

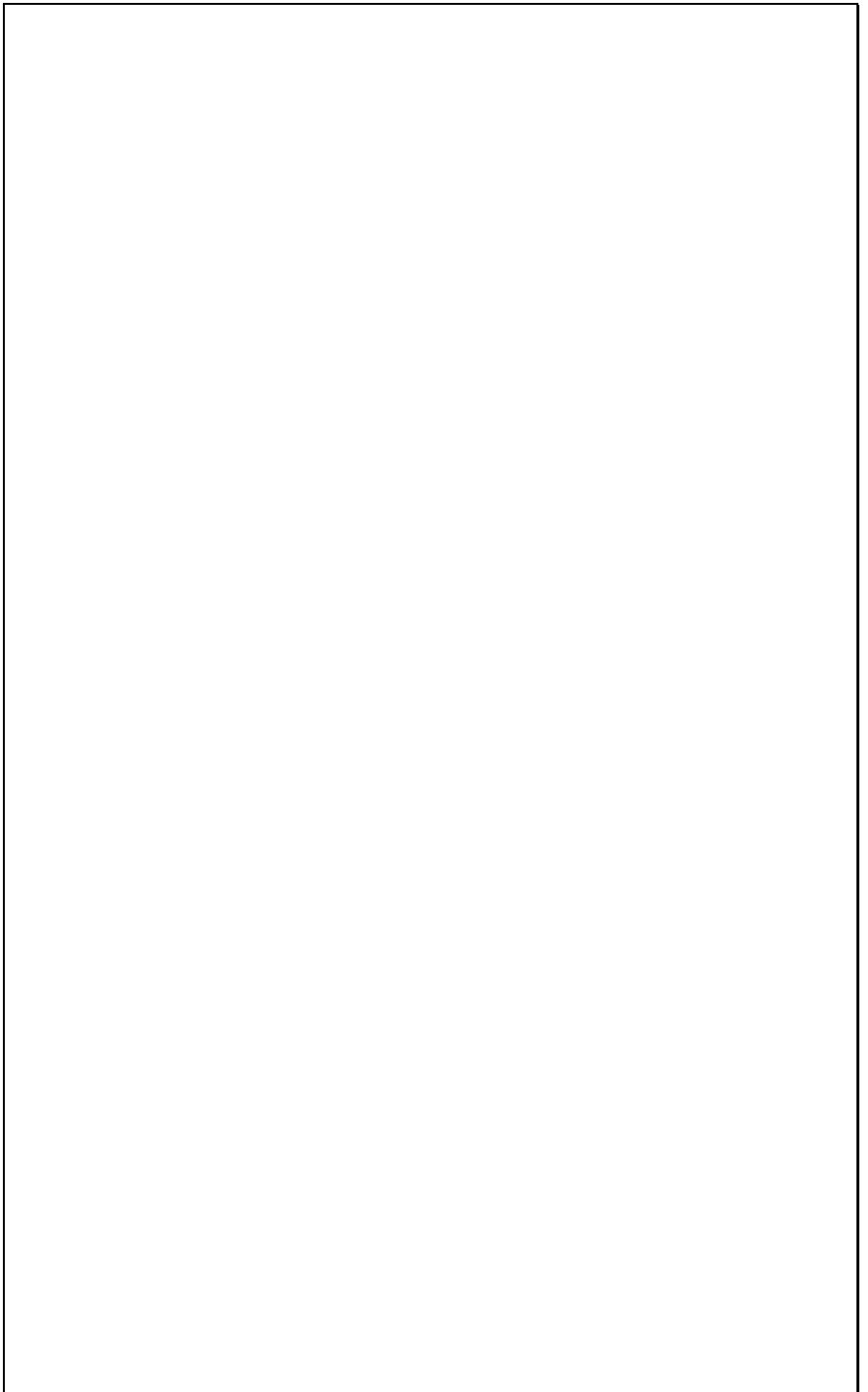
SUCCESS ON THE WARDS

**A student-to-student guide to getting the
most out of your third year:**

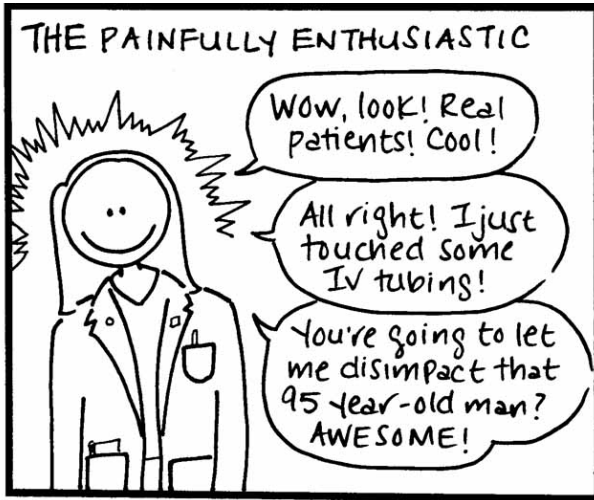


NORTHWESTERN UNIVERSITY

NORTHWESTERN UNIVERSITY
FEINBERG SCHOOL OF MEDICINE
19TH EDITION
SUMMER 2008



YOU (hopefully):



CARTOON BY: MICHELLE AU

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Special thanks to the following members of the class of 2009
for their contributions to this Guide:

Martin Buta
Catherine Chen
Brendan Connell
Sadiya Khan
Albert Kim
Michelle Lin
Melissa Marinelli
Ben Paul

And...to the numerous members of previous classes who originated this
guide and kept it up-to-date over the years.

The Ward Survival Guide is a student publication. We would like to
thank Dr. Amy Kontrick, Dr. James Rosenthal, Dr. Larry Cochard, Sarah
Sproule, and the Augusta Webster, MD, Office of Medical Education for
their support and guidance in this endeavor.

INTRODUCTION

Welcome to the nineteenth edition of the Ward Survival Guide! The following year is guaranteed to be challenging, exciting, and rewarding, and sometimes overwhelming, 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). At this point you are likely very excited to finally enter the clinical phase of your training. With that excitement likely 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 and have survived! 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 fly on your own!

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. So make sure to study hard, pay attention, have fun and, of course, keep this book close at hand. Good luck!

The Class of 2009

If you have any suggestions for ICC or this guide, please contact Dr. Amy Kontrick or Sarah Sproule 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. 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, operating room, or on rounds. Fellows are, in general, exceptionally knowledgeable about their specialty and slightly less overworked than residents. Thus, they make 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 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. Helping the intern with their work can be an excellent learning experience.

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. The 4th year student will not be responsible for your evaluation.

Junior Student You! 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 and expose you to different fields. 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 toward 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, especially not at the beginning. 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. 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, as well as orders on your patients if you are able to do so. These steps will help organize your thoughts about your patients, force you to think through a clinical plan, and ensure that you are up-to-date on your patients. Student orders and notes always need to be cosigned, so an occasional error is acceptable, but **errors in your documentation are still a part of the medical record**. Learn from each error to better avoid them in the future.

You should also help your team to accomplish the tasks necessary for patient care. Taking a detailed 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 be informed of the typical schedule, but it may take a few days to figure it out. 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 house staff 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 coordinate their care. 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, which you will receive at orientation. 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. As mentioned before, ALWAYS have something to read!

However, try to hold yourself back from overfilling your pockets!

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 they are not explained, feel free to ask. 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 often 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 longer questions stems and a more 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. Your patients are giving their bodies for your education, and while you should be assertive in your desire to learn, you must always keep in mind that the person who does a procedure on or has an important conversation with a patient must be the most appropriate team member, and it may not be the junior student. Always treat patients the way that you would like to be treated.
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 invest less in your education. Try to have a positive attitude and try to be an active member of the team. 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 doctors say or do something with certainty. With patients, explain what you are doing and why you are doing it. Residents and attendings will appreciate confidence, however it is good to be assertive without being aggressive or rude. Talk clearly and enunciate. 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?" Then speak up to change things if necessary. During rounds or pimp sessions, volunteer 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!) A note of caution, however: do not try to answer questions about patient data that you do not know the answer to. It is better to say, “I don’t know” than to give incorrect information about a patient.
4. Reading. Assertiveness is best when accompanied by knowledge. By reading, you learn more and prepare yourself for rounds, patient care, and exams. Although the wards experience can teach you a lot that you can never learn from books, reading is essential. Start with reading about your patients and the basics on each rotation, and then move along to less common diseases.
5. Respect your fellow classmates. Learn with and not at the expense of

your colleagues. Never put down or show up another student. 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. Mutual respect will allow for a more pleasant rather than painful experience and allow you to learn from one another.

6. 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 and take care of your health. Eat whenever you can. Sleep whenever you can. Always carry around a granola or snack in your pocket. When you learn to strike a perfect work-life balance, let the rest of us know how!
7. Be friendly with support staff, especially the nurses. Being nice to everyone makes life much easier for you. At this point in your education, nurses know a lot more than you do when it comes to the daily routine of patient care. Introduce yourself to the nurse taking care of your patients, and always turn to the nurse as a resource about what happened overnight. Since you don't get sign-out, this may be your best chance to be prepared for rounds. Better communication means better care for your patients, 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, so plan accordingly. 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 demonstrates interest and an eagerness to learn. 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 and try to avoid questions that could be answered simply by reading a textbook. It is better, however, to focus on clinical decision making skills and questions that can only be answered by someone with experience. At the same time, do not be afraid to ask some simple questions at appropriate times; they still show interest.
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 fine."). Ask if there are any specific things upon which you can improve, and in the remaining

time, improve on those things. Also, 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 multiple 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 anyone, but check-in occasionally to give them an idea of what you have been doing and to offer to help.
- *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 questions, and 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 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”. Cherish the opportunity to get to know your patients—you will not have this much time to do so later in your career.
- *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 never appreciated. Say “I don't know” if you really don't know the answer. Be a team player.

- 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 may be 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 on some rotations.
- 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 modest dresses, skirts or slacks. Socks or pantyhose should always be worn, and open-toe shoes are a JCAHO violation. Scrubs may be acceptable if you are on-call. However, if in doubt, ask your resident. Some attendings expect students to be dressed nicely and clean-shaven (men) even if you're post-call. How you dress may depend upon which clerkship you are on, as for some rotations, you may wear scrubs every day, whereas during others, they are never permitted. Even on surgery business attire in the clinic is expected. 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. 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. Do not memorize your presentations word for word unless your attending tells you this is required. Instead, have notes but do not rely too heavily on them. 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 and presentations as concise as possible (The H&P is the time to show your thought process).
- 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 correcting the error. 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 Progress Note". At the end of all notes and orders that you write, sign your name, print your name, and indicate your status and pager number.

In the Assessment/Plan section of your notes, give your impression of patient management and recommendations. However, always state them as considerations unless you have discussed them with your team. For example, "consider Celexa 20mg PO daily to treat major depression"; never make statements that directly question the recommendations or judgment of others.

The purpose of notes is to communicate. Write clearly and try not to use abbreviations as they are rarely standardized.

Using Powerchart and Epic

Powerchart: You will get powerchart training and your ability to use it will increase with time. Until then, here are a few pointers.

1. Use dot phrases! You will learn to create these in training and they can save a lot of time. You can create these shortcuts for different types of notes as well as for standard text within notes.
2. Use caution when copying notes from the previous day. This is a ripe situation for errors, and while it saves time it is very embarrassing if you do not proofread well. The assessment and plan are particularly vulnerable, as it is easy to include an out-of-date plan or incorrect numbers of days post-op or of antibiotics. It is a liability to enter incorrect information in the medical record.
3. Use the "NEW RESULTS" tab. This is a great way to find out the most recent studies, labs, etc... that you might not even know were ordered.

EPIC: You will be trained to use it there if you are doing rotations there. At NMH it is most useful for reviewing patient charts to find out about outpatient workups, care, and labs.

The Electronic Medical Record

- Your daily notes need to reflect that day's updated information. You are conveying information to others about the patient's hospital course. Be sure that your assessment and plan do not differ too much from your teammates'.
- SAVE, SAVE, SAVE, SAVE!! Losing a note is not something you want to experience.
- Dot phrases are your friend (available on PowerChart and Epic). Try typing ".cbc_chem" or ".vitals" on PowerNote.
- Always remember that the EMR is a legal document and is permanent. Be accurate and respectful.

Please note the *Angusta Webster, MD, Office of Medical Education* 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."

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:

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

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

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

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 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 are not usually reported in a standard format with slash marks as above, so it is best to label all intervals, often in the following order:

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

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&Ps. You should periodically ask for feedback regarding your write-ups from both your attendings and residents. Initially, your H&Ps will be long and detailed in order to show your superiors how much you know and understand about your patient. The assessment and plan is your opportunity to demonstrate your thought process and show your ability to create a differential. At the beginning, you may require some support from your residents to organize this. Gradually, with your growing knowledge, confidence and experience, your H&Ps will become concise and efficient and you will be able to completely formulate differentials on your own.

On Medicine you present the patient to the attending the day after you do the exam and H&P. Some teams will allow you to work on an H&P overnight and leave it unsigned until after presenting the patient to the attending the next morning. Other teams will expect you to commit to a plan before you leave for the night, using the daily progress note the next day as a place for a more updated plan.

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:

- ✓ Any events overnight? (fever, emesis, bowel mvmt, etc.)
- ✓ How the patient is feeling today, according to him/ her!
- ✓ You may document patient care-related discussions, i.e. informed consent, in this section as appropriate

O - Objective:

- ✓ Vitals (Temp, HR, RR, BP, O2 sat)
- ✓ Ins and Outs
- ✓ Focused Physical Exam (Gen, Heart, Lungs, Abd, etc.)
- ✓ Recent lab values and test results

A - Assessment:

- ✓ Most important part of your note
- ✓ Repeat one-liner except now, provide YOUR assessment: i.e. “55yo man with hx of ... who presented with ..., LIKELY DUE TO ...”
- ✓ It is okay to be wrong. This is where you show your team your thought process and reasoning. [If you are uncertain, you could ask your intern/ resident (prior to starting your note) to run over your assessment with you and provide feedback.]
- ✓ On Medicine, it is important to include a justification of your diagnosis or assessment. Explain why your patient’s symptoms are consistent with your diagnosis, but also include some possible reasons as to why it might be unlikely.

P - Plan:

- ✓ Typically organized by problems (ICU and Surgery may use organ systems)
- ✓ Start with pt’s chief complaint or most pressing issue, i.e. “1) Chest pain.”
- ✓ If not already discussed in Assessment, may include a phrase or two as to likely etiology, i.e. “likely cardiac in nature, given pt’s history.”
- ✓ What you are going to do to address the problem, i.e. start/ continue meds, check labs, send X-rays, get Echo.

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

This is often the only way your attendings and/ or senior residents will be able to assess you. Even if this is not the case, the case presentation is the basis upon which your peers form their first impression of your clinical abilities. Presentation skills require experience and knowledge, so don't expect to nail it the first time. Throughout the year, you will learn to formulate and convey a well-ordered, concise summary of the pertinent clinical information.

Important tips:

- 1) Present in order. One of the most common criticisms of student presentations is that they are "disorganized." The SOAP/ H&P format is a good standard to follow.
- 2) If Review of Systems is non-contributory, state "non-contributory." Otherwise, say "ROS remarkable for history joint pain related to arthritis." If it is relevant to the patient's chief complaint, it belongs in the HPI.
- 3) Offer YOUR assessment and plan. Be prepared to justify.
- 4) DO NOT READ. You may refer to notes while presenting, but reading from the page is tedious for everyone. Try highlighting important history/ labs beforehand if you do plan to use notes.
- 5) State only pertinent information. This is a lose-lose situation as a medical student because we often don't know what is pertinent and have been trained to err on the side of thoroughness. Use your best judgment and learn from your (and other students'!) mistakes.

Structure

In general, think of the presentation as a story. Or consider it a persuasive essay where you are leading your listener to your thesis (a.k.a. diagnosis).

HPI: Always start with your one-liner: patient's name, age, race, and sex followed by a statement of the chief complaint. If this person has a relevant past medical history, you may also include these in your one-liner. Otherwise, for a complicated patient, it is generally acceptable to say "history of multiple medical problems."

Continue with an abbreviated history of present illness, including description of symptoms (OLDCARTS, you know the drill), chronologic development of symptoms (state "two days prior to admission" instead of the day of the week or date). Include pertinent positive findings, as well as pertinent negatives.

For the past medical history, list all medical conditions which the patient has had and elaborate on those with special relevance. When you reach

medications, list ONLY 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 “lives with husband, employed as secretary, smokes one pack per day for last 20 years, no alcohol or illicit.” 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 positive and negative findings in their respective organ systems. Always include lungs, heart, and abdomen (if normal, state: “heart regular, lungs clear, abdomen benign.”) 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 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. Lungs clear, heart regular, abdomen soft and nontender with palpable liver edge at 2 cm below costal margin. Back: point tenderness over L4-L5. Neuro: 5/5 strength throughout, sensation intact to light touch bilaterally, (-) straight leg raise test. Basic chemistry panel and CBC were within normal limits except for calcium of 11.5; alk phos of 150. His most recent PSA\ was 10 one month ago, increased from 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 alk phos, 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.

Final Words of Advice

Your presentation should not be your H&P word for word. Your attendings and residents can read, and if they wanted to hear every detail, they would simply look at your note. Therefore, include ONLY PERTINENT INFORMATION.

You may find it helpful to practice beforehand. Often doing so with your peers is helpful, so that they can provide feedback (i.e. saying “um” or “like” every other word). The more relaxed you sound when you present, the more professional you will seem. Be careful of sounding overly rehearsed. Remember that people will be listening to learn important patient information, so it is part of your duty to your patient to keep them engaged.

Do not expect your first presentation to be perfect. If it is, then congratulations. If not, be sure to take constructive criticism with a smile and remember the advice for your future presentations. If no helpful critique is offered, you should approach your resident or attending at an appropriate time, i.e. after rounds, to ask for feedback. Often, doing so before rounds ensures that they will pay more attention and provide more helpful and specific comments.

That said, each attending is unique. Many of the Medicine faculty members want to hear a very thorough and well thought-out presentation, in some cases with particular emphasis on certain sections such as the social history. Other attendings may not be as interested in details and will want you to get to the point. Do not take it personally if you are cut off. Simply learn and adapt to each attending as you rotate. What one attending specifically tells you to do may be another attending’s pet peeve. While this is certainly frustrating, it is often unavoidable. Continue to do your best and offer a complete, concise presentation.

ADMISSION AND DISCHARGE

Admission Orders

With electronic medical records, it is unlikely that you will be writing orders on the floor. However, you WILL BE EXPECTED TO WRITE ORDERS (typed freehand, from memory) on the OSCE exam (for Medicine, Surgery, etc.)

A good way to learn is to practice writing a set of orders for patients your team is admitting, then have your intern/ resident take a look at them. This will give you experience, as well as demonstrate that you are being proactive about your learning. At CMH (if they are still using paper records), residents write admission orders by hand, so you can volunteer to help with these, especially on call!

There are numerous different mnemonics used. PICK ONE AND STICK TO IT. Here, we use **ADC VANDALISM**.

Admit: 12 E, Attending: Dr. Shapiro, Intern: John Smith, pager # 5-1234

Diagnosis: primary reason for admission, or if post-op

➤ *"Chest pain" or "s/p laparoscopic appendectomy"*

Condition: stable or not (of limited use, since you will often hear that "a dead patient is stable")

➤ *"Stable, fair" or "critical" might be more descriptive*

Vitals: how often? When to notify house officer?

➤ *Vitals q6h per protocol. Please also check pulse ox. Call h.o. (house officer) for T>100.5 <96, HR>120 <50, RR>20 <12, BP>160/110 <90/60, O₂sat <92%, glucose <70 >200, urine output <300cc/8^o*

Allergies: self explanatory. Include reactions, if known.

➤ *"Penicillin – rash/ swelling" or "NKDA"*

Nursing orders: things that need to monitored/ checked

➤ *Strict I/O q shift, daily weights, accu check qAM, Foley to gravity, NG tube to LIWS (low intermittent wall suction), incentive spirometer 10x/1^o when awake, TEDs and SCDs while not ambulating*

Diet: self-explanatory.

➤ *"NPO," "general diet," "clears," "mechanical soft," "TLC diet," "NPO after midnight" (for procedures)*

Activity: typically ad lib, remember weight bearing for Ortho

➤ *"Ad lib," "up with assist," "strict bed rest," "OOB to chair," "NWB left leg" (no weight bearing)*

Labs: specify, what, when, and for how long

➤ *CBC, chem 7 + Ca, Mg q-AM x 3d, LFTs and ESR now*

IVF: type and infusion rate (impt for surgery, less so for others)

➤ *"D₅ 0.45 NS @ 125 cc/^o," or "Heplock IV" if none*

Special Studies: diagnostic tests and consults

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

Medications: 1) drug name (generic or trade)
2) dosage
3) administration route (PO, IM, SQ, PR)
4) frequency (Q day, QHS, BID, q 8 hrs, etc.)

➤ *Pepcid 20 mg PO QHS*

Colace 100 mg PO BID

Norco 325/ 75 1 tabs PO q4-6 hours PRN pain

****On SURGERY, when writing post-op orders, remember the following five classes: pain meds, DVT prophylaxis, antibiotics, peptic ulcer prophylaxis, patient's home medications*

The Discharge Note (The bane of house-staff paperwork. Ingratiate yourself by volunteering to help with these.)

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 problem/ organ system.

Condition at Discharge: "improved" (we hope!) If not stable or good, explain.

Disposition: Discharged home, skilled nursing facility, etc.

Discharge Medications:

Instructions: Include please call your doctor if you experience any concerning symptoms.

Follow up Plan:

Prescriptions

To prescribe outpatient meds, use prescription stationery when discharging patients on medications. You can specify either a brand or generic 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. You also want to write these numbers out in long hand, so they cannot be altered.

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:

Navigating the hospitals can be confusing, and finding the results to a particular test can take hours if you don't know where to look. Some commonly visited locations are as follows:

- NMH
 - 1st Floor: Emergency Department and ED Radiology Reading Room
 - 3rd Floor: Department of Medicine and Surgery Offices
 - 4th Floor: Neuroradiology reading room, Ultrasound, MRI, CT, Radiology Film pickup window, GI Lab, Interventional Radiology
 - 5th Floor: Primary surgical suites, post-op recovery rooms
 - 6th Floor: Resident lounge, Surgery resident room, Staff dining room, Telecommunications office (for free pager batteries and paging directory), Scrubs machine
 - 7th Floor: Laboratories, Auxiliary surgical suites (mostly Transplant, Cardiothoracic, & ENT), EEG,
 - 8th Floor: Nuclear Medicine, Echocardiography, Cardiac Catheterization Lab, Electrophysiology
 - 9th Floor: Dialysis
- ENH
 - Ground Floor: Radiology viewing rooms, nuclear medicine, cardiac catheterization, outpatient clinics (Louis), ED
 - 1st Floor: Outpatient labs (Louis), pathology, histology
 - 2nd Floor: CCU (Louis)
 - 3rd Floor: OR/Ambulatory Surgery, ICU, Pediatrics (Louis), EDOU (Louis)
 - 5th Floor: Psych (Louis)

Guide to the Patient Room:

A typical patient room contains several pieces of whirring, beeping, and hissing equipment that may seem daunting at first. A basic understanding of these devices will help you feel more comfortable.

- Bed: Modern hospital beds are surprisingly complicated. Here are a few key points:
 - The entire bed, and its head and tail, can each be raised and lowered independently. The controls sit outside the bed rails. There are also simplified controls inside the rails for patient use.
 - The bed rails are released by a small lever underneath.

- Falls are a serious hospital safety issue. **If you raise the bed or lower a rail, make sure to restore it to its original position before leaving the room.**
- **Table:** Can be adjusted to jut out directly over the bed. Used for meals, and sometimes also as a workspace when doing procedures. You can raise/lower it via the release lever on the side. Some models have an expandable lower leaf or even a fold-out mirror.
- **Remote control:** Adjusts the TV and room lights. Can also call the floor secretary, who can dispatch the patient's nurse.
- **IV pump:** Delivers continuous infusions of fluids and medications to the patient at a set rate, which is indicated on a display. The infused substances hang in bags above, which are labeled with the names of the substance and the patient. The pump has a battery and sits on a wheeled pole, which can be unplugged and taken to the bathroom (or on a walk around the floor!)
 - *Tip #1:* if the pump keeps beeping, this may mean that a bag is empty and needs to be replaced, or that the tubing between the pump and patient is kinked. Check for an obvious obstruction (is the patient laying on the tubing?), and if none is found, contact the patient's nurse. You can silence the beeping briefly by pressing the yellow "Silence" button.
 - *Tip #2:* if IV infusions are no longer needed, the tubing can be disconnected with the IV catheter left in place (e.g., still in the patient's arm), allowing the patient to walk around freely. The remaining catheter is called a heparin lock ("hep-lock") IV.
- **Sequential compression devices (SCDs):** Consists of a small machine and two pneumatic compression sleeves. The machine sits near the tail of the bed and periodically inflates/deflates the sleeves, which are usually worn around the calves. This is an important safety measure that helps prevent deep vein thrombosis (DVT), a frequent complication in hospitalized patients.
- **Thromboembolic devices (TEDs):** This is a fancy name for tight knee-high stockings that are worn around the calves. They also help prevent DVT, and are often used in combination with SCDs.
- **Nasal cannula:** A pair of prongs that sit in the nose and deliver supplemental oxygen (2-6 liters/minute). The tubing goes around the ears and attaches to a port on the wall. Next to the port is a gauge, which looks like a thermometer and measures the rate of oxygen delivery (in L/min), and a knob that adjusts this rate.
- **Face mask:** Used for patients who require additional oxygen. It comes in several varieties, which are beyond the scope of this text.

Key People On The Floor:

Medicine today is a team effort. Getting to know the other members can help you stay on top of your patients, and will also make you look like a star.

- ◆ Unit secretary: One of the most important people on the floor. Can locate a patient's nurse, tell you where a patient has gone, help find a piece of equipment, and otherwise make life easier in numerous ways.
- ◆ Nurses: Are an invaluable source of information about your patients, the floor, and the hospital in general. If you make an effort to keep them informed about your team's plans, they will appreciate it. Don't be afraid to ask them questions!
- ◆ Charge nurse: Manage most aspects of the floor. Among other things, they supervise other nurses and stay on top of all patient arrivals and departures.
- ◆ Nurse practitioners: Work with the medical team to manage a subset of patients and help out with many other miscellaneous tasks.
- ◆ Social workers: Help with myriad social aspects of a hospital stay, including coordinating social support services, obtaining funding, locating housing for visiting families, and finding a place for patients to go after they leave the hospital and helping them to get a ride there.
- ◆ Case managers: Assist with discharge planning. They review medical records daily and help determine whether a patient still needs to be in the hospital, and if not, where they should go.
- ◆ Others: You may also encounter respiratory therapists, radiology technicians, phlebotomists, nutritionists, hospital volunteers, and many others. As usual, it pays to get to know them!

Suggested Pocketbooks for all rotations:

- *Pocrates (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 6th 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.

The NMH Pager Directory

Let your residents know that you can be paged through the general web-texting site by your last name. When paging someone yourself, be sure to leave a call back number and your pager number so that they can

reach you. Do not forget to be succinct and clear as to why you are paging them. Here is an example:

Ann Smith, MS3

CB: 51333

Message here. Pager (249-1631)

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, so 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:

CC: A few words on why the patient presents, usually a symptom such as "arm pain for 1-2 days." Quote the patient if you can.

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), OLDCARTS, 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 (e.g. 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 (e.g. diabetes, heart disease, HTN, stroke) and correlate to the medication list. Patients will sometimes say they do not have any medical problems but are 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.

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

Family Hx: At a minimum, the patient's mother, father, and siblings. Remember to include ages and, if deceased, the cause of death. Also include the age of diagnosis for diseases like cancer and MI.

Social Hx: Tobacco, EtOH, drug use, and sexual activity. Career. If retired, include work history. Living situation (what kind of domicile and with whom).

Physical Exam:

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? Oropharynx clear, erythematous, or with exudate or lesions?
NECK: Neck supple? Thyromegaly? Lymphadenopathy? JVD or bruits?
CHEST: Normal respiratory effort? Clear to percussion and auscultation? Rales/rhonchi/wheezes?
CV: Regular rate & rhythm? PMI palpable? PMI location? Normal S1/S2? No S3/S4, murmurs, rubs or gallops, 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: Include CBC (with differential), chem 7, and other labs done in the ED.

Imaging: X-rays, CT, MRI, US, EKG. Include your own assessment, not just a copy-paste of the report.

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 your 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, ulcer prophylaxis, IV fluids, electrolyte replacement, pending studies, disposition (where they are getting admitted).

Medicine SOAP:

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

O: Vitals: Include the patient's current temperature (Tc) as well as maximum temperature in the last 24 hours (Tm), pulse (including range over 24 h), blood pressure (range over 24 h), respiratory rate, and pulse ox (on oxygen or room air). Ins and Outs should be recorded both over past 24 h and for each 8 h shift.

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.

Imaging: Follow up on any pending imaging from the previous day. Use your own assessment, not just a copy-paste of the report.

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 safe.

Recommended References, Textbooks and Pocketbooks:

- 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.
- Case Files: Internal Medicine: Contains 60 clinical cases with extended discussions, clinical pearls and review questions. It creates a good backbone for the entire clerkship.
- 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.
- The Only EKG Book You'll Ever Need: Interpretation of EKGs 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! This is a concise, well-organized EKG book.
- UpToDate: This website is the saving grace of the entire

healthcare profession. It provides comprehensive, 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). Ask an M4 about a sneaky way to get a 30 day trial to use for free at home.

- 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.

Other References and Textbooks:

- 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.
- Step Up To Medicine: A well-organized, comprehensive, very readable text that blends a bullet-outline format with comprehensive paragraphs. Contains x-rays, ECGs, mnemonics and “Quick Hit” pearls. A good text to read throughout the clerkship.
- 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.
- 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.
- 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.

Testing:

Shelf: 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.

OSCE: The OSCE is an assessment of your clinical skills that usually takes place on the last week of the clerkship. It consists of 4-6 stations with standardized patients with corresponding computer stations, where you will be expected to develop differentials, think about management, and write admission orders.

Other Medicine tips and common pimp questions:

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

SURGERY

Surgery H&P:

Usually, either the H&P will already be completed in the office prior to surgery and found in the **Epic** note, or you can use the **short H&P forms/PowerNote** found in PowerChart.

Each service will need different information. In general you need to focus on:

Brief HPI: why patient is having surgery, what type of surgery is being done, left/right side

Past Surgical History: include any bad reactions to anesthesia

Past Medical History:

Hardware: i.e. artificial heart valves, artificial joints, etc.

Current Medications:

Drug Allergies: include reactions to the medication, e.g. hives

The Postoperative Note:

Pre-op diagnosis: Initial preoperative diagnosis

Post-op diagnosis: Final postoperative diagnosis (often “same”)

Procedure: What procedure was performed

Surgeon: Attending(s)

Assistants: Resident(s) and Student(s)

Anesthesia: Local, Regional, or General (GETA, MAC)

I.V. Fluids (IVF):** Amount crystalloid and/or colloid in mL

Estimate Blood Loss (EBL):** Minimal, or amount in mL

Urine output (UOP):** No Foley or amount in mL

Drains: Type, location, and how much has drained

Findings: Gross pathology as well as significant normal findings

Specimen: What specimens were taken to the lab

Complications: i.e. “None” – Ask attending/resident before putting down any complication other than “none”

Condition: Stable/unstable, intubation status

Disposition: Usually to recovery room, PACU, floor, etc.

****REMEMBER**** Ask the anesthesiologist for IVF, EBL and UOP

Surgery SOAP:

S: Postoperative: Any acute events overnight, incisional pain, flatus, hiccups (a sign of bowel obstruction), bowel movements, urination (if no Foley), nausea/vomiting, fevers/chills/sweats, CP/SOB, lightheadedness/dizziness, pain control (PO, IV, # of times PCA was admin.), whether tolerating PO (if eating), and ambulation

O: Vitals: Tmax, Tcurrent, HR, RR, BP, SaO₂ (if applicable)

I/Os: Total over past 24hrs

Urine Output: over past 24hrs in 8hrs intervals in chronological order (i.e. “200/800/750 for total of 1750ml/24hrs”)

Drain Outputs: over past 24hrs in 8hr intervals, list each drain separately

PEX:

GEN: A&Ox3, NAD

CV: RRR, no m/r/g

ABD: soft, NT/ND, +/-BS

INCISION: c/d/i (clean/dry/intact), erythema/drainage, dressing in place/removed, with steris/staples if present

EXT: no warmth, tenderness, edema (signs of DVT)

Labs, Imaging, Pathology Results, Other Studies, etc.

A/P: POD# __, s/p {procedure} for {reason}. AFVSS, patient is doing __ (list how the patient is doing).

Day of Surgery is POD #0, next day is POD #1.

1. CV/Heme: HD (hemodynamically) stable by vitals/exam, HGB__.
2. Pulm: on __L NC, wean O2, encourage IS
3. GI: wait for return of bowel function, +/- flatus
4. GU: d/c foley? Good UOP? Voiding freely?
5. Pain: epidural, PCA, PO meds?
6. Prophy: SCDs/TEDs, ambulation, SubQ Heparin
7. FEN: IVF@__, diet (i.e. ADAT = advance diet as tolerated)
8. Path: pathology pending
9. Dispo: PT/OT?; continue inpatient management; per attending; transfer to floor, etc.
10. Other: miscellaneous; monitor liver, check thyroid, endocrine, etc

Duties in the OR:

1. **Bring the Patient In:** Help anesthesia bring the patient to the OR
2. **Move the Patient to the Table:** Help move patient from bed to table
3. **Remove Bed:** once patient is on table, put bed in hallway
4. **Put on TEDs/SCDs:** ask nurse for these and put on patient
5. **Help Drape/Position/Strap Down Patient:**
6. **Place Foley:** Ask the nurse for the Foley, do this for them
7. **Retract:** expect to be the person retracting
8. **Cut Suture:** be ready with suture scissors when resident/attending is suturing, on most sutures leave 1cm long suture tails
9. **Retrieve Bed:** when procedure is done, bring bed back in
10. **Transport Patient:** help transport patient to PACU, floor, etc.
11. **Procedure Note:** put in procedure note

Hints/Tips for Surgery:

1. **Look at the OR schedule the DAY BEFORE:** learn the operative anatomy/pathophysiology of the surgery. It's difficult to impress an attending with your knowledge of anatomy, but not knowing it can look quite bad. OR schedule can be found in PowerChart.
2. **Expect to retract:** this is not glamorous, but it will be your job.
3. **Practice knot tying:** If given the opportunity to tie in the OR, it is best to be prepared: if you tie well, they will likely let you tie more.
4. **Cutting suture, expect to get yelled at:** Pay attention and be ready with

suture scissors when asked to cut. If there is any doubt on where to cut or how long to leave the tails: ASK. “There are three types of med students: those who cut too long, those who cut too short, and those who cut too slowly” – Surgery Attending.

5. Be Nice to Scrub/Circulating Nurses: Stay on their good side as they can be very helpful at guiding you in the OR.
6. DO NOT touch instrument table: never touch the table, always ask the nurse to pass you instruments
7. Observe Sterile Field: If you have any doubt whether or not you can touch something, DO NOT TOUCH IT. 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.
8. Learn to place a Foley: This is a great way to help in the OR. The more you help in the OR, the more the residents and attending will let you do during the procedure.
9. General Surgery Call Tips: carry trauma/bandage scissors, for traumas put in the trauma note, for consults put in the consult H&P.
10. Ordering Films: if you need to put in the order for films, you need to give the Patient Name, MRN, Name of Study & Date, Series # and Image #s (number range), Your Name and Pager #.

Recommended References Textbooks:

- 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 lacks much detail.

Other References and Textbooks:

- BRS General Surgery and Surgical Subspecialties: Provide adequate preparation for the shelf. Sometimes not detailed enough, but will have good questions at the end of every chapter.
- Netter's Atlas of Anatomy: Will suffice for all your anatomy needs. Read the night before a surgery for a good anatomy review.
- Pretest Surgery: Decent preparation for the shelf, but it should be noted that a number of the sections are of low-yield and not reflective of the shelf exam. Answer explanations are great.
- Appleton and Lange: 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 several years ago that consists of all of the surgery learning objectives that generally circulates around the class every year. Be warned that in this document some of the answers are good, some are very incomplete and non-informative, and some are incorrect. Most often this document is used to study for the midterm.

Testing/Grading:

There are 3 components to the final surgery grade: an OSCE, your clinical evaluations, and a shelf. To get honors you must score above the class average of your current surgery group on all three components. To get a high-pass you must score above average in 2 of the 3 components. The average for the clinical evaluations is around 7.1 and the average on the shelf exam is usually in the high 60s to low 70s.

There is also a midterm, an in-house test that does contain some slides. It is derived directly from the learning objectives and lectures. The average on the test is usually between 50-60%. While the midterm does not factor into honors/high-pass, it is used to calculate the overall grade to determine pass vs. fail.

<p><u>Post Op Fever:</u> Wind - atelectasis, pneumonia Water - UTI Wound - Infection **Womb - endometritis, uterine infxn (if C-Section) Walking - DVT Wonder-Drugs - Medications</p>	<p><u>Compartment Syndrome:</u> Pain Paresthesia Pallor Paralysis Poikilothermia *NOT pulselessness*</p>	<p><u>Anterior Mediastinal Mass (4 T's):</u> Thymoma Terrible (T-cell) Lymphoma Teratoma Thyroid Goiter</p>
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<u>Sepsis:</u> Systemic Inflammatory Response Syndrome (SIRS)= Temperature: ↑ or ↓ Tachycardia Tachypnea Leukopenia or Leukocytosis Hypotension Sepsis = SIRS + Infxn Septic Shock = Sepsis unresponsive to fluids (must use pressors)	<u>Hematuria (TTS):</u> I - Infection - Infarction - Iatrogenic (drugs) T - Trauma - Tumor - TB S - Stone - Sickle cell - cystitis	<u>Fistula that fails to close:</u> High output Intestinal destruction Short segment Foreign Body Radiation Infection Epithelialization Neoplasm
<u>Appendicitis:</u> Rovsing's Sign Psoas Sign Obturator Sign McBurney's Sign	<u>Ascending Cholangitis:</u> Charcot's Triad – Jaundice Fever (with rigors) RUQ Pain	<u>Septic (Ascending) Cholangitis:</u> Reynold's Pentad – Charcot's Triad Hypotension Altered Mental Status

OBSTETRICS & GYNECOLOGY:

Included are templates of relevant OB/GYN notes that can serve as references throughout the rotation.

Obstetrics H&P:

CC: A few words on why the patient presents, usually a symptom such as “my water broke.” Quote the patient if you can.

HPI: Start with age G_P_ _ _ _ @ *** of weeks dated by (LMP, US {at # of weeks}, or both) admitted for: describe the reason for coming to 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: Complications? 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, gender, and any complications.

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: VS:

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 (e.g. GBS, Gestational diabetes, etc.)

Labor SOAP Note: written every two hours while patient is laboring

S: In any pain? Feeling contractions?

O: VS:

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:

Procedure: NSVD/LFVD/OFVD/Primary LTCS/Repeat CS/Classical CS

PreOp Dx: # of weeks IUP. # of hours in 2nd 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: For C/S ask anesthesiologist

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 degree of laceration 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: VS and I/O's: Include UOP over 24hrs.

CV: RRR. no m/r/g

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: Age, G_P_ _ _ _ at *** of weeks dated by (LMP or US {at # of
weeks} or both) POD # s/p (type of C/S). AFVSS. Adequate/good UOP.

List how patient is doing.

1. d/c foley
2. Advance diet to general
3. PO pain meds
4. HLIV (hep-lock IV)
5. Encourage ambulation
6. Check CBC
7. 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: VS: 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). AFVSS. Adequate/Good UOP. List how patient is doing.

1. General diet
2. Encourage ambulation
3. Lactation consultant as needed
4. Post partum birth control plan

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 Note:

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&O. NAD.

CV: RRR. no m/r/g

LUNGS: CTAB.

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

INCISION: c/d/i. 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.
AFVSS.

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).

Gynecology 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 *** 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 to assist residents.

DUTIES ON OB:

Daytime

1. Check in with residents. Check the board for patients to pick up at the beginning of the 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/S or be willing to go to a C/S at any time during the day.

Night Float

1. Largely the same as days in regards to picking up and following patients. Hours are typically 5:30PM to 7AM.
2. If interested, go to the ER with the Gyne on-call resident.
3. Always have something to read on hand as nights can range from very busy to very slow.

DUTIES ON GYNE:

In The OR

1. Check to see if the patient needs Abx. Fetch them if necessary (they will show you where the pharmacy is on the first day).
2. Take bed out and help roll 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:

Ab – abortion (included elective, therapeutic, and miscarriages)
AFVSS – afebrile, vital signs stable
ASC-H – atypical squamous cells cannot exclude high-grade intraepithelial lesion
ASC-US – atypical squamous cells of undetermined significance
bHCG – beta human chorionic gonadotropin
BPP – biophysical profile
BSO – bilateral salpingo-oophorectomy
BV – bacterial vaginosis
C/D/I – clean/dry/intact
CKC – cold knife cone biopsy
CLE – epidural
CPD – cephalopelvic disproportion
C/S – C-section
Ctx or Ucx – contractions
D&C – dilatation & curettage
D&E – dilatation & /evacuation

DMPA – Depo-Provera
DUB – dysfunctional uterine bleeding
EDC – est. date of confinement
EDD – est. date of delivery
EFW – est. fetal weight
EUA – exam under anesthesia
FAS – fetal alcohol syndrome
FF – fundus firm
FHT – fetal heart tracing
FM – fetal movement
FSE – fetal scalp electrode
FT – full term
FTP – failure to progress
FWB – fetal well being
GA – gestational age
GBS – grp B streptococcus
GETA – general anesthesia
GLT – glucose loading test
GPs – Gravida (number of pregnancies) and Para (number of births in this

order: Term, Preterm, Abortions, Living)	PCOS – polycystic ovarian syndrome
GTT – glucose tolerance test	PID – pelvic inflammatory disease
HELLP – hemolysis, elevated LFTs, low platelets	PIH – pregnancy induced HTN
HPL – human placental lactogen	POBH – past OB history
HSG – hysterosalpingography	POD – post op day (0=day of surgery)
ICSI – intracytoplasmic sperm injection	PP – post partum
IUFD – intrauterine fetal death	PGYNEH – past GYNE history
IUGR – intrauterine growth restricted	Pit – pitocin
IUP – intrauterine pregnancy	PPBC – post partum birth control
IUPC – intrauterine pressure catheter	PPROM – preterm premature rupture of membranes
LBW – low birth weight	PROM – premature rupture of membranes
LEEP – loop electrosurgical excision procedure	ROM – rupture of membranes
LFVD/OFVD – forcep assisted vaginal delivery	RPR – rapid plasma reagin
LGA – large for gestational age	SAB – spontaneous abortion
LGV – lymphogranuloma venereum	SERM – selective estrogen receptor modulator
LMP – last menstrual period	SGA – small for gestational age
LOF – loss of fluids (water breaking)	SUI – stress urinary incontinence
LOT – left occiput transverse	TAB – therapeutic abortion
LTCS – low transverse C-section	TAH – total abdominal hysterectomy
LTL – laparoscopic tubal ligation	TPAL – term, preterm, aborted, living
LTV – long-term variability	TVH – total vaginal hysterectomy
MAC – conscious sedation	TOA – tubo-ovarian abscess
MSAFP – maternal serum AFP	TOLAC – trial of labor after Cesarean
MWB – maternal well being	TOCO – tocometer (measures frequency of contractions)
NRFT – nonreassuring fetal testing	TSST – toxis shock syndrome toxin
NST – nonstress test	UPI – uteroplacental insufficiency
NSVD – normal spontaneous vaginal delivery	U/S – ultrasound
NT – nuchal translucency	VBAC – vaginal birth after Cesarean
NTD – neural tube defect	VDRL – Venereal Disease Research Laboratory
OCP – oral contraceptive pill	
OCT – oxytocin challenge test	
PCOD – polycystic ovarian disease	

Recommended References, Textbooks and Pocketbooks:

- **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. Good 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: 100 question shelf exam. 130 minutes to complete.

OSCE: Typically 6 stations:

- OB exam: evaluate a pregnant pt (fundal ht, FHT, due date, etc.)
- Gyne exam (know how to use speculum)
- Oral exam with an attending
- Internet research skills: answer a clinical question
- Review pt chart and write A/P
- Clinical identification: evaluate pictures and write A/P

PEDIATRICS:

Included are templates of relevant Peds notes that can serve as references throughout the rotation.

Pediatric H&P:

CC:

HPI: "4mo boy/girl w/ PMH sign for *** presents with _____."

- Apply OLD CARTS
- 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.
- Typically report on the ER course here, however some residents and attendings may advise you to put that info 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: As per usual.

Allergies: As per usual.

Diet: Ask about if not yet obtained. BM? What kind of formula? How much, how often?

BirthHx: Pregnancy: Full term? Complications? Prenatal care? Birth: Complications? GBS status? Fevers? ABx? How long was stay in the hospital? Did baby go home w/ mom?

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

Social Hx: Who lives at home? Environment? Apt/house? Pets? Smokers? Who does he spend time with during the day (care taker, day care, school, etc)? Recent travel? Recent sick contacts?

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

PEX:

VS: T/HR/RR/BP

GROWTH: Height/weight/head circumference (if <2yo)/BMI, and corresponding percentiles (look at growth curves).

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

HEAD: NCAT (normocephalic/atraumatic), AFOSF (anterior fontanelle open/soft/flat). If less than 2yo, assess anterior and posterior fontanelles.

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

EARS: TM intact? (have mom or dad help hold 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: CTAB, wheezes, nasal flaring, tracheal tugging, subcostal retractions, accessory muscle use.

ABD: Soft, NTND, +/-BS, no HSM

BACK: Sacral dimple, +/- hair tuft

GU: Tanner Stage, nml ext genitalia (for males, 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 illness is something musculoskeletal or neuro in nature)

* Above PE is a fairly 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.

Lab/Studies: For cultures, always report as "NGTD x how many days" or "pending."

A/P: 4mo infant p/w ***. Discuss differential diagnosis (usually a paragraph or several sentences) and then break down plan by system (may only have main issue and FEN 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: VS:

- Tmax for last 24hr - note other fever spikes (and 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 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).

PEX: GEN, HEENT, RESP, CV, ABD, EXT, NEURO

Labs: As above.

A/P: As above.

Commonly Used Peds Abbreviations:

ABC – apnea, bradycardia, cyanosis
AFOF – anterior fontanelle open and flat
AGA – appropriate for gestational age
BPD – bronchopulmonary dysplasia
CBG – capillary blood gases
CLD – chronic lung disease
CPS – Child Protective Services
ECMO – extracorporeal membrane oxygenation
FAS – fetal alcohol syndrome
GBS – grp B streptococcus
HMD – hyaline membrane disease
HMF – human milk fortifier
ICH – intracranial hemorrhage
IDM – infant of a diabetic mother
IICU – Infant Intensive Care Unit

IRDS – idiopathic respiratory distress syndrome
IVH – intraventricular hemorrhage
LGA – large for gestational age
MAS – meconium aspiration syndrome
MR – mental retardation
NB – newborn
NBN – Newborn Nursery
NEC – necrotizing enterocolitis
NICU – Neonatal Intensive Care Unit
NNB – normal newborn
OFC – Occipitofrontal circumference
PAL – Peripheral Alimentation Line
PDA – patent ductus arteriosus
PIE – pulmonary interstitial emphysema
PKU – phenylketonuria

PTD – prior to delivery
PVL – periventricular
leukomalacia
ROP – retinopathy of prematurity
SGA – small for gestational age
SIDS – sudden infant death
syndrome

TORCH – (titers for)
toxoplasmosis, rubella,
cytomegalovirus, herpes
TTNB – transient tachypnea of
the newborn
UAC – umbilical arterial catheter
UVC – umbilical venous catheter

Recommended References, Textbooks and Pocketbooks:

- **The Harriet Lane Handbook:** Classic pocketbook for the house officer. A must-have if you are 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.
- **Pediatric Articles:** Provided by clerkship director on Blackboard. Covers most relevant subjects in pediatrics, although some articles are too detailed.
- **Clipp Cases:** Accessible via Blackboard. Covers 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. Summary pages included 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 the clerkship.
- **Pretest Pediatrics:** 500+ clinical questions structured after the USMLE Step 2. Good practice for peds shelf exam.
- **First Aid: Pediatrics:** Some find this book too dense, others view it as the only book they need.

Testing:

Shelf: 100 question shelf exam. 130 minutes to complete.

PSYCHIATRY

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, DT's, 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 1st 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 1st 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-Liaison 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.

Also, there is an OSCE with 2 patients that requires you to be document a thorough mental status exam and formulate management plans.

Commonly Used Psych Abbreviations:

ADL – activities of daily living
A/VH – auditory or visual
hallucinations
Chem Dep – chemical dependency
DIGFASST – sx of mania:
Distractibility, Irritability, Grandiosity,
Flight of ideas, Activity (Inc), Speech
(Pressured), Sleep, Thoughtlessness
HI – homicidal ideation

MR – mental retardation
NA – narcotics anonymous
SI – suicidal ideation
SIGECAPS – sx of depression: Sleep
(Inc or Dec), Interests (Dec), Guilt,
Energy (Dec), Concentration (Dec),
Appetite (Inc or Dec), Psychomotor
retardation/agitation, Suicide Ideation

NEUROLOGY

The responsibilities on this rotation vary depending on site between Evanston and NMH. Services include stroke, consult, ER, and outpatient offices. However, always be prepared with a reflex hammer, tuning fork, MMSE, and a dermatome map.

Neurology H&P:

While this is very similar to a medicine note, there are some differences, which will be highlighted below.

HPI: Pt is a _ yo right-handed/left-handed dominant M/F with a PMH significant for (neurologic diseases) presenting with (chief complaint)

Physical Exam:

Gen: NAD

Lung: CTAB

CV: rrr, no mrg, no carotid bruits auscultated

Neuro Exam:

Mental Status: alert and oriented to person, place and time. Language and speech are intact. Able to follow simple and complex commands.

CN I: not tested

CN II: Visual fields full to confrontation. Acuity grossly intact. Pupils equal round and reactive to light.

CN III, IV, VI: EOM full without dysconjugate gaze, no nystagmus or ptosis

CN V: Mastication intact; facial sensation normal

CN VII: face symmetrical

CN VIII: hearing grossly intact to finger rub bilaterally

CN IX, X: Palate and uvula elevation midline

CN XI: 5/5 sternocleidomastoid and trapezius muscles symmetrically

CN XII: tongue protrudes midline and without atrophy or fasciculations.

Motor:

Strength 5/5 in upper and lower extremities bilaterally with no atrophy or fasciculations. Tone is normal without tremor at rest, posture or intention. No cogwheeling or rigidity. Palpation of muscles in LE bilaterally does not elicit pain or discomfort.

Reflexes:

Normoactive, symmetrical reflex in upper and lower extremities in following tested reflexes: biceps, triceps, supinator, patellar and achilles.

Babinski flexor response bilaterally

Sensation:

Intact sensation to pinprick, light touch, vibration, proprioception

Coordination:

Rapidly alternating movements and finger to nose testing performed well and without difficulty

Gait and Stance:

Normal gait and stance. Able to walk on heels, toes, and in tandem. Romberg performed without sway.

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)

- Always document all CN as shown above in the H&P. Usually not acceptable to write “II-XII intact”

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 It touch, pinprick, proprioception and temp.

Gait:

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

A/P: similar to medicine SOAP

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. You may be expected to travel, so be prepared to factor in commuting time. 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.

If you fail to protect the confidentiality of health information you are:

- ◆ Acting unethically and are breaking the law
- ◆ Undermining your relationship with the patient and that of other caregivers (including the patient's personal physician).
- ◆ Placing the medical school, hospital and yourself in legal jeopardy which, depending on the severity of the violation, may include fines and jail time.

Here are a few reminders regarding the basics:

- ◆ Patients have the right to know that the confidential information on their medical record will not be disclosed without their permission
- ◆ Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) - 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.
- ◆ 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 an elder on your team.
- ◆ **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 into unlocked trash bins or other containers. Special containers for such confidential materials are available
- ◆ 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.

You will receive extensive instruction on the privacy regulations.

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. If such an incident does occur, you are automatically excused from whatever you are doing. 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. Remember that 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 immediately call or go to the site specified below:

NMH Corporate Health 312-926-8282 If it is after hours or on a weekend, the office will be closed, but an answering service will take your call and will page the nurse on call.

RIC Corporate Health 312-926-8282 If it is after hours or on a weekend, the office will be closed, but an answering service will take your call and will page the nurse on call.

CMH Employee Health 3-2273 Needle Stick Pager (NAB 103)

ENH Emergency Room Emergency Room

VAL Emergency Room (HEU) Emergency Room (HEU)

VAW Employee Health (Room 1480) 569-7159 Needle Stick Hotline

If at a physician's office or other site, you would still contact Corporate Health at NMH.

While the exact reporting procedure varies from hospital to hospital, the first step is to contact the appropriate person 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.

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.

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.

You should not receive any bills for treatment, but if you do, send them to Christopher Johnson
Director, Office of Risk Management
Northwestern University
2020 Ridge Avenue, #240
Evanston, IL 60208-4335

Phone: (847) 491-8518
Fax: (847) 467-7475
Email: cjohnson@northwestern.edu

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

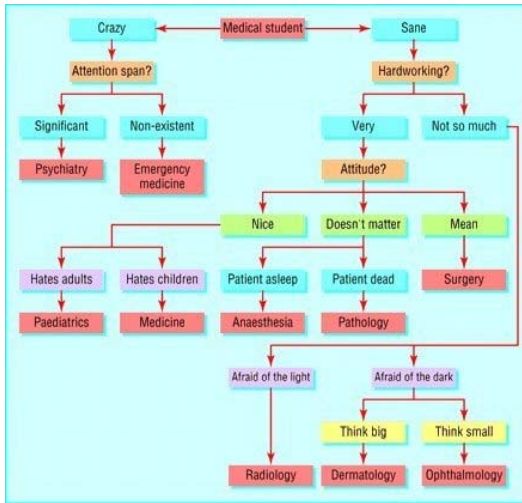
Your junior year will be extremely interesting and may also be quite challenging. You will see and do many things that you may never have the chance to do again – deliver a baby, replace a knee, consider the best anti-psychotic for a schizophrenic with auditory hallucinations, help a child in DKA, give tPA to a stroke victim, and oh so much more.

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. Remember, if your resident is able to finish all the floor work because you helped, there will more time for teaching. When it comes to helping, this includes helping all members of your team, even 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.

<i>T</i>	one (used to substitute for numerical digit)	AFB	acid fast bacilli (think tuberculosis)
<i>TT</i>	two (used to substitute for numerical digit)	afib	atrial fibrillation
<i>TTT</i>	three (used to substitute for numerical digit)	AFP	alpha fetoprotein
<i>a</i>	before (Latin: ante)	AI	aortic insufficiency
AAA	abdominal aortic aneurysm	AKA	above the knee amputation
Ab	antibody or abortion	ALL	allergies; also acute lymphocytic leukemia
Abx	antibiotics	AMA	against medical advice (signing out of hospital)
Abd	abdomen	AML	acute myelocytic (or myelogenous) leukemia
ABG	arterial blood gas	ANA	anti-nuclear antibody
ABI	ankle brachial index	AODM	adult onset diabetes mellitus
a.c.	before meals (Latin: ante cibum)	AP	anteroposterior
AC & BC	air conduction and bone conduction of ear	A+P	auscultation and percussion
ACTH	adrenocorticotropic hormone	A/P	assessment/plan
ADA diet	American Diabetic Association diet	aPPT	activated partial thromboplastin time (PTT)
ADH	anti-diuretic hormone (vasopressin)	appy	appendectomy
ADLS	activities of daily living skills	AR	aortic regurgitation
ad lib	at liberty	ARDS	adult respiratory distress syndrome
		ARF	acute renal failure

AROM	artificial rupture of membranes or active range of motion	D ₅ D ₅ LR	5% dextrose in saline solution 5% dextrose in lactated ringer's solution
AS	aortic stenosis	D ₅ W	5% dextrose in water
ASA	acetylsalicylic acid (aspirin)	D+C	dilatation and curettage
ASAP	as soon as possible	d/c	discontinue or discharge
ASD	atrial septal defect	DCFS	Department of Children and Family Services
AXR	abdominal x-ray		
B/L	bilateral		
c	with	D+E	dilatation and evacuation
CA	carcinoma	DI	diabetes insipidus
C/D/I	clean/dry/intact (in regard to incisions)	DIC	disseminated intravascular coagulation
CHF	congestive heart failure	DJD	degenerative joint disease
CIS	carcinoma in situ	DKA	diabetic ketoacidosis
CM	costal margin or cardiomegaly	DM DNR	diabetes mellitus do not resuscitate
CMH	Children's Memorial Hospital	DOA	(supportive measures only) date of admission or dead on arrival
CMV	cytomegalovirus		
CN	cranial nerve		
c/o	complains of	DOE	dyspnea on exertion
coags	coagulation factors (tested with PT/PTT)	DM DP	diabetes mellitus dorsalis pedis artery
COPD	chronic obstructive pulmonary disease	DPT	diphtheria, pertussis, tetanus immunization
CP	chest pain or cerebral palsy	DT's	delirium tremens
CPAP	continuous positive airway pressure	DTR DUB	deep tendon reflexes dysfunctional uterine bleeding
CPM	continue present management	DVT	deep vein thrombosis
CRF	chronic renal failure	Dx	diagnosis
CRI	chronic renal insufficiency	Dz	disease
C+S	culture and sensitivity	EBL	estimated blood loss
C-section	cesarean section	ECT	electroconvulsive therapy
C/S	cesarean section	ECG	electrocardiogram
CS	chemstrips (measures serum glucose)	EDC	estimated date of confinement (referring to pregnancy)
CSF	cerebrospinal fluid		
CSOM	chronic suppurative otitis media	EEG EFM	electroencephalogram external fetal monitor
CT	computerized tomography	EFW	estimated fetal weight
CTA	clear to auscultation (in lung exam)	EGD EKG	esophagogastroduodenoscopy electrocardiogram
CV	cardiovascular	ELISA	enzyme linked
CVA	cerebral vascular accident (stroke)		immunoabsorbent assay
CVAT	costovertebral angle tenderness	EMG ENT EOM	electromyogram ear, nose, and throat extraocular movements
CVP	central venous pressure	EOMI	extraocular movements
c/w	consistent with		intact
Cx	culture	EPS	electrophysiological
CXR	chest x-ray		study/service

ERCP	endoscopic retrograde cholecystopancreatogram	GP	gravidy (# preganancies), parity (#
ESRD	end stage renal disease		births categorized as TPAL
ESR	erythrocyte sedimentation rate		- term, preterm, abortions, living kisa children)
ESWL	extracorporeal shock wave lithotripsy	GSW	gunshot wound
ETT	endotracheal tube	gt. or gtt.	drop or drops (Latin: gutta)
EXT	extremities	GTT	glucose tolerance test
FB	foreign body	GU	genitourinary
FBS	fasting blood sugar	GYN	gynecology
f/c/s	fevers/chills/sweats	HA or h/a	headache
FDP	fibrin degradation products (same as FSP)	HAL	hyperalimентация
FDLMP	first day last menstrual period	HAV	Hepatitis A virus
F/E/N	fluids, electrolytes, and nutrition	Hb	hemoglobin
FFP	fresh frozen plasma	HBHC	home based health care
FH	Family History	HBV	Hepatitis B virus
FHR	fetal heart rate	HCG	human chorionic gonadotropin
FHS	fetal heart sounds	Hct	hematocrit
FHT	fetal heart tones	HEENT	head, eyes, ears, nose, throat
FIO ₂	fraction of inspired oxygen	HEU	Health Evaluation Unit (the VA's ER)
FLK	funny looking kid (**not very professional**)	Hgb	hemoglobin
FM	face mask	H/H	hemoglobin/hematocrit
FOB	foot of bed	H-J reflux	hepato-jugular reflux
F.P.	Family Planning	HMD	hyaline membrane disease
FROM	full range of motion	h/o	history of
FSH	follicle stimulating hormone	H/O	hemocult
FSP	fibrin split products (same as FDP)	H.O.	house officer
FT IUP	full term intrauterine pregnancy	HOB	head of bed
FTA-Abs	fluorescent treponemal antibody absorption	HOH	hard of hearing
FTT	failure to thrive	hpf	high power field (referring to microscope)
f/u	follow up	HPI	history of present illness
FUO	fever of unknown origin	HR	heart rate
fx	fracture	h.s.	bedtime (Latin: hora somni)
gb	gallbladder	HSG	hystosalpingogram
GBM	glioblastoma multiforme	HSM	hepatosplenomegaly
GC	gonococcus	HTN	hypertension
GDM	gestational diabetes mellitus	hx	history
GERD	gastroesophageal reflux disease	ICU	Intensive Care Unit
GI	gastrointestinal, gastroenterology	I+D	incision and drainage
gm%	grams per hundred milliliters of serum	ID	infectious disease
GOETT	general oral endotracheal tube	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	MCV	mean corpuscular volume
IUP	intrauterine pregnancy	MD	terrapins
IV	intravenous	mg%	milligrams per hundred milliliters
IVAC	a type of infusion pump	MI	myocardial infarct or mitral insufficiency
IVDA	intravenous drug abuse	MICU	medical intensive care unit
IVDU	intravenous drug use	MMMI	mucus membranes moist and intact
IVF	IV fluids	MR	mitral regurgitation
IVP	IV push or intravenous pyelogram	MRI	magnetic resonance imaging
IVPB	IV piggyback	MRSA	methicillin resistant staph aureus
JODM	juvenile onset diabetes mellitis		
JRA	juvenile rheumatoid arthritis (think isolation)		
JVD	jugular venous distention	MS	mitral stenosis or multiple sclerosis
KUB	kidneys, ureters, bladder (referring to abdominal x-ray)	MSO ₄	morphine
L	left	MVC	motor vehicle collision
LAD	left axis deviation or left anterior descending artery	MVI	multivitamin
LBBB	left bundle branch block	MVP	mitral valve prolapse
LDH	lactic dehydrogenase	NABS	normoactive bowel sounds
LE	lower extremity (leg)	NAD	no acute/apparent distress
LFT	liver function tests	NC	nasal cannula
LGA	large for gestational age	NC/AT	normocephalic, atraumatic (a normal head)
LH	luteinizing hormone	NEC	necrotizing enterocolitis
LIH	left inguinal hernia	NG	naso-gastric tube
LLE	left lower extremity (left leg)	NICU	neonatal or neurosurgical intensive care unit
LLL	left lower lobe (referring to lung)	NIDDM	non-insulin dependent diabetic
LLQ	left lower quadrant (referring to abdomen)	NKDA	no known drug allergies
LMA	laryngeal mask airway	nl	normal
LMP	last menstrual period	NMH	Northwestern Memorial Hospital
LOL	little old lady (**do not use**)	Ø	no or none
LP	lumbar puncture	NPO	nothing by mouth (Latin: nihil per os)
L/S	lecithin/sphingomyelin ratio	NS	normal saline
LUE	left upper extremity (left arm)	NSAID	non-steroidal anti-inflammatory drug
LUL	left upper lobe (referring to lung)	NSR	normal sinus rhythm
LVH	left ventricular hypertrophy	NSVD	normal spontaneous vaginal delivery
m/r/g	murmurs/rubs/gallops	NT	nasotracheal (referring to suctioning)
MAL	mid-axillary line	NTND	nontender, nondistended
MAOI	monoaminoxidase inhibitor	NTG	nitroglycerin
MAP	mean arterial pressure	n/v/d/c	nausea/vomiting/diarrhea/constipation
MCH	mean corpuscular hemoglobin	O ₂ sat	oxygen saturation
MCHC	mean corpuscular hemoglobin concentration	OB	obstetrics
MCL	mid clavicular line	OBS	organic brain syndrome
		OCP	oral contraceptive pills

OCOR	on call to the OR (referring to OR meds)	PND	paroxysmal nocturnal dyspnea
OD	right eye	p.o.	by mouth (Latin: per os)
OM	otitis media	POD	postoperative day (followed by a number)
OOB	out of bed (referring to activity)	polys	polymorphonuclear leukocytes
o/p	outpatient		
OPV	oral polio vaccine	post-op	post-operative
OR	operating room	PP	post-partum
os	mouth	PPTL	post-partum tubal ligation
OS	left eye	PPD	purified protein derivative (for tuberculin test)
OT	occupational therapy		
OTD	out the door	p.r.	per rectum (suppository)
OU	both eyes	PRBC's	packed red blood cells
p	after (Latin: post)	prn	when necessary (Latin: pro re nata)
P	pulse	PROM	premature rupture of membrane or passive range of motion
PA	posterior-anterior		
PAC	premature atrial contraction		
Pap smear	Papanicolaou cytologic test		
PAS	para-amino salicylic acid	PSH	past surgical history
PAT	paroxysmal atrial tachycardia	PSVT	paroxysmal supraventricular tachycardia
p.c.	after meals (Latin: post cibum)	PT	physical therapy
PCA	patient controlled analgesia	PTCA	percutaneous transluminal coronary angioplasty
PCN	penicillin		
PCO	polycystic ovary	ψ	psychiatry
PDA	patent ductus arteriosus	pt	patient
PDR	Physician's Desk Reference	PT	prothrombin time or posterior tibial artery
PE	physical examination or pulmonary embolus	PTA	prior to admission
PEEP	positive end expiratory pressure	PTH	parathyroid hormone
PERL	pupils equal and react to light	PTT	partial thromboplastin time
PERRLA	pupils equal, round, and react to light & accommodation	PUD	peptic ulcer disease
PFC	persistent fetal circulation	PVC	premature ventricular contraction
PFT	pulmonary function tests	q	every (Latin: quaque)
PG	prostaglandins	qAM	every morning
PH	past history	qhr or q ^o	every hour
PI	pulmonary insufficiency	qhs	at hour of sleep
PID	pelvic inflammatory disease	qD	daily (Latin: quaque die)
PKU	phenylketonuria	qid	four times per day
Plt	platelets	qMWF	every Monday, Wednesday, and Friday
PMH	past medical history	qod	every other day
PMI	point of maximum impulse (referring to heart)	qPM	every evening
pmns	polymorphonuclear leukocytes (i.e. neutrophils)	q shift	every nursing shift (usually every 8 hours)
PM&R	Physical Medicine & Rehabilitation	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	SMA	sequential multiple analysis (chemistry laboratory tests – usually sodium, potassium, chloride, bicarbonate, BUN, creatinine, and glucose)
RDS	respiratory distress syndrome		
RDW	red cell distribution width		
REM	rapid eye movement	SOB	shortness of breath
Rh	Rhesus blood factor	SOM	serous otitis media
RHD	rheumatic heart disease	sono	sonogram (ultrasound)
RIA	radioimmunoassay	s/p	status post
RIH	right inguinal hernia	SP	speech pathology
RLE	right lower extremity (right leg)	sp gr	specific gravity
		SQ	subcutaneous
RLL	right lower lobe (referring to lung)	SROM	spontaneous rupture of membranes
RLQ	right lower quadrant (referring to abdomen)	SSCP	substernal chest pain
r/o	rule out	STAT	immediately (Latin: statim)
ROC	resident on call	SVC	service
ROM	range of motion	SVT	supraventricular tachycardia
ROS	review of systems	T	temperature
RPR	rapid plasma reagent (syphilis test)	T ₃	triiodothyronine
		T ₃ -RU	triiodothyronine resin
RR	Recovery Room		uptake
RRR	regular rate and rhythm (referring to heart)	T ₄	serum thyroxine
		T+A	tonsillectomy and adenoidectomy
RT	radiation therapy	tab	tablet (Latin: tabella)
RTA	renal tubular acidosis	TAH-BSO	total abdominal hysterectomy bilateral salpingo-oophorectomy
RTC	return to clinic		tuberculosis (think isolation)
RUL	right upper lobe (referring to lung)	TB	thyroxine binding globulin
		TBG	total body surface
RUE	right upper extremity (right arm)	TBS	type and crossmatch
		T+C	tricyclic antidepressant
RUQ	right upper quadrant (referring to abdomen)	TCA	turn, cough, deep breath
		TCDB	transcutaneous electrical nerve stimulator
RVH	right ventricular hypertrophy	TENS	thyroid function tests
Rx	prescription, treatment, or therapy	TFT	transient ischemic attack
s	without (Latin: sine)	TIA	three times a day (Latin: ter in die)
SIS2	first and second heart sounds	tid	to keep open (referring to IV rates)
SBE	subacute bacterial endocarditis	TKO	tubal ligation
SBO	small bowel obstruction		tympenic membrane
SCM	sternocleidomastoid	TL	temporal mandibular joint
sed rate	sedimentation rate	TM	tubal ovarian abscess
SEM	systolic ejection murmur	TMJ	toxoplasmosis, other (syphylis), rubella, CMV, herpes
SGA	small for gestational age	TOA	
SH	social history	TORCH	
SICU	surgical intensive care unit		tissue plasminogen activator
sig	label (latin: signa)		total parenteral nutrition
SL	sublingual (e.g. for nitroglycerin)	tPA	type and screen
		TPN	
SLE	systemic lupus erythematosus	T+S	

TSH	thyroid stimulating hormone	vfib	ventricular fibrillation
TTP	thrombotic thrombocytopenic purpura	VNA	Visiting Nurse Association
TUR	transurethral resection	V/Q	ventilation/perfusion
TURP	transurethral resection of the prostate	VRE	vancomycin-resistant enterococcus (think isolation)
Tx	treatment	VS	vital signs
UA or U/A	urinalysis	VSD	ventricular septal defect
UCLA	bruins, baby	VSS	vital signs stable
UE	upper extremity (arm)	VT	ventricular tachycardia
U/O	urine output	v-tach	ventricular tachycardia
URI	upper respiratory infection	w+d	warm and dry (referring to skin)
U/S	ultrasound	WBC	white blood count
UTC	up to chair (referring to activity)	WDWN	well developed, well nourished
UTI	urinary tract infection	WNL	within normal limits
VA	Veterans' Administration	w/c	wheelchair
VDRL	serologic syphilis test	w/u	work up
VF	ventricular fibrillation	XRT	radiation therapy
VFVTC	visual field full to confrontation	ZE	Zollinger-Ellison

Add your own abbreviations:

NMH Helpful Phone Number

(with thanks to Dr. David Neely)

Hospital Operator

Dial 5-1000 or 0 from an in house phone.

Imaging Locations

Echo Reading – Rm 8-216

XR Viewing – Rm 4-328

CT Body Viewing – Rm 4-546

MR Viewing – Rm 4-525

Ad-Thal Viewing/Nuclear Cardiology – 8-140

** After 5PM, go to ED viewing to go over films with radiologists

Important Phone Numbers

Pharmacy

Analgesic Dosing Service: 5-7246 (pager), 6-3382 (office)

Anticoagulation Dosing Service: 5-6548, 6-8670 (office)

Radiology

Protocol CT: 6-5314

CT Scheduling: 6-6366

IR: 6-5200

Feinberg MRI: 6-4333

Neuroradiology: 6-5245

Inpatient Rads: 6-5105

US (general): 6-7032

Cardiac

Cardiac arrest: 5-5555

Emergency hotline: 5-5555

Cardiac Cath Lab: 6-5135

Cardiac Echo: 6-7483

Cardiac Stress Test: 6-8662

Cardiology pager: 5-7458

Echo reports: 6-7483

Echo scheduling: 6-7483

EKG pager: 6-6935

Patient Services

Case Management: 6-2272

Social Work: 6-2060

PT: 3229

OT: 6-2526

Psych

Chem Dep Inpt Consult: 6-8411

Psych Consult: 6-8411

GI/Renal

GI Lab: 6-2425

Dialysis (inpatient): 6-1696

Labs

Cytopathology: 6-7002

Flow Cytometry Lab: 6-7360

Hematology: 6-3200

Histology: 6-2429

Immunohistochem: 6-7872

Micro: 6-3202

Surgical Path: 6-3211

Miscellaneous

Ethics consult: 6-3112

Nutrition (inpatient): 6-7437

RIC: 238-6000

13E Nursing Station: 6-2356

13W Nursing Station: 6-2381

14E Nursing Station: 6-2365

14W Nursing Station: 6-2358

Add your own numbers:

Notes

Notes

