate order (HPI, PMH, PSH, etc). For example, do not include physical exam findings in your HPI. Obeying these conventions will ensure both that your presentations will be more succinct and that they will be more professional.

## ADMISSION AND DISCHARGE

### Admission and Post-Op Orders

\*\*Note: With the advent of the Electronic Medical Record (EMR), most orders are done on the computer and admission is streamlined via order sets. Still, knowing how to do admission orders is important. We've included the below information for your edification.

In writing admission orders, there are many different mnemonics used. The most common is **ADC VANDALISM**. The most important thing to remember when writing orders is to write legibly. Similarly, write each order on a different line so as not to be missed.

**Admit:** specify location, attending, intern, and pager number (varies with service)

*i.e. admit to 9w, Intern: Stern 5-8989*

**Diagnosis:** primary reason for admission. *Or if post-op, instead of diagnosis, should write what procedure was done (i.e. s/p appendectomy)*

**Condition:** severity of pt's condition - whether pt. stable or not  
*i.e. Stable, fair, guarded, critical*

**Vitals:** how frequent do you want them done

*i.e. Call h.o. (house officer) for  $t > 100.5$   $< 96$ ,  $HR > 110$   $< 50$ ,  $RR > 20$   $< 12$ ,  $BP > 160/110$   $< 90/60$ ,  $PulseOx < 92\%$ , urine output  $< 300cc/8^o$*

**Allergies:** list all drug and food allergies and mention the specific reaction to the drug

*i.e. Penicillin – rash; NKDA*

**Nursing orders:** these are specific orders for nursing care

*i.e. Strict I/O, daily weights, accu check qAM, Foley to gravity, NG tube to LIWS (low intermittent wall suction), incentive spirometer 10x/1<sup>o</sup> when awake,*

**Diet:** what the patient is allowed to eat and drink

*i.e. NPO, general diet, clears, 1800 cal ADA, soft mechanical*

**Activity:** what the patient is allowed to do

*i.e. Ad lib, bed rest, OOB to chair*

**Labs:** laboratory tests

*i.e. CBC, chem 7, LFT, ESR*

**IVF:** type of fluid and infusion rate

*i.e. D<sub>5</sub> 0.9 NS at 125 cc<sup>o</sup>, Heplock IV, TKO,*

**Special Studies:** diagnostic tests and consults

*i.e. CT scan of brain with and without infusion, CXR PA/LAT*

**Medications:** include 1) drug name (generic or trade)

2) dosage

3) administration route (PO, IM, SQ, PR)

4) frequency or if order is prn

*i.e. Pepcid 20 mg po qhs*

*Colace 100 mg po bid*

*Vicodin 1-2 tabs po q4-6<sup>o</sup> prn for pain*

\*\*\* When writing post-op orders, do not forget the following five classes of medications (pain meds, dvt prophylaxis, antibiotics, peptic ulcer prophylaxis, meds pt. on prior to surgery)

### The Discharge Note (Standardized forms available)

**Admission Date:**

**Discharge Date:**

**Admission Diagnosis:** Keep it general (i.e. Abdominal Pain)

**Discharge Diagnosis:**

**Attending:**

**Referring Physician:**

**Procedures:** include anything out of the ordinary (e.g. PPD)

**Consults:**

**Complications:**

**Hospital Course:** If the patient is complicated, the best way to approach this is to organize it by systems.

**Condition at Discharge:** if not stable or good, explain

**Disposition:** Discharged home, skilled nursing facility, etc.

**Discharge Medications:**

**Instructions:**

**Follow up Plan:**

### The Electronic Medical Record

As you are probably aware, nearly all of the hospitals you will be rotating through have an electronic medical record system. At NMH, it is PowerChart, at ENH it is Epic, at the VA it is CPRS. Children's and does not have an EMR system yet, but will be getting one in the future. Each system is different and it would take many pages to go through the nuances. You will receive training on the use of these systems as you rotate through the respective hospitals. You will also figure things out as you practice and learn tricks from the residents and M4s on your service. Here are a few general tips to keep in mind:

- Your daily notes need to reflect that day's updated information. You are conveying information to others about the patient's hospital course.
- SAVE, SAVE, SAVE, SAVE!! Loosing a note you've been working on for 30 minutes is not something you want to experience.
- Remember to do the necessary steps to ensure your notes/orders get cosigned.
- Always remember that the EMR is a legal document and is permanent. Be accurate and respectful.

Please note the *Office of Medical Education and Faculty Development* Policy on the Electronic Medical Record for students:

"It is never appropriate for a student to copy and paste elements of another person's H&P or patient care note into their own note and portray it as their work. All information, other than structured data elements contained within the medical record (vital signs, lab results, medication records, etc) should reflect the student's ability to gather and present patient data. If a student copies and pastes their own note from a previous day, it should reflect all relevant changes in the patient's condition and progression in their understanding/analysis of the patient's underlying disease process. Inappropriate copying and pasting of another person's work will be considered a transgression of the student code of conduct and a professionalism form may be submitted to the Dean's office."

### Prescriptions

To prescribe outpatient meds, use prescription stationery when discharging patients on medications. For inpatient medications, write orders directly on the physician's order sheet located at the beginning of the chart. Be meticulous and legible when writing orders and always have them co-signed.

Although similar to medication orders, prescriptions have a distinct structure. You can specify either a brand or generic drug; however, if you use the latter, your patient will receive the generic form of the drug. Generics usually save the patient money and are required by the Food and Drug Administration (FDA) to have 80% bioequivalence of the brand name drug. However, 20% difference may be important, for example, in cardiac medications and may affect how patients are followed up. You also need to know how the drug is dispensed (i.e. strength and form) at the pharmacy. Next, you want to write the *sig*, which is how you want your patient to take the medication. Finally, the pharmacist needs to know how much to dispense and how many refills. You also want to write these numbers out in long hand, so they cannot be altered. Narcotics should not be refilled. Remember to get your prescriptions cosigned.

John Q. Smith

April 19, 2006

Toprol XL 100mg tablet

Sig: 1 tab PO QD

Disp: 30 (thirty)

May substitute: yes

Refills: none

A. Everhart, MS3/Dr. Neely

## THE ROTATIONS

### Lay of the Land:

The hospitals can be surprisingly complicated to negotiate, and finding the results to a particular test may take hours if you don't know where to look. Some commonly utilized locations are as follows:

- **NMH**
  - 1<sup>st</sup> Floor: Emergency Department and ED Radiology Reading Room
  - 3<sup>rd</sup> Floor: Department of Medicine and Surgery Offices
  - 4<sup>th</sup> Floor: Neuroradiology reading room, Ultrasound, MRI, CT, Radiology Film pickup window, GI Lab, Interventional Radiology
  - 5<sup>th</sup> Floor: Primary surgical suites, post-op recovery rooms
  - 6<sup>th</sup> Floor: Resident lounge, Surgery resident room, Staff dining room, Telecommunications office (for **free pager batteries** and paging directory), Scrubs machine
  - 7<sup>th</sup> Floor: Laboratories, Auxiliary surgical suites (mostly Transplant, Cardiothoracic, & ENT), EEG,
  - 8<sup>th</sup> Floor: Nuclear Medicine, Echocardiography, Cardiac Cath Lab, Electrophysiology
  - 9<sup>th</sup> Floor: Dialysis
- **ENH**
  - Ground Floor: Radiology viewing rooms, nuclear medicine, cardiac cath, outpatient clinics (Louis), ED
  - First Floor: Outpatient labs (Louis), Pathology, histology
  - Second Floor: CCU (Louis)
  - Third Floor: OR/Ambulatory Surgery, ICU, Pediatrics (Louis), EDOU (Louis)
  - Fifth Floor: Psych (Louis)
- **Westside VA**
  - 1<sup>st</sup> Floor: MRI
  - 3<sup>rd</sup> Floor: MICU, CCU, Cath lab, Echo (@ the heart station)
  - 4<sup>th</sup> Floor: Lab, radiology
  - 5<sup>th</sup> Floor: SICU

### Suggested Pocketbooks for all rotations:

- ePocrates(PDA) or Tarascon Pocket Pharmacopoeia (Book): Medication reference including indications, available dosing/form, and Generic/Trade name cross referencing.
- Pocket Medicine [Massachusetts General Hospital]: An excellent source of reference on the wards. Great differential diagnosis, work-up, and treatment plans in an efficient outline format. A must-have text for the medicine rotation.
- Maxwell's: Concise guide of normal lab values, etc, etc, etc.

- Optimizing Medication Use at NMH: standard pocket antimicrobial reference guide. Updated annually. Copies available at NMH Pharmacy.
- Northwestern Memorial Hospital Pager Directory: Contains pager and phone numbers of attendings, residents, and labs. Free on 6<sup>th</sup> floor of Feinberg. This info is also accessible via the computer or by dialing the operator.
- Keep **this book** in your pocket. Refer to abbreviations and phone numbers often.

### MEDICINE:

The medical student H&P is usually the most comprehensive and complete H&P in the medical record, usually more so than the resident or attending note. Remember that your note is part of the permanent medical record and to document accurately and truthfully. One of the hardest parts of your junior year will be accurately and efficiently performing a physical exam. We've tried to provide you with the basic information that you should attempt to ascertain with each H&P.

### Medicine H & P (no different from M2 Clinical Skills write-ups):

- CC:** *A few words on why the patient presents, usually a symptom such as "arm pain for 1-2 days."*
- HPI:** *This part of the H&P should tell a story about the patient's symptoms. Try to maintain chronology, but don't forget to include significant past medical history. Also, don't forget to state pertinent demographic information (age/sex), OLD CARTS, and relevant Review of Systems. Since most patients are admitted by way of the Emergency Department, students often struggle with how and where to include information obtained in the ED (i.e. CT scan). We've found that it varies based on the attending, so your best bet is to take note of what the attending wants and adjust your HPI accordingly. If a patient is admitted for dehydration or hypovolemia, include the amount of fluid the patient was given by bolus in the ED.*
- PMH/PSH:** *Specifically ask about major diseases (i.e. Diabetes, heart disease, HTN, Stroke) and correlate to the medication list. Patients will sometimes say they do not have any medical problems but then they're taking thyroid replacement, diuretics, beta-blocker, and have an inhaler. Another tip that is often helpful is to ask about TB exposure or old PPD reactions in patients with undiagnosed pulmonary issues.*
- Meds:** *Medication name, dosage, route, and frequency. Before presenting your patients to the attending, try to figure out why your patient is on each and every one of his/her meds. You'll likely be asked.*

**All:** Medication/Reaction (An upset stomach, for example, is usually not a true allergy. It is therefore important to include the reaction to the medication.)

**FH:** At a bare minimum, the patient's mother, father, and siblings. Remember to include ages and if deceased, the cause of death. Also include the age of Dx for diseases like CA and MI.

**SH:** Tobacco/EtOH/Drug use. Career. If retired, include work history. Living situation (what kind of domicile and with whom)

**PE (we've tried to include the minimum that should be included in the H&P):**

Gen: A & Ox? Pleasant? Cooperative? Sitting/laying? In distress?

VS: Temp (route), Pulse, RR, BP (at time of interview), orthostatics (if thought to be hypovolemic)

HEENT: NCAT? PERRL? EOMI? Sclera? Anicteric? O/p cl s erythema or exudate or lesions?

NECK: Neck supple? Thyromegaly? Lymphadenopathy? JVD or bruits?

CHEST: Normal respiratory effort? Clear to percussion and auscultation? Rales/rhonchi/wheezes?

CV: Reg rate & rhythm? PMI palpable? PMI location? N1 S1/S2 physiologically split and normal? No S3/4, m/g/r or clicks?

ABD: BS normoactive? Soft? Non-tender? Non-distended? Hepatosplenomegaly? Liver span/palpable?

PULSES: Normal? Without carotid, abdominal or femoral bruits?

EXT: Clubbing?/cyanosis?/edema? Full range of motion? No fluctuation/crepitus?

NEURO: Mini-Mental if relevant, CN II- XII intact? Strength 5/5? Reflexes 2/4? Coordination? Gross sensory?

**Labs:** (if any)

**Imaging:** X-rays, CT, MRI, US, EKG

**A/P:** The assessment and plan are usually the most difficult element of the H&P for the Junior student and are often wrong early in the clerkship, this shouldn't discourage you from putting something down (Just put "CONSIDER" before each recommendation and you are usually safe). Late in the clerkship you'll be amazed at how often you're assessment and plan is correct. That said, in the assessment don't forget to include age/sex/race, an abbreviated restatement of the chief complaint and HPI, and a ranked differential diagnosis based on symptoms, signs, PEX, and other studies. For the plan: some attendings want it systems based, while others prefer it problem based (i.e. "CV" vs. "Chest Pain"). For organization

purposes, it is helpful to number each element of the plan. A common mistake in developing a plan is to not include enough. Items commonly left out are: diet, F/E/N, account for ALL medications, include any HELD medications, TEDs/SCDs, DVT prophylaxis, reflux prophylaxis, IV fluids, electrolyte replacement, pending studies, disposition (where are they getting admitted to?).

### Medicine SOAP:

**S:** Include patient's status, significant overnight events, pain control, sleep, toleration of diet and brief ROS.

**O:** Vitals: It is essential to include the patient's current temperature (Tc) as well as maximum temperature in the last 24 hours (Tm), Pulse including range over 24hours, Blood pressure range in 24h, respiratory rate, and pulse Ox (on oxygen or room air). Ins and Outs out to be recorded for the previous three 8hr shifts then summed for the last 24hr period.

PEX: As in H&P above, although is usually less detailed, more focused and includes fewer organ systems.

Labs: Patients usually have daily CBCs (with differential) and basic chemistry panels so it is helpful to date the labs.

Don't forget to follow up on any pending labs from the previous day.

**A:** Very similar to the H&P, but perhaps less detailed. Be sure to include any changes in your original assessment based on new labs, imaging, etc.

**P:** Again, similar to the H&P. A problem based or systems based approaches are equally viable; do whatever works best for you. Any notes written on patients in the MICU should be systems based and always include every system (CV, PULM, RENAL/GU, NEURO, ENDOCRINE, GI, F/E/N, PROPHYLAXIS, DISPOSITION). Students commonly forget to reflect medications that were added, discontinued or dosage changed. The "disposition" does not mean how the patient is feeling. Instead, it is where the patient's plans for discharge are recorded. When in doubt, "discharge per attending" is usually a safe bet.

### References/Textbooks (Recommended books are checked):

- ✓ First-Aid for Medicine: This text provides a great summary of important topics within medicine, and goes into just the right amount of detail. Supplement this text with practice questions.
- Blueprints in Medicine: Great to read early on in the rotation. Covers all major diseases encountered with emphasis on

differential diagnosis and approach to chief complaints. Good quick review right before the exam.

- NMS Medicine: Well written and short enough to read during the clerkship. Organized by system with easy to read chapters in outline form. Practice questions are very similar to the exam.
- ✓ Pretest Medicine: Great question book; reviews major disciplines of medicine with a nice question/explanation section—the key to success in medicine is practice questions!
- ✓ MKSAP: Recommended by Dr. Neely; collection of patient cases with questions; harder than expected for examination. If you like the Board Simulator Series style of difficult questions, then MKSAP is for you.
- Harrison's Principles of Internal Medicine: The authority on Internal Medicine. Very large, heavy, and full of information.
- Cecil Essentials of Medicine: Excellent tables and charts for understanding pathophysiology. Not as useful for treatment reference.
- ✓ UpToDate: This website is the saving grace of the entire healthcare profession. It provides comprehensive, yet always pertinent, information on diagnosis, management and treatment of nearly every diagnosis you could think of, zebras included. An excellent for when your attending asks you to present a topic to the team. It is available only physically on campus (NMH/VA/Galter). As an M4 about a sneaky way to get a 30 day trial to use for free at home.

**Handbook/Pocketbook:**

- ✓ Pocket Medicine [Massachusetts General Hospital]: An excellent source of reference on the wards. Great differential diagnosis, work-up, and treatment plans in an efficient outline format. A must-have text for the medicine rotation.

**EKG:**

Note: Interpretation of EKG's is really important, as it is a common "pimping point" by many attendings, and it is expected that you know how to interpret them when you start on the wards!

- Dubin's Rapid Interpretation of EKG's: Widely recommended resource since it provides a very good step-by-step method in approaching EKGs, though simplistic.
- ✓ The Only EKG Book You'll Ever Need: Thaler. Concise EKG book. Better organized and more explanations than Dubin's.

**Testing:**

The Medicine test is a shelf examination, consisting of 100 questions. Students over previous years have struggled with timing as the stems to each question are usually long and take a while to digest. Also keep in mind that most shelf exams have about 7 questions at the very end that have 12 or so possible answers. Students often find these questions tricky. The key to success seems to be doing plenty of practice questions and starting to read early.

**Other Medicine tips and common pimp questions:**

|  |  |   |  |
|--|--|---|--|
| <u>Reading a CXR:</u><br>Airway<br>Bones<br>Cardiac silhouette<br>Diaphragms<br>Effusions<br>Fields<br>Gastric bubble<br>Hardware  | <u>Deriving a Differential Dx:</u><br>Metabolic<br>Infectious<br>Neoplastic<br>Traumatic<br>Cardiovascular<br>Allergic/Autoimmune<br>Neurologic<br>Drug Reaction<br>Youth (Congenital) | <u>Causes of Sed Rate &gt;100:</u><br>Temporal Arteritis<br>Chronic Infxn (Osteo, SBE, TB, abscess)<br>Thyroiditis<br>Vasculitis<br>Multiple Myeloma  | <u>Hypercalcemia:</u><br>Calcium Overdose<br>Hyperparathyroidism<br>Iatrogenic (Thiazides)<br>Metastasis/Milk Alkali<br>Paget's Dz<br>Addison's Dz<br>Neoplasm (MM)<br>Zollinger-Ellison<br>Excess Vit D<br>Excess Vit A<br>Sarcoidosis                            |
| <u>Anion Gap Acidosis:</u><br>Methanol<br>Uremia<br>DKA<br>Paraldehyde<br>INH/ Iatrogenic<br>Lactic Acid<br>EtOH/Ethylene Glycol<br>Salicylates  | <u>Eosinophilia:</u><br>Neoplasm<br>Allergy<br>Asthma<br>Churg-Strauss<br>Parasites  | <u>Good Quality Sputum Cx:</u><br><10 Epithelial Cells<br>>25 PMN's   | <u>SLE:</u><br>Serositis<br>Oral Aphthous ulcers<br>Arthritis<br>Photosensitivity<br>Blood (ITP, Hemolytic Anemia)<br>Renal Nephritis<br>ANA (almost always +)<br>Immunology (dsDNA, anti-Sm, low C)<br>Neurologic (Lupus Psychosis)<br>Malar Rash<br>Discoid Rash |
| <u>Small Bowel Obstruction:</u><br>Adhesions<br>Bulges (hernia)<br>Cancer  | <u>Large Bowel Obstruction:</u><br>Cancer<br>Diverticulitis<br>Volvulus  | <u>Lower GI Bleeds:</u><br>Hemorrhoids<br>Diverticulosis<br>IBD<br>Ischemic Bowel<br>AVM's<br>Ulcer   | <u>Emergent Dialysis:</u><br>Acidosis/hypoAlbumin/Anor exia<br>Electrolyte imbalance (inc K)<br>Ingested toxins<br>Overload (volume)<br>Uremia with Sx (cns changes)   |
| <u>Proven Mortality Benefit in CHF:</u><br>Beta-blocker<br>ACE inhibitor<br>Spironolactone in Class IV CHF   | <u>Most common ECG change in PE:</u><br>Sinus tachycardia  | <u>Most common Bone Mets (BLT with a Kosher Pickle):</u><br>Breast<br>Lung<br>Thyroid<br>Kidney<br>Prostate   |  |
| <u>Potassium Repletion:</u><br>Goal = 4.0<br>Every 10meq K will raise serum K by 0.1<br><br>PO: K-Dur<br>**can give 40-60 meq at once<br>IV: KCl 10meq IV peripherally need Central line to give 20meq | <u>Magnesium Repletion:</u><br>Goal = 2.0<br><br>Each 1g Mg will raise serum Mg by 0.1-0.2<br><br>Give IV in multiples of 2g   | <u>IV Fluids (4:2:1 rule):</u><br><br>4ml/kg/hr for first 10kg<br>2ml/kg/hr for second 10kg<br>1ml/kg/hr for remaining kg<br><br><u>Shortcut for pts &gt;60kg:</u><br>Weight in kg + 40 = cc/hr |  |

## **SURGERY:**

### **Surgery H&P:**

*Most often, either the H&P will already be completed in the office prior to surgery, or you can get away with using the short H&P forms found in PowerChart. Important things to focus on are: brief HPI explaining why patient is having surgery, what type of surgery is being done (pay attention to R or L sides), PSHx, PMHx, hardware (i.e. artificial heart valves), current meds including and drug allergies.*

### **The Postoperative Note:**

Pre-op diagnosis: initial preoperative diagnosis  
Post-op diagnosis: final postoperative diagnosis (often “same”)  
Procedure: describe what procedure was performed  
Surgeon: Attending(s)  
Assistants: Resident(s) and student  
Anesthesia: local, regional, or general (GETA, MAC)  
I.V. Fluids (IVF)\*\*: Amount crystalloid and/or colloid  
Estimate Blood Loss (EBL)\*\*: Often “minimal”  
Urine output (UOP)\*\*: Indicate if no Foley  
Drains: type, location, and how much has drained  
Findings: describe gross pathology as well as significant normal findings  
Specimen: what specimens were taken and their destination  
Complications: (i.e. “none”)  
Condition: stable vs. unstable, intubation status  
Disposition: usually to recovery room  
\*\* Ask the anesthesiologist for IVF, EBL and UOP

### **Surgery SOAP:**

**S:** *Postoperatively, always ask about incision pain, flatus, bowel movements, urination (if no Foley), any nausea/vomiting, fevers/chills/sweats, response to pain meds (# of times PCA was admin.), whether tolerating PO well (if eating), and activity (able to ambulate or not).*

**O:** *Vitals: Tmax, Tcurrent, HR, RR, BP, SaO2 (if applicable)  
List urine output for last 24hrs in 8hr intervals. (listed under the I/O tab in PowerChart)  
List drain outputs for last 24hrs in 8hr intervals (listed under the I/O tab in PowerChart)*

#### **Basic Exam:**

Lungs: *clear to auscultation?*

CV: *any new murmurs?*

Abd: *bowel sounds? (important deciding factor when to advance diet)*

Incision: *clean, dry, and intact (C/D/I)? granulation tissue? state of dressing (in place? clean?)*

Ext: *any edema? calf pain/tenderness (sign of DVT)?*

Labs, imaging, path results, studies, etc.

**A/P:** *Always include which post-op day (Day of Surgery is POD #0; next day is POD #1). A/P similar to medicine SOAP note but much shorter. Plan should be to the point. Include pain control, diet, PT/OT and plans for discharge.*

### **Duties while in the OR:**

Regardless of whether you love or hate being in the OR, the following advice will be helpful:

1) Try to look at the OR schedule (it’s available in Powerchart) the day before surgery and learn the operative anatomy and pathophysiology of the surgical problem. It’s difficult to impress an attending with your knowledge of anatomy, but *not* knowing it can look quite bad.

2) While in the OR, your job is often to help retract. It’s not glamorous, but it is often vital to have an extra set of hands there. If you hold your ground, some attending may let you throw a suture or tie a few knots.

3) You will be taught to tie suture knots as part of the clerkship. Especially for those interested in going into surgery, it is recommended that you practice tying. If given the opportunity to tie in the OR, it is best to be prepared: if they see you can tie, they will likely let you tie more.

4) You will also often assume the role of holding the suture scissors and snipping off any suture tails. Again, it is difficult to impress the attending with this task, but it is potentially disastrous if you do it improperly. Pay attention so you are not surprised when asked to cut. Ask what length he/she prefers. Furthermore, if there is any doubt about where to cut, you should just ask.

4) Attempt to befriend the scrub and circulating nurses. Try to get on their good side as they can be very helpful at guiding you in the OR.

5) Always be aware of the sterile field. Stay away from the scrub table when you are not sterile. If you have any doubt whether or not you can touch something, DO NOT TOUCH IT. *When you have scrubbed in, don’t contaminate yourself!!!* When gowned and gloved and not standing at the table, keep your hands above your waist and on your abdomen at all times. If you do become contaminated for any reason, tell someone. You will get training on proper sterile technique.

6) The sooner you learn to place a Foley, prep an incision site, and help transfer patients to and from the surgical bed, the sooner you will feel helpful in the OR.

### **References/Textbooks (Recommended books are checked):**

✓ *Essentials of General Surgery/Essentials of Surgical Subspecialties*: Required textbooks for surgery rotation. Most find the general surgery book concise and useful. Has adequate coverage of pathophysiology as well as some anatomy and surgical

technique, but lacks detail and depth in many areas. The subspecialty text is probably less useful and much of its information is adequately covered in review books.

- ✓ Surgical Recall: An **excellent** pocketbook for surgery rotation. Quick and easy to read...*read it over and over!* Answers to many typical pimp questions and many good mnemonics. An essential for the rotation and very helpful for the tests.
- ✓ First Aid for Surgery: Excellent overview of general surgery topics. Decent subspecialty coverage, though still lacking much detail. Contains high-yield topics and helpful mnemonics.
- BRS General Surgery and Surgical Subspecialties: Good books that provide adequate preparation for the shelf. Sometimes not detailed enough, but have good questions at the end of every chapter.
- Netter's Atlas of Anatomy: Netter will usually suffice for all your anatomy needs. Read the night before surgery for a good anatomy review.
- Pretest Surgery: Good preparation for the shelf exam. Answer explanations are great.
- Appleton and Lang: More than 1000 practice questions to prepare for the shelf exam. Fairly challenging, but the answer explanations are often not very thorough or helpful.
- NMS Surgery Casebook: Several comprehensive case studies. A nice alternative or supplement to practice questions and textbooks.
- Lange Case Files: Surgery: Good review for basic surgical principles though often lacking detail.
- Learning Objectives with Answers: A large document created by M3 students a few years back that consists of all of the surgery learning objectives that each have written answers. You may stumble upon this document (as it circulates around the class every year), but if you do not, don't worry. While it is highly recommended that you study all of the learning objectives, this document is not great study material. Some of the answers are good, but many are very incomplete and non-informative. You may find using this as a primary source is a waste of time.

**Testing:**

There are 3 components to the surgery exam: a midterm, an OSCE and a shelf. The midterm is an in-house test that does contain some slides. It is derived directly from the learning objectives, so if you know your objectives you should do fine. Most people have only covered about half of the total material by the time the midterm rolls around and the average on the test is usually between 50-60%. Don't freak out if you don't get your typical A++ because your midterm grade is relative.

|   |   |  |
|---|---|--|
| <u>Post Op Fever:</u><br>Wind - atelectasis, pneumonia<br>Water - UTI | <u>Compartment Syndrome:</u><br>Pain<br>Paresthesia | <u>Anterior Mediastinal</u><br><u>Mass (4 T's):</u><br>Thymoma |
|---|---|--|

|   |  |  |
|---|--|--|
| Wound - infection<br>**Womb - endometritis, uterine<br>infxn (if C-Section)<br>Walking - DVT<br>Wonder drugs  | Pallor<br>Paralysis<br>Poikilothermia<br>NOT pulselessness   | Terrible (T-cell) Lymphoma<br>Teratoma<br>Thyroid Goiter   |
| <u>Sepsis:</u><br>Systemic Inflammatory<br>Response Syndrome (SIRS)=<br>Temperature: ↑ or ↓<br>Tachycardia<br>Tachypnea<br>Leukopenia or Leukocytosis<br>Hypotension<br>Sepsis = SIRS + Infxn<br>Septic Shock = Sepsis<br>unresponsive to fluids<br>(must use pressors) | <u>Hematuria (ITS):</u><br><b>I</b> - Infection<br>- Infarction<br>- Iatrogenic (drugs)<br><b>T</b> - Trauma<br>- Tumor<br>- TB<br><b>S</b> - Stone<br>- Sickle cell<br>- cystitis | <u>Fistula that fails to close:</u><br>High output<br>Intestinal destruction<br>Short segment<br>Foreign Body<br>Radiation<br>Infection<br>Epithelialization<br>Neoplasm |

## **OBSTETRICS & GYNECOLOGY:**

Included are templates of the necessary OB/GYN notes. They are intended to serve as references throughout the rotation.

### **OBSTETRICS**

#### *History&Physical:*

**CC:** \*\*\*

**HPI:** Start with age G\_P\_\_\_\_@\*\*\* of weeks dated by (LMP, US {at # of weeks}, or both) admitted for : *describe the reason for coming the hospital as you would for other rotations*, making sure to ask about vaginal bleeding, contractions (frequency and intensity), loss of fluid, and fetal movement.

Prenatal Course: Any complications? Any screening tests and their results? Ultrasounds?

**PMH:** As per usual

**PSH:** Particularly any abdominal surgeries

**POBHx:** # of pregnancies; # of births (Term >37wk; Preterm 20-37wk; Abortions/Miscarriages <20wk; Living); Ask about route of delivery, duration of labor, size of baby, sex of baby, and any complications.

**PGYNEHx:** Abnormal PAPs, Workup for abnormal PAP and if PAPs have been normal since, Gynecological procedures, STDs.

**MEDS:** As per usual

**Allergies:** As per usual

**Social Hx:** EtOH, Tobacco, other drugs.

**Family Hx:** History of birthing complications or birth defects, bleeding diatheses.

**PEX:** Vitals

GEN –

CV –

LUNGS –

ABD – gravid, NT, fundal height

EXT – comment on edema

**FHT** (*fetal heart tones*) – baseline, long-term variability, accels, decels, variables (describe the decel or variable) –you’ll learn how to read these during the first few days on L&D.

**TOCO** (*tocometer-measures uterine contractions*) – q\*\*\*min; level of Pit

**SVE** (*sterile vaginal exam*) – dilation/effacement/station (done by the resident or attending; students write “deferred”).

**Labs/Studies:** Be sure to include GBS status, Blood type, Ab status, Hep B, RPR/VDRL, Rubella and HIV.

**A/P:** Age, G\_P\_\_\_\_ at \*\*\* of weeks dated by (LMP or US {at # of weeks} or both) admitted for \_\_\_\_\_.

1. Maternal Well Being (*MWB: usually “reassuring”*)
2. Fetal Well Being (*FWB: usually “reassuring”*)
3. Labor (*expectant management? Start Pit? AROM?*)
4. Other issues (*like GBS, Gestational diabetes, etc.*)

## **Labor SOAP NOTE: written every two hours will patient is laboring**

**S:** In any pain? Feeling contractions?

**O:** Vitals

FHT – baseline, long-term variability, accels, decel, variables (describe the decel or variable).

TOCO – q\*\*\*min; level of Pit

SVE – dilation/effacement/station (done by the resident or attending; students write deferred).

**A/P:** Age, G\_P\_\_\_\_@\*\*\* weeks dated by (LMP or US # of weeks or both?) in latent/active labor.

1. FWB – reassuring.

2. MWB – how is the mother doing? Does she need pain meds? Are pain meds helping her?

3. Labor – cont pit if being used. Include any change in labor.

4. GBS status – if positive then indicate antibiotic being given.

### **Delivery Note: Resident will likely have you use a template off of EPIC or PowerChart, but here are the basics**

**Procedure:** NSVD/LFVD/OFVD/Primary LTCS/Repeat CS/Classical CS  
**PreOp Dx:** # of weeks IUP. # of hours in 2<sup>nd</sup> stage of labor. If C/S, give reason why.

**PostOp Dx:** same

**Attending:** \*\*\*

**Asst:** resident and/or student present for delivery

**Anesthesia:** typically CLE (epidural)

**EBL:** Ask anesthesiologist in case of a C/S

**IVF:** for C/S ask anesthesiologist

**UOP:** for C/S ask anesthesiologist

**Findings:** \*\*Viable M/F infant. Weight. Apgars at 1 and 5 minutes.

\*\* Placenta delivered via manual expression/extraction. Intact?

3 Vessel Cord? Abnl?

\*\* If C/S, note status of uterus, tubes, and ovaries bilaterally.

**Lacerations:** If vaginal delivery, indicate the lacerations, repair and type of suture material used.

**Specimen:** indicate if cord blood collected.

**Complications:** \*\*\*

**Condition:** stable

**Disposition:** LDR (for vaginal deliveries) or RR (for C/S) with infant

**Dictation:** (Resident or attending does dictation)

### **Post Partum Progress Note for a Cesarean Section:**

**S:** Ask about pain, diet (and if tolerating it), nausea, vomiting, flatus, voiding, vaginal discharge, ambulation, and breastfeeding (and how it is going). Ask about post partum birth control plans.

**O:** Vitals and I/O’s (especially UOP over 24hr)

CV – RRR.

LUNGS – CTAB.

ABD— +/- BS. Soft. Appropriately tender. ND. Uterus firm @ 1-2cm +/- umbilicus. *Be sure to have pt lying flat for abdominal exam*

INCISION – c/d/i.(clean, dry, intact)

EXT – check edema/calf tenderness.

Labs – if POD #1.

**A/P:** POD # s/p [Type of C/S]. AFBVSS. Adequate/Good UOP. Doing well.

Include on: POD #1 – d/c foley

Advance diet to general

PO pain meds

HLIV (hep-lock IV)

Encourage ambulation

Check CBC

Lactation consultant PRN

**\*\*Remove bandage on POD #1\*\***

POD #2 – Continue above recommendations

Advance diet if not already on general

POD #3 – Continue above recommendations

**\*\*Staples are usually removed on POD #3 for TRANSVERSE INCISIONS**

**ONLY.** If in doubt, ask your resident. Apply Benzoin and steri-strips

perpendicular to incision.

#### Post Partum Progress Note for a Vaginal Delivery:

**S:** Ask about pain, eating/drinking, nausea, vomiting, voiding, vaginal bleeding, and breastfeeding (and how it is going). Ask about post partum birth control plans.

**O:** Vitals. I/Os (if they have been recorded).

GEN – A&OX3. NAD.

CV – RRR.

LUNGS – CTAB

ABD - +/- BS. Soft. Appropriately tender. ND. Uterus firm @ 1-2cm +/- umbilicus. *Be sure to have pt lying flat for abdominal exam.*

EXT – check for edema/calf tenderness.

**A/P:** PDD # s/p NSVD (or forceps assisted VD). AFBVSS. Adequate/Good UOP. List how patient is doing.

-General diet

-Encourage ambulation

-Lactation consultant as needed

-Post partum birth control plan

### GYNECOLOGY

#### Gynecology Op Note:

**Pre-Op Dx:** \*\*\*

**Post-Op Dx:** \*\*\*

**Procedure:** \*\*\*

**Surgeon:** \*\*\*

**Asst:** Include resident(s) and medical student(s)

**Anesthesia:** usually either GETA (general) or CLE (epidural)

**EBL:** Get from Anesthesiologist

**IVF:** Get from Anesthesiologist

**UPO:** Get from Anesthesiologist

**Findings:** From both exam under anesthesia and Intra-op findings

**Specimen:** What you found and where it went

**Complications:** \*\*\*

**Condition:** Stable to PACU

**Dispo:** \*\*\*

**Dict:** Resident or Attending will do

#### Gynecology SOAP:

**S:** Ask about pain control (on IV or PO meds), fever, nausea, vomiting, diet (and if tolerating), flatus, voiding, CP, and SOB.

**O:** VS and UOP (if not in computer be sure to ask nurse)

GEN – A&OX3. NAD.

CV – RRR. No RMG

LUNGS – CTAB.

ABD – Note +/- BS. Soft. ND. Appropriate tenderness.

INCISION – cdi. No erythema or drainage. {Remove bandage on POD #1 unless specifically told not to}

EXT – Note edema and +/- SCDs/TEDs

Labs/Studies – \*\*\*

**A/P:** POD # s/p {procedure} for {what reason}. List how patient is doing. AFBVSS.

1. FEN – IVF, diet

2. GU – d/c foley?

3. CV – stable?

4. Pain – change to PO meds?

5. Other medical problems and their tx

6. Path – pending if not back yet. When back print a copy for the chart (if at Prentice).

#### Gyne Discharge Instructions:

Admit Date: \*\*\*

D/C Date: \*\*\*

Procedure: \*\*\*

Meds: in pt's language; Pts usually leave with:

Norco 10/325mg 1 PO Q4H prn for pain; Disp: 30 (no refills)

Motrin 600mg PO Q6H prn for pain; Disp: 30 (no refills)

FeSO4 325mg PO BID; Disp: 60 (3 refills)

Colace 100mg PO BID; Disp: 60 (3 refills)

Stairs: as tolerated

Lifting: No more than 10-15lbs for 2-6wks

Diet: No restrictions

Driving: Not while taking pain meds (Norco)

Other: Call if: temp>100.5, uncontrolled pain, severe nausea or vomiting, or with any questions.

In case of questions or emergency call Dr {the attending} at {the phone number} or 911

**\*\*Be sure to fill out the appropriate D/C form and write out the prescriptions. This is good to do on POD #0 so that it is done for the residents.**

## **DUTIES ON OB**

### Days

1. Check in with residents, check the board for patients to pick up at the beginning of your day
2. Write H&Ps on new patients throughout the day
3. Check on patients every 2 hours and write a labor progress note
4. Work with nurse when patient is pushing
5. Gown up promptly for delivery (always wear the blue-knee high boots!) and be ready to be an active participant in the delivery (obviously attending and patient dependent)
6. Follow patients to C-sections or be willing to go to a C-section at anytime during the day

### Night Float

1. Largely the same as days in regards to picking up and following patients, hours are typically 7PM to 7AM.
2. If interested, go to the ER for with the Gyne on-call resident
3. Always have something to read on hand as nights can range from very busy or very slow.

## **DUTIES ON GYNE**

### In The OR

1. Check to see if the patient needs Abx. Go fetch them if necessary (they will show you where the pharmacy is on the first day)
2. Take bed out and help put it back in
3. Write your name on the board
4. Pull your gloves
5. Introduce yourself to the circulating and scrub nurses
6. Put SCDs on the pt's legs
7. Exam under anesthesia with resident and/or attending
8. Place foley and do thorough vaginal prep

### On The Floors

1. Daily SOAP notes and orders done and in chart by 6:30am so resident can add addendum
2. Take off bandage in AM of POD #1 unless specifically told not to. Leave dressing for the resident to examine.
3. Check POD #1 CBC
4. D/C instructions and scripts
5. PostOp Check and note
6. PM checks (no note needed, but done to update team) – Diet changes? Pain control? Voiding? Flatus? New orders?
7. Follow-up on pathology POD #1 or 2. Print copy to put in chart.

### **Commonly Used OB/GYNE Abbreviations:**

GPs! (Learn this early on!)

G\_P\_\_\_\_\_  
Gravida : number of pregnancies

Para: number of births in this order:  
Term, Preterm, Abortions, Living

### **References/Textbooks (Recommended books are checked):**

- ✓ **Beckmann's Obstetrics and Gynecology:** Same book from SBM. An easy and concise read with helpful tables, figures, and diagrams. Helpful practice questions at the end of the book.
- ✓ **Blueprints in Ob/Gyn:** Good concise easy read. Adequate to prepare you for the shelf.
- ✓ **First Aid—OB/GYN:** Good preparation for the shelf.
- **Obstetrical Pearls/Gynecologic Pearls:** Great pocketbook. Provides a concise summary of all of the major topics. Can be read within a day at a moderate pace. Good to read day before starting new block of either OB, GYN surgery, or clinics.
- ✓ **Pre-Test OB/GYN:** 500+ clinical questions structured after the USMLE Step 2. Excellent practice for OB/GYN shelf exam.
- ✓ **Case Files: OB/GYN:** Excellent preparation for Shelf and OSCE. For many students a must read. Case based, so easy to work through.

### **Testing:**

- SHELF: typical 100-question shelf exam with ~2hours.

- OSCE: In the past, it has consisted of 6 stations including a pregnant patient (fundal height, FHT, due date, etc), an ethics related oral question, a web search, a chart review station, a pathology/ultrasound station and a vaginal exam station.

### **Commonly Used OB/GYNE Abbreviations:**

|   |   |
|---|---|
| Ab – abortion (included elective, therapeutic, and miscarriages)  | LOF – loss of fluids (water breaking)                 |
| AFVSS – afebrile, vital signs stable  | LTCS – low transverse C-section                       |
| BSO – bilateral salpingo-oophorectomy   | LTV – long-term variability                           |
| C/D/I – clean/dry/intact  | MAC – conscious sedation                              |
| CLE – epidural  | MWB – maternal well being                             |
| C/S – C-section   | NSVD – normal spontaneous vaginal delivery            |
| Ctx or Ucx – contractions   | POBH – past OB history                                |
| FF – fundus firm  | POD – post op day (0=day of surgery)                  |
| FHT – fetal heart tracing   | PP – post partum                                      |
| FM – fetal movement   | PGYNEH – past GYNE history                            |
| FT – full term  | Pit – pitocin   |
| FWB – fetal well being  | PPBC – post partum birth control                      |
| GETA – general anesthesia   | PPROM – preterm premature rupture of membranes        |
| GPs – Gravida (number of pregnancies) and Para (number of births in this order: Term, Preterm, Abortions, Living) | PROM – premature rupture of membranes                 |
| IUP – intrauterine pregnancy  | ROM – rupture of membranes                            |
| LFVD/OFVD – forcep assisted vaginal delivery  | TAH – total abdominal hysterectomy                    |
| LMP – last menstrual period   | TVH – total vaginal hysterectomy                      |
|   | TOCO – tocometer (measures frequency of contractions) |
|   | U/S – ultrasound                                      |

## PEDIATRICS:

All students will spend 3wks on inpatient ward and 3wks on outpatient clinic. Inpatient will be either at Children's Memorial or at Evanston Northwestern Hospitals.

**CMH inpatient:** either on General, ID/Rhem, or Pulm/Allergy service

\* CMH is switching to EPIC, but now is paper charting. There are binders for each patient w/ notes in them. Labs looked up on computer. Imaging in PACS.

**ENH inpatient:** on General service. May see lot of cystic fibrosis pts b/c one attending specializes in this.

### Pediatric H&P:

#### **CC:**

**HPI:** "4mo boy w/ no sig PMH presents with \_\_\_\_\_."

- Typical OLDCARTS stuff.

- How much is he drinking/eating/peeing/pooping? What does he eat (BM = breast milk, formula)? How much and how often? Normal for them? Last time they pooped, consistency?

- How much is he sleeping? More/less than usual? Is he easily arousable? Is he more fussy than usual? Is he consolable? \*Parents throw around the words "lethargic" and "irritable" and "more fussy." When we say a child is lethargic (and not easily arousable) or irritable (and not consolable), we have to start thinking about meningitis - so be careful with your terminology.

- You can report what they did in the ER here, but some people like you putting it in your A/P.

**PMH: Ongoing medical problems?** Hospitalizations? ER visits? Who is his PMD? Hx of asthma/allergies/eczema? (Always ask about the three b/c they always go together) Immunizations up to date?

#### **Meds/Allergies:**

**Diet:** Ask it if you haven't gotten it yet. BM? What kind of formula? How much, how often?

**BirthHx:** Pregnancy: Full term? Any complications? Any prenatal care?

Birth: Any complications? GBS status? Any fevers? Any ABx? How long stay in the hospital? Did he go home w/ mom?

**Developmental Hx:** Assess the milestones. Ask parents, but observe as many as you can (head lag, rolling over, grasp).

**SocHx:** Who lives at home? Environment? Apt/home? Any pets? Any smokers? Who does he spend time with during the day (care taker, day care, school, etc)? Recent travel?

**FamHx:** Hx of asthma/allergies/eczema? Childhood diseases in family, genetic disorders, cancer? (Parents/Grandparents/Sibs)

#### **PEX:**

VITALS: T/HR/RR/BP

height/weight/head circumference (if<2yo)/BMI, and their percentiles -- which you can get from growth curves.

GEN: Describe what the child is doing. Is (s)he well-appearing/ill-appearing? Crying? Consolable?

HEENT: Head: NCAT (normocephalic/atraumatic), AFOSF (anterior fontanelle open/soft/flat). If less than 2yo, assess anterior

and posterior fontanelles.

Eyes: PERRL, EOMI, tears production, red reflex (looking for retinoblastoma/cataracts/etc) with an ophthalmoscope. Don't worry about looking at the fundus.

Ears: TM? (have mom or dad help hold the child's arms down)

Throat: OP clear?, MMM?, erythema or exudates?

NECK: no LAD (a shotty node should be less than 1cm)

CV: RRR, nml S1S2, no m/r/g

LUNGS: CTA B, wheezes, nasal flaring, tracheal tugging, subcostal retractions, accessory muscles.

ABD: soft, NTND, bowel sounds, no HSM

BACK: sacral dimple

GU: Tanner Stage, nml male ext genitalia - circumcised penis, testes descended bilaterally

RECTAL: Anus patent

EXT: good cap refill (<2cm) or WWP (warm and well-perfused), no c/c/e.

SKIN: no rashes

NEURO: "Appropriate" usually good enough. MAEW (moves all ext well). Can comment on tone/strength/reflexes (esp. sucking, palmar grasp, Moro, Babinski... DTR's are less important unless it's something musculoskeletal or neuro in nature)

\* Above PE is pretty comprehensive list of what you should assess. Some attendings/residents will not want/expect you to record such a detailed exam, especially if findings are normal.

#### **LABS/STUDIES:**

- For cultures, always report as "NGTD x how many days" - no growth to date, and if it's still pending

**A/P:** 4mo boy p/w whatever. Then start working on your differential diagnosis. Usually a paragraph or a couple of sentences. Then break down your plan by system. (may only have main issue and FEN [fluids, electrolytes, nutrition] depending on level of complexity of patient) You may commonly see POAL (PO ad lib) in the FEN section.

### Pediatric SOAP:

**S:** What happened overnight - per mom, per nursing staff, per pt. Update on main issue. Eating (tolerating PO? any emesis?), peeing, pooping.

#### **O:** Vitals:

- Tmax for last 24hr - note other fever spikes (when)
- Tcurrent
- HR + 24hr range
- RR + 24hr range
- BP + SBP range/DBP range over 24hr
- O2 sat + 24hr range
- daily weight
- I/Os 24hr total in (break it down by IV/PO) over 24hr total out = total up or down.  
For example, 500 in (300 PO, 200 IV)/600 out = -100 down.

- UOP: look specifically at urine output (record as cc/kg/hr, >1 is nml) and stool output (record as cc/kg/day, <20 is nml).

Exam: At the very least: GEN, HEENT, RESP, CV, ABD, EXT, NEURO

Labs: As above.

A/P: As above.

**References/Textbooks (Recommended books are checked):**

- The Harriet Lane Handbook: Classic pocketbook for the house officer. A must-have if you're going into Pediatrics, although usefulness for our level of education is questionable. One is usually available on the floor for reference.
- ✓ Blueprints in Pediatrics: Extremely good overview of peds. Easy read through. Good review material
- Pediatric Articles: Collection of articles given by clerkship director during introduction to Pediatrics. Covers most relevant subjects in pediatrics, although some articles are too detailed.
- ✓ Clip Cases: A computer program that you will be given info on during your orientation. Teaches you peds topics in a case-based manner. You are required to do about half of them. Many students find them an excellent way to learn. Has summary pages at the end of each case. Consider printing out these summary pages and studying from them. Many students have felt these were the most important study aid for this clerkship.
- ✓ Pretest Pediatrics: Prepares you for the Shelf Exam
- ✓ First Aid: Pediatrics: *Some find this book too dense, others view it as the only book they need.*

**Testing:**

The pediatrics exam is a 100 question shelf examination.

Grade determined by shelf exam score + clinical evals + 10min presentation + participation.

Psychiatry H&P:

**CC:** Describe CC, as you would do with any H&P

**HPI:** Include age, sex, and history of psychiatric d/o. Include living situation, employment, recent stressors and funding status if pertinent to the CC.

**Psych ROS:** -Assess mood (depression screen ask SIGECAPS; mania/hypomania/mixed episodes ask DIGFAST)

-Assess anxiety (excessive worry, panic attacks, obsessions, compulsions, social anxiety)

-Assess psychosis (including A/VH, paranoia, delusions, disorganized thinking/behavior)

-Assess functionality (missed work or unemployment, ADLs)

-Assess chemical dependency

-Pt's subjective sense of cognition (concentration and memory)

**Past Psych Hx:**

-Previous inpatient hospitalizations – when, where, why

-Previous outpatient tx – therapist/psychiatrist and when last seen, meds used, how long tx lasted, and if it was beneficial.

-Get written consent to speak with therapist if possible.

-Previous suicide attempts/aborted attempts/self-destructive behavior (such as cutting)

**Chem Dep:**

-Current use of EtOH (CAGE screen), drugs (ask about specific drugs), and tobacco – quantity, frequency, pattern of use, last use of each, triggers for use.

-If positive drug abuse, ask about history of withdrawal seizures, DTs, blackouts

-Be sure to ask when first used, if there have been periods of sobriety, rehab/detox/AA/NA programs attended.

**PMH:** ask specifically about – seizure d/o, h/o head trauma and LOC, stroke, In women with children ask about post partum depression

**PSH:**

**Meds:** List meds on prior to admission and while in hospital. List use of PRN meds. Don't forget herbal, over the counter meds and birth control

**Allergies:**

**Family Hx:** h/o depression, bipolar d/o, anxiety, "nervous breakdowns," psychosis, suicide attempts, psych hospitalizations, and pertinent family medical hx.

**Social Hx:** Include living situation, significant others, social support system, education level, employment status, source of income, legal problems, abuse hx.

**Mental Status Exam:**

Vitals:

GEN – appearance relative to age, race, dress, hygiene, behavior, eye contact, cooperativeness, alertness, orientation

SPEECH – rate (accelerated/slowed/normal), rhythm

(halting/hesitancy/stuttering), volume (loud/soft/normal), lack of spontaneity? Hypervocal?

PSYCHOMOTOR – psychomotor retardation or agitation, tremor, ataxia, wheelchair bound.  
 MOOD – in the pt’s words.  
 AFFECT – objective sense of pt’s mood: range (constricted/full/labile), intensity, mood congruent/incongruent?  
 THOUGHT CONTENT – passive or active SI, intent, plan, HI, A/VH, paranoia, delusions, obsessions, ruminations, etc.  
 THOUGHT PROCESS – linear, focused and goal oriented?  
 Disorganized flight of ideas/logical/illogical/tangential/circumstantial?  
 INSIGHT – poor/fair/good/excellent  
 JUDGEMENT – poor/fair/good/excellent. Is pt making good decisions for themselves and others in their care?

MMSE – (mini mental) – use card from 1<sup>st</sup> year or pocket book.

**Labs/Studies:**

**Assessment:** Brief statement of overall impression.

Axis I: Primary psychiatric dx (major depressive d/o, somatization d/o, panic d/o, schizophrenia, bipolar d/o)

Axis II: Personality d/o and mental retardation. (Don’t dx a personality d/o for the first time in the hospital. It is not a dx that can be made in that setting. Instead, always write “DEFERRED”.)

Axis III: Medical d/o

Axis IV: Psychosocial stressors (chronic mental illness, financial or employment stressors, relationship strain)

Axis V: Global Assessment of Functioning – Found in DSM IV

**Plan:** Include med suggestions, suggestions for placement, suggestions for additional consults, suggestions of how to deal with family, etc.

**Psychiatry SOAP:**

**S:** Events o/n. Use of PRN meds (found in MAR)

**O:** Vitals

GEN – appearance, race, dress, hygiene, behavior, eye contact, cooperativeness, alertness, orientation

SPEECH – rate (accelerated/slowed/normal), rhythm (halting/hesitancy/stuttering), volume (loud/soft/normal), lack of spontaneity? Hypervocal?  
 PSYCHOMOTOR – psychomotor retardation or agitation, tremor, ataxia, wheelchair bound.

MOOD – in the pt’s words.  
 AFFECT – objective sense of pt’s mood: range (constricted/full/labile), intensity, mood congruent/incongruent?  
 THOUGHT CONTENT – passive or active SI, intent, plan, HI, A/VH, paranoia, delusions, obsessions and ruminations  
 THOUGHT PROCESS – linear, focused and goal oriented?  
 Disorganized/scattered/logical/illogical/tangential/circumstantial?  
 INSIGHT – poor/fair/good/excellent

JUDGEMENT – poor/fair/good/excellent. Is pt making good decisions for themselves and others in their care?

MMSE – (mini mental) – use card from 1<sup>st</sup> year.

Labs/Studies –

**A/P:** Brief impression.

-Med suggestions, placement suggestions, suggestions of additional consults, f/u on outpatient treatment options.

**References/Textbooks (Recommended books are checked):**

- Stoudemire's Clinical Psychiatry for Medical Students: Should already have this book from SBM. Extremely wordy, but it contains all the necessary information.
- Diagnostic Statistical Manual IV: For those students who consider Psych as a specialty, as well as those students on the Consultation-Liason service.
- ✓ First-Aid for Psychiatry: Many students find this book as helpful for psychiatry as the First-Aid for Medicine was during that rotation.
- ✓ Pretest Psychiatry: Good questions in preparation for the shelf exam.
- NMS Psychiatry: Many students use the NMS series to read as the clerkship progresses. To study for the final exam, *NMS Psychiatry* has many useful questions.
- Psychiatry by Current Clinical Strategies Publishing: Excellent Pocketbook with most of the information you’ll need for the shelf

**Testing:**

The Psychiatry exam is a 100 question shelf examination. This exam is traditionally very difficult to finish due to long question stems. Watch your time carefully. Exams in previous years have included a number of child and adolescent psychiatry questions. You will be minimally exposed to child psych on the wards, so you are responsible for learning this material independently. Also, there is a pass/fail OSCE that will be further explained during the clerkship.

**Commonly Used Psych Abbreviations:**

|  |  |
|--|--|
| ADL – activities of daily living   | MR – mental retardation  |
| A/VH – auditory or visual hallucinations   | NA – narcotics anonymous   |
| Chem Dep – chemical dependency   | SI – suicidal ideation   |
| DIGFAST – sx of mania: Distractibility, Irritability, Grandiosity, Flight of ideas, Activity (Inc), Speech (Pressured), Sleep, Thoughtlessness | SIGECAPS – sx of depression: Sleep (Inc or Dec), Interests (Dec), Guilt, Energy (Dec), Concentration (Dec), Appetite (Inc or Dec), Psychomotor retardation/agitation, Suicide Ideation |
| HI – homicidal ideation  |  |

## **NEUROLOGY:**

### **Neurology SOAP:**

**S:** similar to Med. SOAP

**O:** similar to Med. SOAP

Should include a full neurological exam like the following:

MSE (mental status exam)

- A&O x 3 (alert and oriented to person, place, and time)
- Mini mental 24/30 unable to recall 3 objects at 5 min and unable to spell “world” backwards

CN (cranial nerves)

- Usually acceptable to put “CN II-XII intact” unless they aren’t. If there’s an abnormality, describe it.

Motor:

- 5/5 is normal
- Be sure to check for pronator drift and examine distal and proximal muscle groups.

Reflex:

- 2+ is normal (scale 0-4, 0 =absent)
- Check biceps, triceps, brachioradialis, patellar and Achilles
- Assess Babinski (flexor response (toes down) is normal)

Coordination: Assess finger to nose, fast finger movements, rapid alternating movements, heel to knee, Romberg

Sensory: Assess lt touch, pinprick, proprioception and temp.

Gait:

- Describe their gait
- Can they walk on the toes? Heels? In tandem?

**A/P:** similar to Med. SOAP note.

### **References/Textbooks (Recommended books are checked):**

- ✓ Clinical Neurology by Gelb: This is the recommended textbook by the clerkship director. It is an easy read and we would recommend reading the text twice in preparation for the exam.
- High Yield Neuroanatomy: Great review of neuroanatomy! Good basis for neurological principles. Not always a necessary book, but can definitely help with the basics.
- Pre-Test Neurology: If you like practice questions, then this book isn’t bad; however it tends to have many detailed questions that will likely not be assessed on the shelf exam.

### **Testing:**

Like other clerkships, there is a shelf exam at the end of the rotation. 100 questions, with some long question stems. Also like other shelf exams, this is thought to be a challenging test.

## **PRIMARY CARE:**

You will have the option of working in a family medicine, pediatrics, or internal medicine clinic, all of which will provide a different experience, but with the same underlying principles of outpatient care. If you have this rotation near the end of the year, think of it as a culmination of all you have learned from previous clerkships and as a way to apply the various skills you have picked up along the way. If you have this rotation in the beginning of the year, use it as a refresher course for honing your PEX skills, as you may be a little rusty after studying for Boards.

The format of your day will vary from clinic to clinic, but will be much like any CSA exam you have taken. You may shadow your preceptor for the first day or so, but make sure you express your wish to see patients on your own. Because of the high volume of patients, you may end up helping out your preceptor, but beware that if you take too long, you end up slowing them down. Efficiency is the key (aka focused histories and physicals). Become familiar with the patient’s chart beforehand and always keep a look out for interesting patients, as you can present them during Weekly Report.

There is an OSCE, but it does not contribute towards your grade. There is no shelf exam, but rather an in-house test developed by the department. Use this rotation as a way to brush up on physical exam skills and focus your differentials. For example, if you are not comfortable with the otoscopic exam, ask your patients if you can take a look at their ears (time permitting).

### **References/Textbooks (Recommended books are checked):**

- Primary Care Medicine: Excellent reference for the clerkship. Will be lent to you on the first day of the rotation.
- *Otherwise, same books as medicine!*

### **Testing:**

The final exam is departmental exam that is based on the recommended reading and topics covered in lecture. Therefore, go to class, pay attention and do the recommended reading. Also, don’t neglect the derm module...there are a few questions (with pictures) from that module that could be gimmies if you have studied. The test is about 75 questions and traditionally has a very high mean.

## PATIENT PRIVACY

Respect the privacy of patients at all times. Being in the hospital is highly stressful. Patients have the right to know that the confidential information on their medical record will not be disclosed without their permission. This right is enforced by law, especially the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which ensures that individuals moving from one health plan to another will have continuity of coverage and that their privacy and the confidentiality of their health information is protected. If you fail to protect the confidentiality of health information you are acting unethically and are breaking the law. You are also undermining your relationship with the patient and that of other caregivers (including the patient's personal physician). You also place the medical school, hospital and yourself in legal jeopardy which, depending on the severity of the violation, may include fines and jail time. You will receive extensive instruction on the privacy regulations. Here are a few reminders regarding the basics:

- ◆ Look at charts or other printed or electronic medical records only if you are assigned to be involved in that patient's care (the so-called *need to know* principle). So, if you hear that your former high school principal is in the hospital and you are curious as to how she is doing, it would be a violation for you to look at her medical records if you are not involved in her care.
- ◆ Do not talk to anybody who is not involved in the patient's care about the case. Never disclose patient information without the patient's permission. If you are ever approached by somebody who asks you about a case and you are not sure if you should tell them anything, don't! Check with somebody else (your resident, hospital administrator, etc).
- ◆ NEVER *talk about* patients in public places like elevators, hallways, cafeterias, or anywhere else where somebody might overhear the conversation. For all you know, the person standing in the corner of the elevator is the patient's boss who will overhear things that the patient does not want him to know.
- ◆ NEVER *talk to* patients in front of others if you aren't sure that the patient wants them to overhear the conversation: For instance, it is inappropriate to speak with a patient about his medical condition in a crowded waiting room.
- ◆ Don't throw papers with identifiable patient information (like names, social security numbers, addresses, etc) into unlocked trash bins or other containers. Special containers for such confidential materials should be available on the wards and in doctors' offices.
- ◆ Be careful to turn off computer screens and log off programs that contain patient information when you are finished. Don't leave diskettes or other sources containing patient information where others might be able to look at them.

## SAFETY ISSUES

### Needle Sticks

If stuck with a contaminated needle, or otherwise subjected to contamination by bodily fluids from a patient, there is a small but very real risk of acquiring a serious infection from the host. It is to your benefit to report all incidents because, if necessary, you will need to prove that you were infected during your training in order to claim the disability insurance offered through the medical school. If such an incident does occur, you are automatically excused from whatever you are doing. Remember you are paying to go through medical school, so your health comes first.

Medical attention will include *cleansing and treating any wound, obtaining both your blood and the host blood for testing, and the provision of counsel on follow-up treatment and testing*. At the time of any potential contamination, you should excuse yourself from the activity under way and go immediately to the site specified below:

|     | <u>8:00 am to 4:30 pm</u>          | <u>Weekends and other hours</u>  |
|-----|------------------------------------|----------------------------------|
| NHM | Corporate Health Staff<br>926-8282 | 7 days a week                    |
| RIC | Corporate Health Staff<br>926-8282 | 7 days a week                    |
| CMH | Employee Health<br>(NAB 103)       | Needle Stick Pager<br>3-2273     |
| ENH | Emergency Room                     | Emergency Room                   |
| CHP | Emergency Room                     | Emergency Room                   |
| VAL | Emergency Room (HEU)               | Emergency Room (HEU)             |
| VAW | Employee Health<br>Room 1480       | Needle Stick Hotline<br>569-7159 |

If at a physician's office or other site, call the Student Health Service (312-695-8134) or SHS Physician on call (312-908-6999) for direction on where to seek treatment.

It is very important that as soon as possible you call the Student Health Service (695-8134) or SHS Physician on call (312-908-6999). This will assure proper follow up, counseling and payment of treatment fees. If in spite of this you receive any bills for treatment, send them to the associate dean for student programs for payment by the University.

While the exact reporting procedure varies from hospital to hospital, the first step is to contact the infectious disease fellow immediately. This individual deals with such incidents on a routine basis. He or she can order testing of the patient and you, provide counseling regarding the need and desirability of further testing or treatment, and answer any questions you may have. If you have health insurance through Northwestern University, Student Health Service must be notified of the incident from the start. To reach them, call (312) 695-8134 or page the Student Health physician on call. The University Hospitalization Insurance Program will cover the costs of the policyholder, but coverage provisions for those privately insured will depend upon their policy.

For your own information and for patients who ask, it is important to differentiate between confidential and anonymous testing. Confidential testing is done at a medical institution, and the result becomes part of the medical record, which is available to insurance companies and may affect future insurability. Anonymous testing is done by “neutral” organizations like Family Planning and state/county health agencies, and only the patient will know the result. Consider this issue before being tested.

In order to minimize your risk of exposure, follow the universal precautions. Wear gloves, eye protection, and facemask during procedures. Treat all patients and bodily fluids as if they are infected. Wash your hands frequently. Don't recap needles, and dispose of all sharp objects immediately after use. If you follow them consistently, they will become second nature.

### **Immunizations**

**PPD:** Yearly PPD or CXR results are required at all hospitals. The Office of Student Programs will periodically announce class PPD placement by Student Health.

**Tetanus:** Shots must be on record within the last 10 years. Usually, this is done on enrollment at FSoM.

**Hepatitis B:** This series of three shots is usually done during M1 year.

**MMR:** Documented proof of 2 doses is required.

**Flu:** Each year the flu kills thousands of people. Although it is unlikely that you will die from this disease, you can suffer its effects as well as transmit it to your sick patients. So, it is highly recommended that all hospital personnel receive the yearly influenza vaccine. Most hospitals offer the vaccine to their personnel. Students may not always receive these benefits. The VA offer free flu shots to students rotating in late fall or early winter. Children's may also offer free flu shots if you are rotating through peds in the late fall/early winter. The flu vaccine is also available from Student Health for a nominal fee.

### **Security**

As medical students, we have terrible hours; we come to the hospital early in the morning and leave late at night. Those are also the times when most crimes occur. Fortunately, students have been mostly spared from these unpleasant events in the past.

To further reduce your risk of being a victim, be street smart. Stay in well traveled areas and be alert of your surroundings. Look like you know what you are doing. Do not carry or wear expensive jewelry or bulging wallets. If you feel threatened, get attention by running and crying out for help. Finally, if you have questions about the general safety of an area, talk to the hospital personnel. Most likely, they have been working at the hospital for several years and know the places you should avoid.

### **ABUSIVE BEHAVIOR**

Over the past few years, a growing awareness of abusive behavior by faculty, housestaff, and others toward medical students and junior housestaff has appeared in the medical education literature. A preponderance of the reported incidents occurred during the junior and senior medical school years, when the difference in power is greatest. While there is reason to believe that such incidents are relatively infrequent during clerkships, they are not absent.

#### **What is Abuse?**

Abuse can be a subjective entity depending on the perceptions of the victim. However, it is not the rare outburst of verbal invective, directed at whoever happens to be nearby. Such events do happen and are unpleasant, but are not intended to be abusive. However, recurring comments of an insulting or demeaning nature directed intentionally toward a specific person or group of people is abuse. So too is any physical contact of a disciplinary or harassing nature, repeated requests for the use of a student's time to carry out personal tasks or errands, or any threat of grade retribution as a penalty for action or inaction unrelated to educational or patient duties. These are inappropriate and unprofessional behaviors.

#### **The Response**

The issue of student abuse has been discussed at the Curriculum Committee, Deans' meetings, individual departmental meetings, and housestaff orientation programs.

When an abusive situation arises, the student should first attempt to confront the abuser and inform the senior resident if necessary. If the abuse continues or if the student anticipates retribution, the student should then approach the appropriate department representative with the case. At the beginning of each clerkship, the director should

identify specific individuals that will accept reports of suspected incidents. Furthermore, the incident(s) should be reported as soon as possible, so that corrective actions can be made.

In addition, Dean Angela Nuzzarello (312-503-4318) and/or Dean John X. Thomas (312-503-1691) should be alerted to any suspected incident. This is particularly important if it is felt that a departmental authority does not understand or does not want to be concerned with pursuing the issue.

Also, be liberal with your utilization of the Student Senate. The members of the Senate have been elected to represent the student voice and to serve as your advocates when the opportunity arises. If at any time you feel that your concerns as a student are not being heard, inform your senator.

### **Perspective**

Student abuse is a rare, but sad reality that arises during the clinical years. Every physician must do her part to interrupt the occasional pattern of abusive attitudes. In another two years, you will be assuming the role of an authority figure and the responsibility to be a role model for your patients, students, and colleagues.

## **CONCLUSION**

Your junior year will be extremely interesting and may also be quite challenging. You will see and do many things that you may never have the chance to do again.

It has frequently been said that a student's experience is team-dependent. Unfortunately, there is no standard of resident teaching as there is a standard of medical care, but one can make the best of the situation. As with any working environment and life in general, there can be personality differences, prejudices, and unfair treatment. Although one should try to resolve those conflicts as smoothly as possible, sometimes it is better to simply accept such circumstances unless they qualify as abuse.

Remember, you are here to learn (and you are paying quite a large sum of money to do so). While it is your right to be taught, it is also your duty to help out as much as possible. This includes helping all members of your team. Although you should be helping out your assigned resident/intern, you can also help by not hurting your peers. This will allow for a more enjoyable working atmosphere.

In addition to learning more about medicine, you will hopefully learn more about yourself. You will be exposed to many different situations and people, and these experiences will help you grow as a person and become a great doctor.

Have a great year and welcome to the wards!

## APPENDIX: Abbreviations

The following represents a very extensive list of commonly and uncommonly used abbreviations. After spending some time on the wards, these abbreviations will become almost second nature.

|          |   |
|----------|---|
| T        | one (used to substitute for numerical digit)              |
| TT       | two (used to substitute for numerical digit)              |
| TTT      | three (used to substitute for numerical digit)            |
| a        | before (Latin: ante)                                      |
| AAA      | abdominal aortic aneurysm                                 |
| Ab       | antibody or abortion                                      |
| Abx      | antibiotics   |
| Abd      | abdomen   |
| ABG      | arterial blood gas  |
| ABI      | ankle brachial index                                      |
| a.c.     | before meals (Latin: ante cibum)                          |
| AC & BC  | air conduction and bone conduction of ear                 |
| ACTH     | adrenocorticotropic hormone                               |
| ADA diet | American Diabetic Association diet                        |
| ADH      | anti-diuretic hormone (vasopressin)                       |
| ADLS     | activities of daily living skills                         |
| ad lib   | at liberty  |
| AFB      | acid fast bacilli (think tuberculosis)                    |
| afib     | atrial fibrillation                                       |
| AFP      | alpha fetoprotein   |
| AI       | aortic insufficiency                                      |
| AKA      | above the knee amputation                                 |
| ALL      | allergies; also acute lymphocytic leukemia                |
| AMA      | against medical advice (signing out of hospital)          |
| AML      | acute myelocytic (or myelogenous) leukemia                |
| ANA      | anti-nuclear antibody                                     |
| AODM     | adult onset diabetes mellitis                             |
| AP       | anteroposterior   |
| A+P      | auscultation and percussion                               |
| A/P      | assessment/plan   |
| aPPT     | activated partial thromboplastin time (PTT)               |
| appy     | appendectomy  |
| AR       | aortic regurgitation                                      |
| ARDS     | adult respiratory distress syndrome                       |
| ARF      | acute renal failure                                       |
| AROM     | artificial rupture of membranes or active range of motion |
| AS       | aortic stenosis   |
| ASA      | acetylsalicylic acid (aspirin)                            |
| ASAP     | as soon as possible                                       |
| ASD      | atrial septal defect                                      |
| AXR      | abdominal x-ray   |
| B/L      | bilateral   |
| c        | with  |
| CA       | carcinoma   |
| C/D/I    | clean/dry/intact (in regard to incisions)                 |
| CHF      | congestive heart failure                                  |
| CIS      | carcinoma in situ   |

|                   |   |
|-------------------|---|
| CM                | costal margin or cardiomegaly                                     |
| CMH               | Children's Memorial Hospital                                      |
| CMV               | cytomegalovirus   |
| CN                | cranial nerve   |
| c/o               | complains of  |
| coags             | coagulation factors (tested with PT/PTT)                          |
| COPD              | chronic obstructive pulmonary disease                             |
| CP                | chest pain or cerebral palsy                                      |
| CPAP              | continuous positive airway pressure                               |
| CPM               | continue present management                                       |
| CRF               | chronic renal failure   |
| CRI               | chronic renal insufficiency                                       |
| C+S               | culture and sensitivity   |
| C-section         | cesarean section  |
| C/S               | cesarean section  |
| CS                | chemstrips (measures serum glucose)                               |
| CSF               | cerebrospinal fluid   |
| CSOM              | chronic suppurative otitis media                                  |
| CT                | computerized tomography   |
| CTA               | clear to auscultation (in lung exam)                              |
| CV                | cardiovascular  |
| CVA               | cerebral vascular accident (stroke)                               |
| CVAT              | costovertebral angle tenderness                                   |
| CVP               | central venous pressure   |
| c/w               | consistent with   |
| Cx                | culture   |
| CXR               | chest x-ray   |
| D <sub>5</sub>    | 5% dextrose in saline solution                                    |
| D <sub>5</sub> LR | 5% dextrose in lactated ringer's solution                         |
| D <sub>5</sub> W  | 5% dextrose in water  |
| D+C               | dilatation and curettage  |
| d/c               | discontinue or discharge  |
| DCFS              | Department of Children and Family Services                        |
| D+E               | dilatation and evacuation   |
| DI                | diabetes insipidus  |
| DIC               | disseminated intravascular coagulation                            |
| DJD               | degenerative joint disease  |
| DKA               | diabetic ketoacidosis   |
| DM                | diabetes mellitus   |
| DNR               | do not resuscitate (supportive measures only)                     |
| DOA               | date of admission or dead on arrival<br><b>(** do not use **)</b> |
| DOE               | dyspnea on exertion   |
| DM                | diabetes mellitus   |
| DP                | dorsalis pedis artery   |
| DPT               | diphtheria, pertussis, tetanus immunization                       |
| DT's              | delirium tremens  |
| DTR               | deep tendon reflexes  |
| DUB               | dysfunctional uterine bleeding                                    |
| DVT               | deep vein thrombosis  |
| Dx                | diagnosis   |
| Dz                | disease   |
| EBL               | estimated blood loss  |
| ECT               | electroconvulsive therapy   |

|                  |   |
|------------------|---|
| ECG              | electrocardiogram   |
| EDC              | estimated date of confinement (referring to pregnancy)                                    |
| EEG              | electroencephalogram  |
| EFM              | external fetal monitor  |
| EFW              | estimated fetal weight  |
| EGD              | esophagogastroduodenoscopy  |
| EKG              | electrocardiogram   |
| ELISA            | enzyme linked immunoabsorbent assay   |
| EMG              | electromyogram  |
| ENT              | ear, nose, and throat   |
| EOM              | extraocular movements   |
| EOMI             | extraocular movements intact  |
| EPS              | electrophysiological study/service  |
| ERCP             | endoscopic retrograde cholecystopancreatogram   |
| ESRD             | end stage renal disease   |
| ESR              | erythrocyte sedimentation rate  |
| ESWL             | extracorporeal shock wave lithotripsy   |
| ETT              | endotracheal tube   |
| EXT              | extremities   |
| FB               | foreign body  |
| FBS              | fasting blood sugar   |
| f/c/s            | fevers/chills/sweats  |
| FDP              | fibrin degradation products (same as FSP)   |
| FDLMP            | first day last menstrual period   |
| F/E/N            | fluids, electrolytes, and nutrition   |
| FFP              | fresh frozen plasma   |
| FH               | Family History  |
| FHR              | fetal heart rate  |
| FHS              | fetal heart sounds  |
| FHT              | fetal heart tones   |
| FIO <sub>2</sub> | fraction of inspired oxygen   |
| FLK              | funny looking kid (**not very professional**)   |
| FM               | face mask   |
| FOB              | foot of bed   |
| F.P.             | Family Planning   |
| FROM             | full range of motion  |
| FSH              | follicle stimulating hormone  |
| FSP              | fibrin split products (same as FDP)   |
| FT IUP           | full term intrauterine pregnancy  |
| FTA-Abs          | fluorescent treponemal antibody absorption  |
| FTT              | failure to thrive   |
| f/u              | follow up   |
| FUO              | fever of unknown origin   |
| fx               | fracture  |
| gb               | gallbladder   |
| GBM              | glioblastoma multiforme   |
| GC               | gonococcus  |
| GDM              | gestational diabetes mellitus   |
| GERD             | gastroesophageal reflux disease   |
| GI               | gastrointestinal, gastroenterology  |
| gm%              | grams per hundred milliliters of serum  |
| GOETT            | general oral endotracheal tube  |
| GP               | gravidy (# pregnancies), parity (# births categorized as TPAL - term, preterm, abortions, |

|             |  |
|-------------|--|
|             | living children)                                       |
| GSW         | gunshot wound  |
| gt. or gtt. | drop or drops (Latin: gutta)                           |
| GTT         | glucose tolerance test                                 |
| GU          | genitourinary  |
| GYN         | gynecology   |
| HA or h/a   | headache   |
| HAL         | hyperalimantation                                      |
| HAV         | Hepatitis A virus                                      |
| Hb          | hemoglobin   |
| HBHC        | home based health care                                 |
| HBV         | Hepatitis B virus                                      |
| HCG         | human chorionic gonadotropin                           |
| Hct         | hematocrit   |
| HEENT       | head, eyes, ears, nose, throat                         |
| HEU         | Health Evaluation Unit (the VA's ER)                   |
| Hgb         | hemoglobin   |
| H/H         | hemoglobin/hematocrit                                  |
| H-J reflux  | hepato-jugular reflux                                  |
| HMD         | hyaline membrane disease                               |
| h/o         | history of   |
| H/O         | hemocult   |
| H.O.        | house officer  |
| HOB         | head of bed  |
| HOH         | hard of hearing  |
| hpf         | high power field (referring to microscope)             |
| HPI         | history of present illness                             |
| HR          | heart rate   |
| h.s.        | bedtime (Latin: hora somni)                            |
| HSG         | hystosalpingogram                                      |
| HSM         | hepatosplenomegaly                                     |
| HTN         | hypertension   |
| hx          | history  |
| ICU         | Intensive Care Unit                                    |
| I+D         | incision and drainage                                  |
| ID          | infectious disease                                     |
| IDDM        | insulin dependent diabetes mellitus                    |
| IFM         | internal fetal monitor                                 |
| IM          | intramuscular  |
| I+O or I/O  | fluid intake (e.g. IVF) and output (e.g. urine, stool) |
| IPPB        | intermittent positive pressure breathing               |
| ITP         | idiopathic thrombocytopenic purpura                    |
| IUD         | intrauterine device                                    |
| IUFD        | intrauterine fetal death                               |
| IUGR        | intrauterine growth retardation                        |
| IUP         | intrauterine pregnancy                                 |
| IV          | intravenous  |
| IVAC        | a type of infusion pump                                |
| IVDA        | intravenous drug abuse                                 |
| IVDU        | intravenous drug use                                   |
| IVF         | IV fluids  |
| IVP         | IV push or intravenous pyelogram                       |
| IVPB        | IV piggyback   |
| JODM        | juvenile onset diabetes mellitus                       |
| JRA         | juvenile rheumatoid arthritis                          |

|                  |  |
|------------------|--|
| JVD              | jugular venous distention                                |
| KUB              | kidneys, ureters, bladder (referring to abdominal x-ray) |
| L                | left   |
| LAD              | left axis deviation or left anterior descending artery   |
| LBBB             | left bundle branch block                                 |
| LDH              | lactic dehydrogenase                                     |
| LE               | lower extremity (leg)                                    |
| LFT              | liver function tests                                     |
| LGA              | large for gestational age                                |
| LH               | luteinizing hormone                                      |
| LIH              | left inguinal hernia                                     |
| LLE              | left lower extremity (left leg)                          |
| LLL              | left lower lobe (referring to lung)                      |
| LLQ              | left lower quadrant (referring to abdomen)               |
| LMA              | laryngeal mask airway                                    |
| LMP              | last menstrual period                                    |
| LOL              | little old lady (**do not use**)                         |
| LP               | lumbar puncture  |
| L/S              | lecithin/sphingomyelin ratio                             |
| LUE              | left upper extremity (left arm)                          |
| LUL              | left upper lobe (referring to lung)                      |
| LVH              | left ventricular hypertrophy                             |
| m/r/g            | murmurs/rubs/gallops                                     |
| MAL              | mid-axillary line  |
| MAOI             | monoaminoxidase inhibitor                                |
| MAP              | mean arterial pressure                                   |
| MCH              | mean corpuscular hemoglobin                              |
| MCHC             | mean corpuscular hemoglobin concentration                |
| MCL              | mid clavicular line                                      |
| MCV              | mean corpuscular volume                                  |
| MD               | terrapins  |
| mg%              | milligrams per hundred milliliters                       |
| MI               | myocardial infarct or mitral insufficiency               |
| MICU             | medical intensive care unit                              |
| MMMI             | mucus membranes moist and intact                         |
| MR               | mitral regurgitation                                     |
| MRI              | magnetic resonance imaging                               |
| MRSA             | methicillin resistant staph aureus (think isolation)     |
| MS               | mitral stenosis or multiple sclerosis                    |
| MSO <sub>4</sub> | morphine   |
| MVC              | motor vehicle collision                                  |
| MVI              | multivitamin   |
| MVP              | mitral valve prolapse                                    |
| NABS             | normoactive bowel sounds                                 |
| NAD              | no acute/apparent distress                               |
| NC               | nasal cannula  |
| NC/AT            | normocephalic, atraumatic (a normal head)                |
| NEC              | necrotizing enterocolitis                                |
| NG               | naso-gastric tube  |
| NICU             | neonatal or neurosurgical intensive care unit            |
| NIDDM            | non-insulin dependent diabetic                           |
| NKDA             | no known drug allergies                                  |
| nl               | normal   |
| NMH              | Northwestern Memorial Hospital                           |

|                    |   |
|--------------------|---|
| Ø                  | no or none  |
| NPO                | nothing by mouth (Latin: nihil per os)                  |
| NS                 | normal saline   |
| NSAID              | non-steroidal anti-inflammatory drug                    |
| NSR                | normal sinus rhythm                                     |
| NSVD               | normal spontaneous vaginal delivery                     |
| NT                 | nasotracheal (referring to suctioning)                  |
| NTND               | nontender, nondistended                                 |
| NTG                | nitroglycerin   |
| n/v/d/c            | nausea/vomiting/diarrhea/constipation                   |
| O <sub>2</sub> sat | oxygen saturation                                       |
| OB                 | obstetrics  |
| OBS                | organic brain syndrome                                  |
| OCP                | oral contraceptive pills                                |
| OCOR               | on call to the OR (referring to OR meds)                |
| OD                 | right eye   |
| OM                 | otitis media  |
| OOB                | out of bed (referring to activity)                      |
| o/p                | outpatient  |
| OPV                | oral polio vaccine                                      |
| OR                 | operating room  |
| os                 | mouth   |
| OS                 | left eye  |
| OT                 | occupational therapy                                    |
| OTD                | out the door  |
| OU                 | both eyes   |
| p                  | after (Latin: post)                                     |
| P                  | pulse   |
| PA                 | posterior-anterior                                      |
| PAC                | premature atrial contraction                            |
| Pap smear          | Papanicolaou cytologic test                             |
| PAS                | para-amino salicylic acid                               |
| PAT                | paroxysmal atrial tachycardia                           |
| p.c.               | after meals (Latin: post cibum)                         |
| PCA                | patient controlled analgesia                            |
| PCN                | penicillin  |
| PCO                | polycystic ovary  |
| PDA                | patent ductus arteriosus                                |
| PDR                | Physician's Desk Reference                              |
| PE                 | physical examination or pulmonary embolus               |
| PEEP               | positive end expiratory pressure                        |
| PERL               | pupils equal and react to light                         |
| PERRLA             | pupils equal, round, and react to light & accommodation |
| PFC                | persistent fetal circulation                            |
| PFT                | pulmonary function tests                                |
| PG                 | prostaglandins  |
| PH                 | past history  |
| PI                 | pulmonary insufficiency                                 |
| PID                | pelvic inflammatory disease                             |
| PKU                | phenylketonuria   |
| Plt                | platelets   |
| PMH                | past medical history                                    |
| PMI                | point of maximum impulse (referring to heart)           |
| pmns               | polymorphonuclear leukocytes (i.e. neutrophils)         |

|                       |  |
|-----------------------|--|
| PM&R                  | Physical Medicine & Rehabilitation                       |
| PND                   | paroxysmal nocturnal dyspnea                             |
| p.o.                  | by mouth (latin: per os)                                 |
| POD                   | postoperative day (followed by a number)                 |
| polys                 | polymorphonuclear leukocytes                             |
| post-op               | post-operative   |
| PP                    | post-partum  |
| PPTL                  | post-partum tubal ligation                               |
| PPD                   | purified protein derivative (for tuberculin test)        |
| p.r.                  | per rectum (suppository)                                 |
| PRBC's                | packed red blood cells                                   |
| prn                   | when necessary (Latin: pro re nata)                      |
| PROM                  | premature rupture of membrane or passive range of motion |
| PSH                   | past surgical history                                    |
| PSVT                  | paroxysmal supraventricular tachycardia                  |
| PT                    | physical therapy   |
| PTCA                  | percutaneous transluminal coronary angioplasty           |
| ψ                     | psychiatry   |
| pt                    | patient  |
| PT                    | prothrombin time or posterior tibial artery              |
| PTA                   | prior to admission                                       |
| PTH                   | parathyroid hormone                                      |
| PTT                   | partial thromboplastin time                              |
| PUD                   | peptic ulcer disease                                     |
| PVC                   | premature ventricular contraction                        |
| q                     | every (Latin: quaque)                                    |
| qAM                   | every morning  |
| qhr or q <sup>o</sup> | every hour   |
| qhs                   | at hour of sleep   |
| qD                    | daily (Latin: quaque die)                                |
| qid                   | four times per day                                       |
| qMWF                  | every Monday, Wednesday, and Friday                      |
| qod                   | every other day  |
| qPM                   | every evening  |
| q shift               | every nursing shift (usually every 8 hours)              |
| qwk                   | every week   |
| R                     | right  |
| RA                    | rheumatoid arthritis                                     |
| RAI                   | radioactive iodine                                       |
| RBBB                  | right bundle branch block                                |
| RBC                   | red blood count  |
| r/c/g/m               | rubs, clicks, gallops, murmurs                           |
| RDS                   | respiratory distress syndrome                            |
| RDW                   | red cell distribution width                              |
| REM                   | rapid eye movement                                       |
| Rh                    | Rhesus blood factor                                      |
| RHD                   | rheumatic heart disease                                  |
| RIA                   | radioimmunoassay   |
| RIH                   | right inguinal hernia                                    |
| RLE                   | right lower extremity (right leg)                        |
| RLL                   | right lower lobe (referring to lung)                     |
| RLQ                   | right lower quadrant (referring to abdomen)              |
| r/o                   | rule out   |
| ROC                   | resident on call   |

|                    |  |
|--------------------|--|
| ROM                | range of motion  |
| ROS                | review of systems  |
| RPR                | rapid plasma reagent (syphilis test)   |
| RR                 | Recovery Room  |
| RRR                | regular rate and rhythm (referring to heart)   |
| RT                 | radiation therapy  |
| RTA                | renal tubular acidosis   |
| RTC                | return to clinic   |
| RUL                | right upper lobe (referring to lung)   |
| RUE                | right upper extremity (right arm)  |
| RUQ                | right upper quadrant (referring to abdomen)  |
| RVH                | right ventricular hypertrophy  |
| Rx                 | prescription, treatment, or therapy  |
| s                  | without (Latin: sine)  |
| SIS2               | first and second heart sounds  |
| SBE                | subacute bacterial endocarditis  |
| SBO                | small bowel obstruction  |
| SCM                | sternocleidomastoid  |
| sed rate           | sedimentation rate   |
| SEM                | systolic ejection murmur   |
| SGA                | small for gestational age  |
| SH                 | social history   |
| SIADH              | syndrome of inappropriate antidiuretic hormone   |
| SICU               | surgical intensive care unit   |
| sig                | label (latin: signa)   |
| SL                 | sublingual (e.g. for nitroglycerin)  |
| SLE                | systemic lupus erythematosus   |
| SMA                | sequential multiple analysis (chemistry laboratory tests – usually sodium, potassium, chloride, bicarbonate, BUN, creatinine, and glucose) |
| SOB                | shortness of breath  |
| SOM                | serous otitis media  |
| sono               | sonogram (ultrasound)  |
| s/p                | status post  |
| SP                 | speech pathology   |
| sp gr              | specific gravity   |
| SQ                 | subcutaneous   |
| SROM               | spontaneous rupture of membranes   |
| SSCP               | substernal chest pain  |
| STAT               | immediately (Latin: statim)  |
| SVC                | service  |
| SVT                | supraventricular tachycardia   |
| T                  | temperature  |
| T <sub>3</sub>     | triiodothyronine   |
| T <sub>3</sub> -RU | triiodothyronine resin uptake  |
| T <sub>4</sub>     | serum thyroxine  |
| T+A                | tonsillectomy and adenoidectomy  |
| tab                | tablet (Latin: tabella)  |
| TAH-BSO            | total abdominal hysterectomy bilateral salpingo-oophorectomy   |
| TB                 | tuberculosis (think isolation)   |
| TBG                | thyroxine binding globulin   |
| TBS                | total body surface   |
| T+C                | type and crossmatch  |



Notes

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