SUCCESS
ON THE WARDS

a student-to-student guide to getting the most out of your third year

EDITION 24. SUMMER 2012.
You:
(hopefully)

(hopefully not)

**THE PAINFULLY ENTHUSIASTIC**

Wow, look! Real patients! Cool!

All right! I just touched some IV tubing!

You're going to let me disimpact that 95-year-old man? AWESOME!

by Michelle Au

---

**mons hubris** by Tom Kim

“Lil' too much?”

“Yeah... lil' bit.”

the honors med student retractor

Tom Kim
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&

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Introduction

To the Feinberg M3 Class of 2014:

Welcome to the twenty-fourth edition of Success on the Wards! Your third year promises to be a fun, challenging, exciting and rewarding opportunity. At times, though, it may seem overwhelming, intimidating and frustrating. We hope that this booklet will help ease some of the confusion and worry and, at least a little bit, prepare you for what lies ahead.

Though difficult, the first two years of medical school were something that you were used to—you spent your time in the library or the classroom (or neither). But, as you look forward to this year with excitement, we’re sure many of you have that sinking feeling in the pit of your stomach that you have no clue what you’re doing. Rest assured, none of us did (well, maybe a few...you know who you are). Generations of medical students before you have experienced that same feeling, have survived and more importantly, thrived! But much like learning how to swim, you will learn the most by simply jumping in. The information in this booklet is designed to help you float in the beginning. As the year progresses, you’ll realize that you no longer need it and are gaining the confidence all your lecturers, deans and upperclassman promised you would find.

The next two 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. Hopefully, these experiences will guide your decisions about the rest of your 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 2013

If you have any suggestions for ICC or this guide, please contact Dr. Amy Kontrick or Lisa Wittig 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. They are ultimately responsible for the patient’s care and will thus make or approve all major decisions. Clerkship evaluations are most often solicited from your attending physician.

**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 in their residency training, usually referring to doctors with more than one year of postgraduate training (PGY-2 and above). 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, help you with your notes and presentations, and offer a good evaluation of your performance to the resident. Helping the intern with their work can be an excellent learning experience and makes their lives much easier (therefore, they are much happier and less stressed).

**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 fourth-year student will not be responsible for your evaluation but they can be a great resource for all of those silly questions that you have but are afraid to ask the residents. Remember, they were in your shoes a year ago so they can really help you make the transition.

**JUNIOR STUDENT** That’s you! Described fully in the next section.
What is Junior Year?

The goal of the junior clerkships is to begin to learn the clinical skills of a physician and expose you to different fields. You will learn to apply the knowledge and skills from M1 and M2 year to actual patient care. This is a challenging endeavor, but you will slowly improve as the year progresses. Especially in the beginning, you will frequently find that you lack knowledge of a particular disease process or the skills to perform a certain procedure. No one expects you to know everything. But, they do expect that you try to find the information and teach yourself (this is where PBL skills come in handy…and Up To Date). As the year progresses, we promise that your clinical judgment, problem solving skills, time management and efficiency, and ability to manage patients issues will continue to develop.

Your Role

Your first priority is to learn as much as possible. Read, read, read. Carry something with you in your white coat pockets at all times because spare time on the wards is unpredictable.

Aside from learning, your second priority is to make the lives of your team easier. Every day, write the daily progress notes for the patients you are following. In addition to helping you integrate your knowledge, 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. Be a team player. Taking a detailed history and physical (H&P), following up laboratory results, obtaining outside hospital records, etc. will provide 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. Medical students spend more time with patients and can often learn about their questions, fears & concerns, and can partner with the nurse to make sure these are addressed. Use your residents and attendings as mentors—they are here to teach you but that’s a second priority to patient care.

Daily Schedule

The routine varies with every rotation. The first day of each rotation is orientation where you will receive your clinical assignment and be informed of the typical schedule. You will often join your new team that first day and may even pick up patients, so be prepared to hit the ground running. On most rotations, you are responsible for pre-rounding on all of your individual patients. This involves seeing the patient and collecting all relevant new information including vitals, lab results, etc before you are scheduled to round with your residents/and/or physician. After this, the team rounds, and you will often present the SOAP presentation on your patients. The team will then make decisions about the daily tasks.
For the rest of the day, you may go into the operating room, see your patients individually, finish your notes, help coordinate their care, contact patient’s private physicians and follow-up on results of tests. Efficiency is a critical skill to learn and refine. You will get better as the year progresses. At the end of the day, sign-out rounds are usually done to update the team members and hand off patients to the on-call resident.
Rules to Live By

The Ten Seventeen Commandments

1. **REMEMBER THAT THERE IS A PERSON ON THE OTHER END.** Patients deserve our time, help, and most importantly our respect. Check with your resident or attending before revealing any potentially sensitive information to a patient. You are often not the appropriate person for this role.

2. **BE ENTHUSIASTIC.** This is pretty self-explanatory but hard to remember when you’re overworked. Remember anyway.

3. **ASSERTIVENESS.** Patients appreciate it if doctors or medical students explain what they’re doing and why, with appropriate certainty. Tread the line between assertiveness and cockiness carefully. During rounds or ‘pimp sessions’, volunteer answers if you know them. (But always give the person to whom the question is asked a chance to answer first!) If you don’t know, say so (see #1).

4. **READ.** Assertiveness is best when accompanied by knowledge. Start with reading about your patients. You will remember things better if you have a patient to connect to the disease, procedure or treatment.

5. **RESPECT YOUR FELLOW CLASSMATES.** Learn with, not at the expense of, your colleagues. Never put down or show up another student. Your team will spot “brown-nosing” and backstabbing easily. Give your classmates a heads-up if you’re going to present an article. Remember, good students can make each other look better.

6. **TAKE CARE OF YOURSELF.** Despite the fact that medical students are “lowest on the totem pole,” you do not have to suffer. Eat when you can, sleep when you can. Always carry around a snack in your pocket (especially on surgery and Ob/Gyn). 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. Introduce yourself and learn their names. The nurses know more than you do about how the hospital functions and day-to-day clinical care—ask them. During pre-rounds, don’t hesitate to turn to the nurse as a resource about what happened overnight.

8. **BE ON TIME.** Even if your residents aren’t.

9. **ASK QUESTIONS.** This demonstrates interest and an eagerness to learn. It is better, however, to focus on clinical decision making skills and questions that can only be answered by someone with experience. Recognize when it may not be a good time to ask a question and save it for later.

10. **SEEK FEEDBACK.** It is your responsibility to find out how your team regards you. Ask specific questions and you will get more helpful answers. It is often helpful to sit down at the halfway mark of the rotation and ask for formal feedback.
11. **BE ACCOUNTABLE.** Post a schedule of your lectures and give your team your pager number. Check-in throughout the day but don’t annoy your residents. Update them and offer to help with their work if you have free time.

12. **WORK HARD; TAKE INITIATIVE; BE PROACTIVE.** Being a medical student, it is almost a given that you are a hard worker. But, you need to show it (in a respectful way). Volunteer to take on an extra patient. Go walk with your patient who needs to get out of bed. Offer to stay a little longer at the end of the day to help out. Be proactive when you can and anticipate the times when you can be helpful to your team. But, remember #6 (and #5).

13. **KNOW YOUR PATIENTS BETTER THAN ANYONE ELSE.** Even though it might not always feel like it, you have the most time. Spending time with patients carries a responsibility to communicate their fears, questions & concerns to the team and make sure they are addressed. Your residents will appreciate it and it makes you look like you are on top of things. Most importantly, this may have impact on the patient’s care.

14. **REMEMBER HUMILITY.** As a medical student, you should show the appropriate respect to the residents and attendings that were once in your position. Do not try to outsmart, embarrass, or correct them in the middle of conference (or ever).

15. **LOOK PRESENTABLE.** You are a member of the team in a professional environment. Socks or pantyhose should always be worn, and open-toe shoes are a violation of Occupational Safety and Health Administration (OSHA) rules, and risk your own safety. Jeans and denim are prohibited by hospital policy. NMH and Illinois Department of Public Health regulations require that scrub attire must not be worn outside hospital buildings. If you leave the OR or area where scrubs are required, scrubs must be covered at all times by closed lab coats or disposable lab coats, even in cases when you have no intention of returning to the designated unit. DO NOT wear scrubs, even with a cover, in neighborhood restaurants and shops.

16. **BE PREPARED TO BE ON-CALL THE FIRST NIGHT.** This is a possibility on some rotations.

17. **PREPARE/PRACTICE FOR ORAL PRESENTATIONS.** Always expect to present your patient, whether you have admitted them or picked them up. Your oral presentation is your time to show what you know and how you have assessed your patient. This is often the only way for your attending to evaluate you, in addition to what he or she hears about you secondhand from your resident.

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**Remember Patient Confidentiality.**

Respect your patients. Corridors, elevators, stairwells, Au Bon Pain, and other public locations are inappropriate areas to talk about patients, even if you leave out their name. There have been incidents in which patients’ families have complained to the hospital. And plus, it’s just bad form.
Basic Charting Information & Tips

One of your duties will be writing the progress note and sometimes putting in orders for patients. Keep in mind that the primary purpose of the note is to communicate. So, write clearly and concisely. Excessively long notes may not be read, and bare notes may not convey enough information or thought. Also, try not to use abbreviations as they are rarely standardized.

At the beginning of all written notes, it may be helpful to indicate which service you represent and your individual status, e.g. “Neurology MS3 Progress Note.” At the end of all your notes and orders, print your name and indicate your status and pager number (“Joe Smith, MS3 Pager: 33333”). In Powerchart, there are note titles specifically for medical students to help identify your note as a student note (“Medical student progress note”).

In the Assessment/Plan section of your note, 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.” Your assessment and plan should not differ too much from your teammates’. Never make statements that directly question the recommendations or judgment of others.

Also, remember that the patient’s chart is a legal document. Thus, if you are using paper charts and you make a mistake, cross out the mistake once, write “error” or “err” and initial it. On the computer, “in error” the note and write an addendum correcting the error. You must sign your notes for them to appear as a proper note in Powerchart; orders must be cosigned by an intern or resident.

Using Powerchart and Epic

- Electronic records make it easy to copy and paste. So be sure you are not plagiarizing other people’s notes. You can often copy-forward your own progress notes, but be sure to update daily information, assessments, and plans. It is a liability to enter incorrect information in the medical record.
- SAVE, SAVE, SAVE, SAVE!! Especially whenever you step away from a computer. Losing a note is not something you want to experience.
- Some residents will have you sign and forward your notes; others will have you forward your unsigned note. Ask them what they prefer.
- Always remember that the EMR is a legal document and is permanent. Be accurate and respectful.

Powerchart: Powerchart is the EMR for the inpatient/hospital. You will get Powerchart training, and your ability to use it will increase with time. Until then, here are a few pointers.
- Dot-Phrases: You will learn to use and create these in training. They can be used as shortcuts for different types of notes as well as for standard text within notes, saving you lots of time.
  - Use existing dot phrases: useful Powerchart dot-phrases: ".cbc_chem"; ".vitals"; ".hb"; ".wbc"; ".urinalysis", etc.
• Create your own dot phrases:
  o Useful personalized dot phrases: ROS, PEX, Your signature (“Joe Smith, MS3 Pager: 33333”), post-op note (see OB/GYN/Surgery sections) with blanks. ***Make sure to edit each dot phrase as it pertains to your patient; this is the danger of using generic dot phrases and has gotten medical students in trouble in the past if not tailored to their individual patient
  o In Powerchart, type out the text you would like to have readily available.
  o Highlight the text and right-click, select “save as auto-text.”
  o There will be a space where you can enter the “name” of your dot-phrase. It is useful to start all of your dot phrases the same way—many people use their initials. Don’t forget to start each dot phrase with a period! Example: Joe Michael Smith may make the following dot phrase: “JMSros”

• MAR View Tab: great way to check on the medications and fluids your patient is receiving, including how much and when they were given (great for monitoring pain PRN medication requirements, zofran use for nausea, PRN antihypertensives, etc).

• 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.

• Orders Tab: the reality of third year medical school is that you are often out of the loop when it comes to small changes in management of your patients. The orders tab can help keep you updated. This is where to look for the patient’s diet (NPO v. clears v. general diet, etc); IVFs, new medication orders, etc.

EPIC: EPIC is the EMR for NMFF outpatient clinics as well as Lurie Children’s. You will be trained to use it before rotating at Lurie Children’s and will learn the basics before then. It is useful to look up a patient in EPIC because you may be able to see outpatient workups, care and labs. Tips: if you are simply looking up a patient and won’t be writing a note on the patient, simply click the “review” tab instead of “opening” their file. If you are writing notes on EPIC, never click “close encounter” unless your attending specifically asks you to do so.

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Feinberg School of Medicine 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.

Students have FAILED the entire clerkship for this in the past.”
Documenting Laboratory Values

One of the most commonly ordered tests is the **basic chemistry panel**, previously referred to as "Chem-7" (right), since it provides a quick assessment of electrolytes, renal function, and serum glucose. Another common test is the **complete blood count (CBC)** (left). The following skeleton or "fishbone" is used:

```
\ Hgb /       Na | Cl | BUN /
WBC ----- Plts ---------------------  Glucose
/ Hct \      K | HCO3 | Cr \
```

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, e.g. %Neut if you suspect bacterial infection.

The traditional method to report **arterial blood gas (ABG)** results is:

```
FiO2 / pH / pCO2 / pO2 / HCO3 / BE / O2 saturation
```

Frequently, the FiO2 is left out if the patient is on room air (FiO2=21%), and the anion gap is appended to the end to help evaluate acid-base disturbances.

A note about abbreviations: Abbreviations can be confusing and dangerous. There are specific prohibitions in Joint Commission accreditation standards against using abbreviations for medication names. Do not ever abbreviate a diagnosis. See the abbreviation section in this guide for more information, but in general, stay away from abbreviations wherever possible.
The Case Presentation

This is how your attendings and/or senior residents assess your clinical reasoning skills. Presentation skills require experience and knowledge, so expect to grow over time. Throughout the year, you will learn to formulate and convey a well-ordered, concise summary of the pertinent clinical information.

Important tips

- Organization is key→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.

- If Review of Systems is non-contributory, state “non-contributory” (okay in presentations, not in notes). Otherwise, say “ROS remarkable for history of joint pain related to arthritis.” If it is relevant to the patient’s chief complaint, it belongs in the HPI.

- Physical exam: presenting this is attending-dependent—always better to ask before presenting. Always start with vitals: “afebrile overnight, BPs ranged from 120-150/70-90, HR, RR, satting well on room air.” Many times it’s ok to state the pertinent findings or the exam you are most interested (if the patient has a cardiac problem—you care most about heart, lungs, edema; a GI surgery case—you care about the abdomen)

- Offer YOUR assessment and plan. Be systematic by problem or by system (service/attending dependent). Be prepared to justify.

- TRY NOT TO 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.

- 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.

H&P Presentation Structure

Consider your presentation a persuasive argument in which you provide evidence for your differential diagnosis.

One-liner:

Patient’s name, age, sex, chief complaint and any relevant past medical history.

HPI:

- You can and should abbreviate this for the purposes of presentation
- Plan to include:
  - Description of symptoms i.e. OLDCARTS
- Chronologic development of symptoms in days prior to admission
- Include pertinent positive symptoms, as well as pertinent negatives

**PMHx:**
- Simply a list of medical conditions which the patient has had
- Elaborate only on those with special relevance

**MEDS:**
- List ONLY the names unless otherwise directed by an attending or resident

**ALLERGIES:** list any major drug allergies

**SOCIAL Hx:**
- Condense to relevant details: “lives with husband, employed as secretary (attending dependent) smokes one pack per day for last 20 years, no alcohol or illicits.”

**FAM Hx:**
- Only include something that might point in the way of one diagnosis or another. It’s ok to say here (but not in your note!) that family history is non-contributory.

**PEX:**
- Begin with a description of the patient and vital signs. If vital signs are all within normal limits, it is usually ok to say so without mentioning specific numbers. Have them on hand just in case.
- List the pertinent positive and negative findings in their respective organ systems.
- Not every organ system needs to be presented every time.
- Always include lungs, heart, and abdomen (if normal, state: “heart regular, lungs clear, abdomen benign.”)

**LABS/STUDIES:**
- Include pertinent (pointing toward or away from a diagnosis) laboratory values and results from tests or procedures.
- Have the other labs that were done readily available just in case you thought one was less important than it actually was.
- Be prepared to look at and thoughtfully discuss any imaging that was done.

**ASSESSMENT:**
- Finish with a summary statement that includes what you think is going on, and what you want to do about it. Offer YOUR assessment, plan and justification.
- This is a great place to teach the team about a treatment option/discuss a paper pertaining to the management of your patient’s problem (if your team is not rushed for time)-being concise is key-articulate the main take aways in 2 minutes or less; if they have more questions or want more detail-they will ask you for it.

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

*Mr. Foley is a 53 year old man with history of stage III prostate cancer diagnosed in March 2009 s/p radical prostatectomy and adjuvant radiation therapy, who presents with intermittent, non-radiating lower back pain x 2 months. Pain began gradually and has increased in severity to 8/10 on pain scale. Pain is worse at night but independent of position. He has been taking Advil without relief. He denies history of trauma to area, change in urination, change in bowel habits, weakness of proximal muscles, fevers, and chills.*
His medical history is significant for chronic urinary retention for which he takes bethanechol. He has no known drug allergies. He 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 exam significant for point tenderness over L4-L5. Neuro exam with 5/5 strength throughout, sensation intact to light touch bilaterally, and a negative 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 one month ago was 10, increased from three months previously which was 5.

In summary, the patient is a 53 year old man with history of prostate cancer who now presents with back pain, point tenderness on exam, hypercalcemia and elevated alk phos and PSA. This likely represents metastasis to the lumbar vertebrae. The enlarged liver may represent liver metastasis. I would like to start 1mg IV dilaudid for the pain, obtain a bone scan to evaluate for bone metastasis, and obtain abdominal CT to evaluate for liver metastasis.
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 Surgery and Pediatrics.

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.

There are numerous different mnemonics used. Pick one and stick to it. Here, we use ADC VANDALISM.

Admit: Ward, Hospital care team names and contact info
12 E, Attending: Dr. Shapiro, Intern: John Smith, pager #5-1234

Diagnosis: Primary reason for admission or if post-op
Chest pain.
s/p laparoscopic appendectomy

Condition: Stable or not (of limited use, since you may hear that “a dead patient is stable”).

Vitals: Which? 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/8h.

Allergies: Include reactions if known. “NKDA” if none.
Penicillin – rash/swelling

Nursing orders: Things that need to be 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/1h when awake, TEDs and SCDs while not ambulating.

Diet: Choices include the following:
NPO after midnight (for procedures). NPO.
TLC diet. ADA diet. Renal diet.
Continuous G-tube feedings.

Activity: Typically ad lib. Remember non-weight bearing (NWB) for Ortho.
Ad lib. Up with assist. Strict bedrest. OOB (out of bed) to chair. NWB left leg (no weight bearing).

Labs: Specify what, when, how often, and for how long.
CBC, Chem 7 + Ca, Mg qAM x 3d. LFTs and ESR now.
**IVF:** Type and infusion rate (more important for surgery). “HLIV” (heplock IV) if none.

D5 0.45 NS @ 125 cc/h.

**Special Studies:** Diagnostic tests and consults.

CXR PA/Lat. CT brain w/wo contrast.

**Medications:** Be sure to specify these four:

1) drug name (generic or trade)
2) dosage
3) administration route (PO, IV, IM, SQ, PR)
4) frequency (QD, QAM, QHS, BID, q 8 hrs, etc.)

Pepcid 20 mg PO QHS
Colace 100 mg PO BID
Norco 10/325 mg, 1 tab PO q4-6 hours PRN pain
Heparin 5000U SQ q8h

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

**Discharge Notes**

The bane of house-staff paperwork. Volunteer to help with these. There is a similar form in Powerchart.

**Admission Date:**

**Discharge Date:**

**Admission Diagnosis:** keep it general (e.g. Abdominal Pain)

**Previous Diagnosis:** what other diagnoses the patient had coming in

**Discharge Diagnosis:**

**Attending:**

**Referring Physician:**

**Continuity Physician:**

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

**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:** Make note of changed medications.

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

**Follow-up Plan:** Appointment date/time, physician/clinic, contact info

Review all medications the patient reported before hospitalization and reconcile with all medications prescribed after discharge. NEVER write 'resume previous medications' (prohibited by The Joint Commission). Give the patient a complete list with name, medication, dose, frequency, route, reason for the medication, and how to take each.
Prescriptions

To prescribe outpatient meds, use prescription stationery (“scrip pads”) when discharging patients on medications. Use patient stickers to mark the patient’s name. As always, write the drug name, dosage, route of administration, dosing frequency, indication for drug, number of pills to dispense (“Disp”), and number of refills (“R”). Be sure to spell out the numbers of pills and refills or strike any zeroes, so they cannot be altered. Hand the script to an MD to sign. Controlled substances will also require their DEA number.

<table>
<thead>
<tr>
<th>John Q. Smith</th>
<th>April 1, 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norco 10/325mg</td>
<td>Sig: Take 1 tab PO every 4-6 hrs PRN pain</td>
</tr>
<tr>
<td>Disp: 30 (thirty)</td>
<td>Refills: Ø</td>
</tr>
</tbody>
</table>

You can also specify substitution with a 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.

<table>
<thead>
<tr>
<th>PRESCRIPTION SHORTHAND: Abbreviations are not recommended for patient safety reasons, but you may see these used.</th>
</tr>
</thead>
<tbody>
<tr>
<td>sig label (Latin: signa)</td>
</tr>
<tr>
<td>T one (used to substitute for numerical digit)</td>
</tr>
<tr>
<td>T.TT three (used to substitute for numerical digit)</td>
</tr>
<tr>
<td>tab tablet (Latin: tabella)</td>
</tr>
<tr>
<td>BID twice per day</td>
</tr>
<tr>
<td>TID three times a day (Latin: ter in die)</td>
</tr>
<tr>
<td>q every (Latin: quaque)</td>
</tr>
<tr>
<td>qAM every morning</td>
</tr>
<tr>
<td>qh or q’ every hour</td>
</tr>
<tr>
<td>qhs at hour of sleep</td>
</tr>
<tr>
<td>qid four times per day</td>
</tr>
<tr>
<td>qMWF every Monday, Wednesday, and Friday</td>
</tr>
<tr>
<td>qod every other day</td>
</tr>
<tr>
<td>qPM every evening</td>
</tr>
<tr>
<td>qwk every week</td>
</tr>
<tr>
<td>PRN: As needed (Latin: Pro re nata; “as the circumstance arises”)</td>
</tr>
<tr>
<td>Ø no or none</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Official JCAHO Abbreviation “Do Not Use” List</th>
</tr>
</thead>
<tbody>
<tr>
<td>U – instead write “unit”</td>
</tr>
<tr>
<td>IU – instead write “International Unit”</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd – instead write “daily”</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d, qod – instead write “every other day”</td>
</tr>
<tr>
<td>Trailing zero (X mg) – instead write “X mg”</td>
</tr>
<tr>
<td>Lack of leading zero (.X mg) – instead write 0.X mg</td>
</tr>
<tr>
<td>MS, MSO4 and MgSO4 – write “morphine sulfate” or “magnesium sulfate”</td>
</tr>
</tbody>
</table>
# The Rotations

## Lay of the Land

### NMH Feinberg Pavilion

<table>
<thead>
<tr>
<th>Floor</th>
<th>Units [East/West]</th>
</tr>
</thead>
<tbody>
<tr>
<td>15, 16</td>
<td>General Medicine</td>
</tr>
<tr>
<td>14</td>
<td>Gen Medicine/Pulmonary</td>
</tr>
<tr>
<td>13</td>
<td>General Medicine</td>
</tr>
<tr>
<td>12</td>
<td>General Surgery</td>
</tr>
<tr>
<td>11</td>
<td>Transplant/Gen Surgery</td>
</tr>
<tr>
<td>10</td>
<td>Neuro/Spine</td>
</tr>
<tr>
<td>9</td>
<td>Dialysis, NSICU</td>
</tr>
<tr>
<td>8</td>
<td>SICU</td>
</tr>
<tr>
<td>7</td>
<td>CVICU/CTICU</td>
</tr>
<tr>
<td>6</td>
<td><strong>Scrub machines</strong>, Paging Services office, surgery resident room</td>
</tr>
<tr>
<td>5</td>
<td>Primary surgical suites, post-op recovery rooms</td>
</tr>
<tr>
<td>4</td>
<td>Neuroradiology reading room, US, MRI, CT, GI lab, IR</td>
</tr>
<tr>
<td>3</td>
<td>Health Learning Center, Conference Rooms, Auditorium</td>
</tr>
<tr>
<td>2</td>
<td>Cafeteria, NM Academy</td>
</tr>
<tr>
<td>M</td>
<td>Mezzanine (ED), Observation Unit</td>
</tr>
<tr>
<td>1</td>
<td>Emergency Department, ED CT, ED Radiology</td>
</tr>
</tbody>
</table>

### NMH Galter Pavilion:

<table>
<thead>
<tr>
<th>Floor</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Outpatient Cancer Center</td>
</tr>
<tr>
<td>20</td>
<td>Outpatient Urology, Neurosurgery, Neurology</td>
</tr>
<tr>
<td>19</td>
<td>Outpatient Cardiology, CT surgery, Vascular, Plastics</td>
</tr>
<tr>
<td>18</td>
<td>Outpatient IM, Geriatrics, Allergy, Pulmonary, Nephrology</td>
</tr>
<tr>
<td>17</td>
<td>Outpatient Orthopedics, Pain, Lifestyle Medicine, GI, GI Surgery</td>
</tr>
<tr>
<td>15</td>
<td>Outpatient ENT, Ophthalmology</td>
</tr>
<tr>
<td>14</td>
<td>Outpatient Endocrinology, Rheumatology, Gynecology</td>
</tr>
<tr>
<td>13</td>
<td>Stone Inpatient Psychiatry</td>
</tr>
<tr>
<td>10</td>
<td>Inpatient Heart Failure Unit</td>
</tr>
<tr>
<td>9</td>
<td>CCU, MICU</td>
</tr>
<tr>
<td>3</td>
<td>Departments of Medicine and Surgery</td>
</tr>
<tr>
<td>2</td>
<td>Medical Records</td>
</tr>
<tr>
<td>1</td>
<td>Patient Services Center</td>
</tr>
</tbody>
</table>

### Olson Pavilion

6th Floor: Ambulatory surgery

### Prentice Women's Hospital

<table>
<thead>
<tr>
<th>Floor</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Med Onc/Palliative</td>
</tr>
<tr>
<td>15</td>
<td>Heme/Stem</td>
</tr>
<tr>
<td>14</td>
<td>Gyn/Gyn-Onc</td>
</tr>
</tbody>
</table>
Lurie Children’s Hospital of Chicago:

<table>
<thead>
<tr>
<th>Floor</th>
<th>Units [East/West]</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Gen Med, Pulmonology, Allergy/Immunology, ID, MOU</td>
</tr>
<tr>
<td>20</td>
<td>GI/Hepatology, Nephrology, Ortho, ENT, Gen Surg</td>
</tr>
<tr>
<td>19</td>
<td>Neurology, Neurosurgery, Endocrine, Epilepsy Unit</td>
</tr>
<tr>
<td>18</td>
<td>Outpatient Cancer Center</td>
</tr>
<tr>
<td>17</td>
<td>Heme/Onc Inpatient</td>
</tr>
<tr>
<td>16</td>
<td>PICU</td>
</tr>
<tr>
<td>15</td>
<td>CCU, Respiratory Therapy</td>
</tr>
<tr>
<td>14</td>
<td>NICU</td>
</tr>
<tr>
<td>12</td>
<td>Family Life Center</td>
</tr>
<tr>
<td>11</td>
<td>Sky Cafe, Conference Rooms, Health Sciences Library</td>
</tr>
<tr>
<td>8</td>
<td>Psych Inpatient, Psych Outpatient</td>
</tr>
<tr>
<td>7, 6,</td>
<td>Surgical Suites, Post-Anesthesia Recovery Units</td>
</tr>
<tr>
<td>5</td>
<td>CT, MRI, Cardiac Cath, NM, IR, EP</td>
</tr>
<tr>
<td>4</td>
<td>Outpatient Clinics</td>
</tr>
<tr>
<td>3</td>
<td>Outpatient Clinics, Walgreens Pharmacy, Sleep Medicine</td>
</tr>
<tr>
<td>2</td>
<td>ER, Triage, Lobby</td>
</tr>
<tr>
<td>1</td>
<td>Lobby</td>
</tr>
</tbody>
</table>

Jesse Brown VA Medical Center Bed Tower

<table>
<thead>
<tr>
<th>Floor</th>
<th>Units [East/West]</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>6</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>5</td>
<td>Medicine, Surgery</td>
</tr>
<tr>
<td>4</td>
<td>Medicine, Oncology</td>
</tr>
<tr>
<td>1</td>
<td>Emergency Department</td>
</tr>
</tbody>
</table>

John H. Stroger, Jr. Hospital of Cook County
1st Floor: Clinics A-F
3rd floor: OR, OR scrub machines
4 North: Gyne, Gyne Onc
4 South: OB triage, L&D, Antepartum, Postpartum, ATU, L&D scrub machines
Fantus Clinic 4th floor: Gyne clinic, family planning clinic

Guide to the Patient Room

As you enter AND leave any patient room for ANY reason whatsoever, clean your hands every time without exception. Random mystery audits are conducted constantly and you may well be stopped if you fail to do this. Use the hand gel or soap and water. Observe and follow any additional isolation directions on the door signs.
Bed:
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, to prevent DVTs.

Thromboembolic devices (TEDs): This is a fancy name for tight knee-high stockings that are worn around the calves. They also help prevent DVTs, and are often used in combination with SCDs.

Nasal cannula: A pair of prongs that sit in the nose and deliver supplemental oxygen (2 to 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 with a little ball inside that indicates 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 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:** 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 the 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, chaplains, hospital volunteers, and many others. As usual, it pays to get to know them!

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**The NMH Pager Directory**

You can find the paging website through NMConnect or Infoplex. Pay attention to the paging etiquette — it is strongly adhered to (most of the time).

**Paging Etiquette**

- Make sure you are paging the right person at a reasonable time of day.
- **Always use your first and last name when paging.**
- Don’t leave the phone that you’ve paged someone to; give the person time to get back to you (around 15 minutes).
- Never page someone to your pager or to an out-of-area code phone number.
- Change your battery if you hear your pager beeping/vibrating.

**Books & References**

**Suggested Pocketbooks and electronic references for all rotations:**

- **ePocrates (PDA/Phone) or Tarascon Pocket Pharmacopoeia (Book):** Medication reference including indications, available dosing/form, and generic-trade name cross referencing.
- **UCentral:** Includes access to Medline journals, Davis’s Drug Guide, Harrison’s Manual of Medicine, NU News, Pocket Guide to Diagnostic Tests, and Taber’s Cyclopedic Medical Dictionary. Available free online through the Galter website.
- **QxCalculate:** Phone application with risk formulas for all areas of medicine and surgery.
- **Medscape Mobile:** A great free resource covering a wide variety of topics. Available online at http://www.medscape.com/public/mobileapp
- **Pocket Medicine** (aka “the Green Book”): An excellent source of reference on the wards, especially for the medicine clerkship. Great differential diagnosis, work-up, and treatment plans in an efficient outline format.
- **Maxwell’s:** Concise guide of normal lab values, dermatomes, etc. Bare-bones but useful information.
- **Sanford Guide to Antimicrobial Therapy:** A guide to choosing the appropriate antibiotic for a given disease or pathogen. Can be a little intimidating at first, but very useful once you get the hang of it!
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. If you do not perform a part of the physical exam, do not write that it is normal in your note. On this clerkship, never write the phrase “non-contributory” in your written H&P (however when giving an oral case presentation you may often say this phrase).

*Note: your attendings will probably change every two weeks and your residents will usually change monthly, but on a different schedule from the students.

**Medicine H&P:**

**CC:** A few words on why the patient presents. Quote the patient if you can, and always include the duration of the complaint. For example: instead of “arm pain,” you should write “left arm pain x 3 days.”

**HPI:** Tell the story. Why is the patient presenting with this NOW? Try to maintain chronology, but include significant past medical history, pertinent demographic information (age/sex), OLDCARTS, and relevant Review of Systems. It’s important to include the most important relevant history (including ROS/FH etc) in the HPI. For example if the patient comes in with chest pain it may be relevant that his father/mother both had MIs at early ages. Try to include pertinent positive and negative symptoms that help separate between two diagnoses.

Many attendings prefer a few words right after the opening sentence elaborating on pertinent PMH (e.g. ‘55 yo woman with hx of breast cancer, HTN, CHF presents with R arm pain. Her breast cancer was diagnosed 4 years ago, treated with chemo/XRT, followed with biannual mammograms without evidence of recurrence most recently 2 months ago’).

Since most patients are admitted by way of the Emergency Department or have been admitted overnight, students often struggle with how and where to include information obtained in the ED/previous workup overnight (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, then adjust your HPI accordingly. One way to include this is to add a final section of your HPI briefly discussing the ED course. For example, if a patient is admitted for septic shock, you could write “ED Course: pt received 2L NS bolus and was received one dose of ** antibiotics.”

**Review of Systems:** (ROS can also be placed just before the PEX section, helpful to make a dotphrase and alter accordingly)

**GEN:** unintentional weight loss/gain? Appetite? Fatigue?
Lightheadedness/dizziness? Fevers/chills? Night sweats?
Sore throat? Dysphagia/odynophagia? Hoarseness? 
PULM: Chest pain? Shortness of breath? Dyspnea on exertion? Cough? 
Incontinence? If female: LMP or age at menopause? 
VASC: Lower extremity edema? Claudication? 
MUSCULOSKELETAL: Myalgias/arthralgias? Stiffness? 
NEURO: Numbness/tingling? Weakness? 
HEME: Easy bruising or bleeding? 
SKIN: Rashes? 
PSYCH: Mood? Anxiety/depression? 

PMH/PSH: Ask specifically about major or common diseases (HTN, CAD, HL, DM) and account for all meds on med list. If that patient has a significant illness, ask specifics (for example, any CHF hospitalizations, for renal failure, dialysis schedule). Ask about prior hospitalizations and ED visits (e.g. for CHF exacerbation). How long have they had the illness and how well is it managed (e.g. “How many times a week do you forget to take your meds?”). Remember that patients’ memories and health vocabularies vary widely and that you should tailor your questions and wording to the situation. 

Meds: Medication name, dosage, route, and frequency. Before presenting your patients to the attending, find out why your patient is on each and every one of his/her meds. You’ll likely be asked! 

PCP: Name and phone number 

Allergies: Medication/Reaction 

Family Hx: At a minimum, ask about the patient’s mother, father, and siblings. Alive and healthy? What health problems? Specifically ask if anyone had diabetes, HTN, heart disease, stroke, or cancer? Remember to include ages and, if deceased, the cause of death. If the patient is very old (ie 80+), this may not be that relevant since they have outlived most. Most attendings prefer to have students parse this down to the most relevant components when presenting (ie if the patient is presenting with possible new diagnosis of cancer-mention the family history of cancer). 

Social Hx: Tobacco, EtOH, drug use, and sexual activity. Career. If retired, include work history, especially if it involved occupational exposures. Living situation (what kind of domicile and with whom). “Patient communicates comfortably in [language].” 

Physical Exam: (making a dotphrase for this would be helpful, but be careful. The physical exam is easy to lie about. It is not necessary to check for femoral bruits on every patient, so don’t say that you did. Measuring JVD is a helpful skill, but certainly not needed on every patient. Make sure you really measured, if you say it is normal.) 

VS: Temp (route), Pulse, RR, BP (at time of interview), SpO2 
HEENT: NCAT? PERRLA? EOMI? Sclera anicteric? Oropharynx clear, erythematous, or with exudate or lesions? 
NECK: Neck supple? Thyromegaly? Lympadenopathy? JVD or bruits? 
CHEST: Normal respiratory effort? Clear to percussion and auscultation? Rales/rhonchi/wheezes/crackles? 
CV: Regular rate & rhythm? PMI palpable? PMI location? Normal S1/S2? No S3/S4, murmurs, rubs or gallops, or clicks?
PULSES: Normal? Without carotid, abdominal or femoral bruits?
EXT: Clubbing/cyanosis/edema? Full range of motion? No fluctuation/crepitus? Cool or warm to touch?
NEURO: There are six components. Document what you actually do. Better to say “sensory normal to soft touch in hands and feet” than “grossly intact.” “Grossly intact” usually means you didn’t really test. Every patient does not need all 12 cranial nerves tested. You might just check extra-ocular motion or sensory in the face. Tell us what you did. Check some reflexes on every patient. This is how you learn how to do them. Describe which motor tests were done, “5/5 throughout” has little meaning. (See Neurology section for more detailed exam)
Labs: Include CBC (with diff), Chem 7, and other labs done in the ED. If applicable—include urinalysis, blood/urine cultures, troponins, BNP, etc.
Imaging: X-rays, CT, MRI, US, EKG. Include your own assessment when you can, not just a copy-paste of the report. Be sure to note whose assessment you are giving (i.e. your own, the radiologist’s, your intern’s, etc.). It’s often helpful to write the date of imaging and the study “4/19 CXR: _______

A/P: The assessment and plan are usually the most difficult elements of the H&P for the junior student and are often wrong (and time-consuming!) early in the clerkship; this shouldn’t discourage you from putting something down (some students feel more comfortable writing “CONSIDER” before each recommendation). In the assessment, don’t forget to include age/sex, an abbreviated restatement of the chief complaint and HPI, and a ranked differential diagnosis based on symptoms, signs, PEX, and other studies. For each item in the differential diagnosis explain your reasoning of why this may or may not be the correct diagnosis. The entire write up is a case that you are building and the A/P is your conclusion to bring it all together. All the evidence you sum together here should have been presented earlier in the write up. Expect your assessment to be longer and more detailed than your interns’. For the plan: some attendings want it systems based (i.e. Respiratory, CV, GI, etc.), but most medicine attendings seem to prefer it problem based (i.e. “Chest Pain,” “Difficulty breathing,” etc). Some residents like you to number each element of the plan for organizational purposes. Remember to include diet/F/E/N, TEDs, SCDs, DVT prophylaxis, ulcer prophylaxis, IV fluids, electrolyte replacement, pending studies, and disposition (the floor to which they are getting admitted), and the code status. Also be sure to account for all medications, including any held medications. Don’t be afraid to talk to your interns and residents about your plans if they are willing and have time. Make it a point to do this before rounds to make sure that your thoughts are up to date and generally correct.

Medicine SOAP:

S: Include patient’s status, significant overnight events (if nothing major—can write “no events overnight”), pain control, toleration of diet and brief ROS. Helpful to talk to the night nursing team to get information about this.
**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. **Always** address vitals in your oral presentation.

**PEX:** As in the H&P, although this should be more focused and may include fewer organ systems (General, CV, Lungs, Abdomen, and Extremities is a good bare minimum, place any other system with a problem you are following). When presenting, it is very attending dependent on how much detail they want you to go into. Some will want heart, lungs, and abdominal exam on every patient everyday regardless of their chief concern while others will only want relevant updates. Check with your attending on expectations.

**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 (ie blood cultures with sensitivities). When presenting, be prepared with the previous day’s labs to track changes.

**Imaging:** Follow up on any pending imaging from the previous day. Use your own assessment when you can, and be sure to note whose assessment you are giving (i.e. your own, the radiologist’s, your intern’s, etc.)

**A:** Very similar to what you did for the H&P, but perhaps less detailed. Highlight any changes from your original assessment based on new labs, imaging, etc.

**P:** Again, similar to the H&P. Students commonly forget to reflect medications that were added, discontinued or dosage changed. It is helpful to add which day number in a course of medication the patient is on, i.e., “day 2 of 7”. Also check the MAR view and ORDERS in PowerChart to see which medications the patients are still on and which ones they no longer need to be one. Each medication should be addressed in the Plan. Additionally always know what diet your patient is on and what fluids, if any the patient is receiving. In the context of a progress note, “disposition” refers to the plans for discharge. When in doubt, “discharge per attending” is usually a safe answer.

**Being Helpful:** Students are integral members of the team while on the medicine rotation. Ways to help include obtaining the patient’s PMD name and number and sending them a quick page letting them know their patient is in the hospital for ** (always make sure your attending/resident are OK with this before you do it the first time). Additionally, you can help your team by obtaining outside hospital records—must have the patient sign a form and fax the form to the OSH with the exact studies you want (HINT-write “STAT” on the faxed consent form if you need the forms more urgently; call the hospital records department and alert them that the fax is coming). If there is a lab or study that you are waiting for—don’t hesitate to call down to the lab and ask about it. You can also help your team by offering to set up appointments for the patient right before they are discharged (ex: follow-up with their PMD). Last, you can proactively help your interns with discharge forms/hospital course summary.
Recommended References, Textbooks, and Pocketbooks:

- **MKSAP**: Collection of patient cases with questions; very similar to shelf questions. This is the one resource that the vast majority of students use in preparation for the shelf exam.

- **Pocket Medicine (aka “The Green Book”)**: 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. If you had this book memorized you could be an attending (don’t attempt this in the 3 month rotation).

- **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. It is recommended that you briefly review EKGs before starting your medicine rotation. Most important is establishing a systematic way to review EKGs and going through this method each time you review an EKG.

- **UpToDate**: This is the first resource most students use on the wards to find a quick answer to a clinical question.

- **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 great text to read throughout the clerkship.

- **USMLE World Question Bank** is useful for every SHELF exam but is the most useful for this rotation. About ¾ of the Qbank is dedicated towards medicine. The more you do the better off you’ll be. Start early on. Try doing 10 questions a day starting on your first day of medicine and you should be able to tackle a majority of the questions.

Testing / Grading:

**SHELF**: The Medicine SHELF examination consists of 100 questions. Students often struggle 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. The key to success seems to be doing plenty of practice questions and starting to read early. If you start the rotation by doing 10 UWorld questions a day—you will be able to do most questions by the end of the rotation and be very well prepared for the medicine shelf.

**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. The OSCE is written by Feinberg faculty and so reflects much of what was taught in didactic sessions and the wards.

**GRADING**: Your grade on medicine is heavily based on your clinical evaluations, so spend a lot of time reading up on your patients and being the best ward clerk that you can be. Each inpatient month counts for 30% (total 60%), the shelf for 20%, OSCE for 10%, and your specialty month for 10%.
### Top 20 Pearls for Pimping:

<table>
<thead>
<tr>
<th>Reading a CXR:</th>
<th>Deriving a Diff Dx:</th>
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<tbody>
<tr>
<td>Airway</td>
<td>Metabolic</td>
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<td>Infectious</td>
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<td>Cardiac silhouette</td>
<td>Traumatic</td>
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<td>Cardiovascular</td>
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<td>Effusions</td>
<td>Allergic/Autoimmune</td>
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<td>Fields</td>
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### “Don’t-miss” Causes of Chest Pain:
- Myocardial Infarction
- Aortic Dissection
- Pulmonary Embolism
- Pneumothorax
- Esophageal perf.

### Causes of ESR >100:
- Temporal Arteritis
- Chronic Infxn (Osteo, SBE, TB, abscess)
- Thyroiditis
- Vasculitis
- Multiple Myeloma

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<td>Ethylene Glycol</td>
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<td>Salicylates</td>
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### Obstruction, sm bowel:
- Adhesions
- Bulges
- Cancer

### Obstruction, lg bowel:
- Cancer
- Diverticulitis
- Volvulus

### Lower GI Bleeds:
- Hemorrhoids
- Diverticulosis
- IBD
- Ischemic Collitis
- AVM's
- Upper Gl bleed

### ECG changes with PE:
- Sinus tachycardia
- Specific but not sensitive: S1Q3T3 sign - an S wave in lead I, Q wave in lead III, and inverted T wave in lead III

### Common bone mets:
- Breast
- Lung
- Thyroid
- Kidney
- Prostate
- “BLT w/ Kosher Pickle”

### Emergent Dialysis:
- Acidoysis / hypoAlbumin / Anorexia
- Electrolyte imbalance (inc K)
- Overload (volume)
- Uremia with Sx (cns changes)

### Mortality Benefit in CHF:
- Beta-blocker
- ACE inhibitor
- Spironolactone if Class IV CHF
- AICDs

### CHADS2 Score:
- Risk stratification for anticoagulation in A-fib
- CHF = 1 pt
- HTN = 1 pt
- Age > 75yo = 1 pt
- DM = 1 pt
- Stroke or TIA hx = 2 pts
- Score ≥ 2 : warfarin (unless poor candidate)

### Modified Wells criteria for Pulmonary Embolism

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The surgery clerkship consists of one general surgery month (at NMH, the VA, or at MacNeal), one specialty month, and one ambulatory month. You will be busy during your general surgery month but will find that the medical student is an integral part of the team and you can make a difference in patient care.

**Surgery H&P:**

For every surgery that’s performed, an H and P must be written on the patient the day of surgery (before the patient actually goes to surgery). It is often the medical student’s job to write this H and P before surgery so the resident may modify it (some residents have you sign it, others have you save it—you should ask for their preference). The best way to write this note is to look up the patient in EPIC and find the H and P written by the attending doing the surgery. You may also find the patient’s PMH/PSH/Meds/Allergies listed more reliably as an uploaded “PCO” document, which is a PDF uploaded to Powerchart. If the H and P has been written within 30 days of the surgery, you may use a Powernote “2G Surgery <30 days NO change in condition.” Always ask the patient about their health the morning of surgery—any new medications, changes in health, hospitalizations, allergies etc since they were last seen by the doctor and perform a physical exam the day of surgery.

You will also write H and Ps if your team is consulted on a patient in the hospital or when you’re on trauma call.

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

- **Brief HPI:** Brief history of presenting symptoms/previous treatment/course and why the patient is having surgery. Include the type of surgery that is being done and the location of the surgery.
- **Past Surgical History:** Include any bad reactions to anesthesia or difficulty with bleeding during and after surgery
- **Past Medical History:** As per usual.
- **Hardware:** e.g. artificial heart valves, artificial joints, pacemaker, etc.
- **Current Medications:** As per usual.
- **Drug Allergies:** Include reactions to the medication, e.g. hives
- **Assessment/Plan:** If the patient is going to the OR, you can write “**yo woman with history of ** with newly diagnosed **. To the OR today for ** (insert the exact surgery that the patient has consented). Patient consented and marked. Peri-op abx ordered. Type and cross ordered (if applicable).”

**The Postoperative Note:** you will often write and sign this note after each operation.

- **Pre-op diagnosis:** Initial preoperative diagnosis
- **Post-op diagnosis:** Final postoperative diagnosis (often “same”)
- **Procedure:** What procedure was performed and which side
- **Surgeon:** Attending(s)
- **Assistant(s):** Resident(s) and Student(s)
- **Anesthesia:** Local, Regional, or General/GETA (general endotracheal intubation), MAC (monitored anesthesia care - IV)
**Fluids:** IV fluids in mL. Specify crystalloid, colloid, blood products

**EBL:** estimated blood loss; minimal or amount in mL (oops down below)

**UOP:** urine output; none or amount in mL. If no foley—may write “voided prior to procedure”

**Drains:** Type, location

**Findings:** Gross pathology as well as significant normal findings

**Specimen:** What specimens were taken to the lab, i.e. cultures, frozen sections, histology, etc.

**Complications:** i.e. “None apparent” – 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:**

*The day of surgery is POD #0, the next day is POD #1.*

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

**O:** **Vitals:** Tmax, Tcurrent, HR, RR, BP, Sp02 (if applicable)

**I/Os:** Total over past 24hrs

**UOP:** Over past 24hrs in 8hrs intervals in chronological order starting with the current shift (i.e. “200/800/750/600 for total of 2,350 mL/24hrs”). On ICU patients—record UOP in cc/hr [it’s always best to ask your senior resident what he/she prefers]

**Drain Outputs:** over past 24hrs in 8hr intervals, list each drain separately—amount and what kind of effluent i.e. NG450 mL bile stained fluid or 30 mL serosang from JP

**GEN:** A&Ox3, NAD

**CV:** RRR, no m/r/g

**ABD:** soft, +/- BS, soft/rigid, tender/distended? NGT?

**INCISION:** c/d/i (clean/dry/intact), erythema/serosanguinous drainage, dressing in place/removed, with steri-strips/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 ____.

Neuro: pain well-controlled on: epidural, PCA, PO meds?

Pulm: stable on ___L NC, wean O2, encourage incentive spirometer use

CV: hemodynamically stable by vitals/PEX/UOP. EBL **cc.

GI: await for return of bowel function, +/- flatus. Stool softener PRN. Zofran PRN.

GU: Good UOP? d/c foley? Voiding freely?
ID: afebrile, no leukocytosis. Wound C/D/I. Continue peri-op abx (know which antibiotics, day #)
Prophy: SCDs/TEDs, ambulation, SubQ Heparin
FEN: IVF@__, diet (i.e. ADAT = advance diet as tolerated)
Path: pathology pending
Dispo: PT/OT?: continue inpatient management; per attending; transfer to floor, etc.
Other: miscellaneous; monitor liver, check thyroid, endocrine, etc

**General Surgery Trauma Initial Evaluation:**

For general surgery call, you will have two duties: taking H&Ps for surgical consults in the ED and writing the initial trauma evaluation note when a trauma patient first arrives to the ED (which includes the primary and secondary assessments). When the trauma pager goes off, head to the ED trauma bay, stand behind the line marked at the foot of the patient’s bed, and start taking notes (highly recommended you make a copy of this form below and carry it with you on your trauma call). There will be residents and nurses saying things out loud and it is your job to mark them on the sheet because you will eventually be writing the H and P. There will also be a nurse recording many of these as well. Listen to communication between the nurse and other team members but try not to get in the way!

**Primary Assessment:**
- **AMPLE hx:** Allergies, Meds, PMH, Last meal, Events surrounding injury (including hx source and trauma level)
- **Attending:** name, notified when?
- **Airway:** airway patent?
- **Breathing:** equal chest expansion? b/l breath sounds?
- **Circulation:** carotids? radial? femoral? DP? PT?
- **Disability:** GCS score
- **Exposure:** clothing removed? warm blankets applied?
- **Procedures:** backboard removed when? C-collar cleared when?
- Tetanus booster given? FAST scan +/-?

**Secondary Assessment:**
- **Vitals:** BP, HR, RR, Temp
- **Head:** bony step-offs? Midface stable to palpation?
- **Neck:** ROM? C-collar? JVD?
- **Trachea:** midline?
- **Chest wall:** pain with palpation? instability? crepitus?
- **Eye:** PERRLA? acuity grossly intact? EOM grossly intact?
- **Ear:** auditory acuity grossly intact? discharge in external auditory canal?
- **Nose:** normal septum?
- **Oropharynx:** mucosa normal? tongue lacerated?
- **Dentition:** normal teeth?
- **Pulses:** carotid, radial, femoral, PT, DP
- **HR:** rate, rhythm, extra sounds
- **Lungs:** consolidation? breath sounds b/l? rales? wheezes?
Duties in Surgery

In the OR:
1. Help anesthesia bring the patient to the OR from pre-op/provide a surgical hat for the patient if anesthesia has not done so already.
2. Help move the patient to the OR table (make sure the gown is untied in the back).
3. Once patient is on table, put bed in hallway.
4. Ask nurse for TEDs/SCDs, place on patient.
5. Help position/strap down patient with seatbelt/cover with blankets (seatbelt usually placed a hand’s-width above the knee; not too tight b/c it may compress nerves!)
6. Pull your gloves and a gown (handing them to scrub nurse in sterile fashion!).
7. Ask the nurse if you may place the foley.
8. Participate in the preop signs-in and time-out (say your name after the resident, “Name, Medical student”)
9. Retract and cut suture. Be ready with suture scissors when resident/attending is suturing. Place your right hand onto your left before cutting for stabilization, leaving 1cm long suture tails for most sutures; sometimes when deep sutures you may leave only a few millimeters—bring scissors down to knot, angle upwards and cut. **ASK “how long” if you’re unsure.**
10. When patient extubated, bring bed back in (wait till extubation in case there is a complication and additional personnel needs to enter the room).
11. Help transport patient to PACU, floor, etc.
12. Put in a post-op note. (If there’s time, do in OR before extubation.)

Hints/Tips for Surgery:
1. Look at the OR schedule the DAY BEFORE sx (Powerchart → surgery schedule → put in password → click your service → Task → Preview → put in date with time 0000-2359).
2. Learn the pertinent operative anatomy/pathophysiology prior to each surgery. Know why they are having surgery, the indications/contraindications, etc.
3. Each morning before rounds, you will “get numbers”: print your team’s signout list, and for each patient, write down the I/O’s for past 24 hours in 8hr shifts, listing each drain separately. Make copies for each team member (your intern or senior resident will explain this to you on your first day)
4. On rounds, carry wound dressing supplies: bandage scissors, 4x4’s, abdominal pads, tape, and 10 mL sterile saline IV flushes (these can be found in the supply closet on the floor, get the code from the charge nurse the first day).
5. Introduce yourself (name and rank—they need it for the chart) to the scrub/circulating nurses, and be friendly! They can be very helpful at guiding you in the OR.
6. DO NOT touch the instrument table (Mayo). ALWAYS ask the scrub 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. You don’t want to infect your patient!
8. Practice knot tying/suturing early on in the rotation or even the weekend before the rotation. Learn two-handed knots first. Later learn one-handed. Ask your residents for a practice session in NCASE. There are good Youtube videos if you need more help. FYI-You can get a free knot tying board from Ethicon: www.ethicon.com
9. Learn to place a foley, NG tube: This is a great way to help in the OR and on the floor. See NEJM website for great videos on foley placement and NG tube insertion.

Being Helpful: Carry supplies for dressing changes in your white coat on rounds. Pro-actively cut tape and prepare the dressings while the senior resident removes the dressing. Write the surgery H and P in the morning before surgery so your resident may edit/sign the note. Write post-op progress notes on your patients on the day of surgery ~6 hours after the case finishes. Always be on time!

Recommended References and Textbooks:

- Primary Texts
  - Lawrence
  - Doherty
- Reviews
  - Surgical Recall: A useful pocketbook for surgery rotation. Quick and easy to read. Answers to many typical pimp questions and many good mnemonics.
  - Pestana Review: A word/pdf file passed down throughout the generations. Great review for the shelf. Can be found on infoplex.
  - NMS Surgery Casebook (the red book): Tons of comprehensive case studies. A nice alternative or supplement to practice questions and textbooks.
  - Casefiles – Surgery: Another solid basic review of the essentials of surgery.
- Other
  - Netter’s Atlas of Anatomy: Will suffice for all your anatomy needs. Read the night before a surgery for a good anatomy review.
  - USMLE World Question Bank: Helpful but currently <300 surgery specific questions. A few medicine subspecialty questions are helpful but there’s a heavy focus on trauma.

Testing/Grading:

There are 4 components to the final surgery grade: your total score, the OSCE, your clinical evaluations, and the shelf. To get honors you must score above the class average of your current surgery group on OSCE, clinical work and Shelf. To get a high-pass you must score above average in 2 of the 3.

You will get an evaluation from each attending and senior resident that you work with. Each evaluation is weighted equally. Your evaluation from your month-long general surgery attending is equal to your evaluation from outpatient attending with whom you work 1-3x/week.
The average on the shelf exam is usually in the low 70s. The shelf is difficult and covers the medical portions of surgery. It can be thought of as the surgical management of medical patients. The OSCE is long and difficult – many consider this the hardest OSCE of the year. There are 12 10 minute stations, including 4 SP stations covering the specialties of general surgery, urology, ENT, and orthopedics, and 2 computer stations covering neurosurgery and ophthalmology. Be prepared and be efficient. It can be helpful to practice/simulate the OSCE in groups.

There is also a midterm, an in-house test that contains some slides/photos. It is derived directly from the learning objectives and lectures. The average on the test is usually between 50-60%. The midterm does not factor into your grade.

**Pearls for Pimping:**

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<td>Hematuria (ITS): I Infection Infarction iatrogenic (drugs) T Trauma Tumor TB S Stone Sickle cell cystitis</td>
<td>Fistula that fails to close: Foreign Body Radiation Infection Epithelialization Neoplasm Distal obstruction</td>
</tr>
<tr>
<td>Appendicitis: Rovsing’s Sign Psoas Sign Obturator SignMcBurney’s Sign</td>
<td>Ascending Cholangitis: Charcot’s Triad: Jaundice Fever (with rigors) RUQ Pain</td>
<td>Septic (Ascending) Cholangitis: Reynold’s Pentad: Charcot’s Triad plus Hypotension Altered Mental Status</td>
</tr>
<tr>
<td>Calot’s Triangle: 1. Edge of liver 2. Common hepatic duct 3. Cystic duct</td>
<td>Hesselbach’s Triangle: 1. Rectus muscle 2. Inferior epigastric vessels 3. Inguinal ligament</td>
<td>Arcuate Line: Superior to the arcuate line, the internal oblique aponeurosis splits to envelope the rectus abdominis muscle. Inferior to the arcuate line, the internal oblique and transversus abdominis aponeuroses merge and pass superficial (i.e. anteriorly) to the rectus muscle</td>
</tr>
</tbody>
</table>
The OBGYN rotation is a 6 week rotation consisting of 2 weeks of L&D, 2 weeks of gyn surgery, 1 week of L&D night float, and 1 week of outpatient clinics. You will spend the majority of your time at Prentice or at Stroger.

**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 and G_P_ _ _ _ _ _ @ *** of weeks dated by (LMP and first trimester ultrasound, usually abbreviated LMP=FTUS if consistent), admitted for: _____. Describe the reason for coming the hospital as you would for other rotations. Be sure to ask about vaginal bleeding, pain, contractions (frequency, intensity, when they started), loss of fluid (what color, what time), and fetal movement.

**G_P_ Notation:**

- **G** = gravida → number of lifetime pregnancies, including current
- **P** = para → results of pregnancies (Term/Preterm/Abortion/Living children)

Ex.: a currently pregnant pt with one prior full term delivery would be a G2P1001

**Prenatal Course:** Complications (diabetes, hypertension, hyperemesis gravidum, any antepartum hospitalizations and treatments, if Rh neg did the pt receive Rhogam at 28wks)

**Ultrasounds:** Most uncomplicated patients will have a growth ultrasound (Level I) at 20wks

**PMH:** As per usual

**PSH:** Particularly any abdominal surgeries

**POBHx:** # of pregnancies; # of births; Ask about date, route of delivery, duration of labor, birth weight, gender, anesthesia requirement and any complications (including postpartum hemorrhage, preeclampsia, gestational diabetes, etc)

**GYN Hx:** Abnormal pap smears? STDs?

**Meds:** As per usual, including prenatal vitamins

**Allergies:** As per usual

**Social Hx:** EtOH, tobacco, illicits. Specify if used during pregnancy. "Patient communicates comfortably in [language]." Domestic violence?

**Family Hx:** History of birthing complications or birth defects, mental retardation, bleeding diatheses, clotting disorders, HTN, DM, CAD, gyne cancers, genetic/chromosomal abnormalities

**Physical Exam:**

- **Vitals, GEN, CV, LUNGS**
  - **ABD:** Gravid uterus, nontender, fundal height, estimated fetal size by Leopold’s maneuver
  - **EXT:** Note if edema is present (1+? 2+?) or absent, reflexes/DTRs (including clonus)

- **FHT:** (fetal heart tones) For patients on continuous external fetal monitoring in the hospital

**4 components:**
- Baseline HR (normal 110-160)
- Variability [absent (0), minimal (1-5), moderate (normal, 6-25), marked (>25)]
- Accelerations (generally a 15x15 increase from baseline)
- Decelerations (early, late, variable)

**TOCO:** (tocometer measures uterine contractions) q*** min; level of Pitocin (mU/min)

**SVE (sterile vaginal exam):** Dilation/Effacement/Station (done by the resident or attending; students write “deferred” or “per [examiner]”).

**SSE (sterile speculum exam):** nitrazine/pooling/ferning (often done in triage by resident/attending).

**Prenatal Labs:** Blood type /Rh status /antibody status/Rubella /RPR /Hep B-SAg/HIV/Gonorrhea/Chlamydia/GBS status (done @ 35-37wks)

**A/P:** Age, G_P_ _ _ _ at *** weeks admitted for ____________.

1. **Dating:** by LMP/US (which trimester was the ultrasound performed)/IVF/IUI
2. **Maternal Well Being (MWB):** usually “reassuring,” AF, normal BPs, include any major PMH. Plan for CLE when uncomfortable?
4. **Labor:** Expectant management? Induce/Augment with Pit? AROM?
5. **Route of Delivery (ROD):** Vertex? Confirmed by Leopolds/BSUS?
6. **Prenatal labs (PNL):** Maternal blood type, Rh status, Rubella immune, HIV, RPR
7. **GBS:** neg/pos; if pos, antibiotics given
8. **Other issues** (e.g. gestational diabetes, other medical issues, PPBC etc.)

Obstetrics Presentation One-Liner Ex. “Sally Jones is a 32-year-old G3 P1102 who presents at 32 weeks, 5 days by 1st trimester ultrasound with complaints of regular, painful uterine contractions.”

**Labor SOAP Note**

*This is written every two hours while patient is laboring.*

**S:** Any pain? Feeling contractions? Rectal pressure? Leakage of fluids? Vaginal bleeding? Fetal movement?

**O:** VS: Temp, HR, BP

- **FHT:** Baseline, variability, accels, decels (early, variable or late)
- **TOCO:** q***min; level of Pit (mU/min)

(Note: VS, FHT, and TOCO are found in a separate system (QS), NOT in PowerChart. You will be given a login and password during orientation).

- **SVE:** Dilation/Effacement/Station (done by the resident or attending; students write “deferred” or “per [examiner]”).

**A/P:** Age, G_P_ _ _ _ @ *** weeks in latent/active labor.

- **MWB:** How is the patient doing? Does she need pain meds? Are pain meds helping her?
- **FWB:** Reassuring. Cat ___ tracing. EFW.
- **Labor:** Cont pit (dose) or expectant management. Stage of labor. Include any change in labor.
- **GBS status:** If positive, then indicate antibiotic given and # doses.
Delivery Note:

There is a specific “AdHoc” form in PowerChart for this (OB Delivery Note). Check with the attending/resident before signing this note, as some have specific preferences.

Procedure: NSVD/LFVD/Primary LTCS/Repeat CS/Classical CS
PreOp Dx: # of weeks pregnant. # of hours in 2nd stage of labor. If C/S, give reason why.
PostOp Dx: Same

Attending: ***
Assistant(s): Resident and/or student present for delivery

Anesthesia: Typically CLE (epidural) or spinal (for C/S)
EBL: For C/S ask anesthesiologist (for vaginal delivery this is estimated or measured together with attending)
IVF: For C/S, ask anesthesiologist (include crystalloid, colloid and any blood products given)

UOP: For C/S, ask anesthesiologist or measure from foley bag


Lacerations: If perineal, indicate the degree of laceration (1st – 4th degree) and type of suture material used.

Specimen: Indicate if cord blood collected or cord segment for gases.

Complications: ***

Condition: Good/Fair/Poor

Disposition: LDR (for vaginal deliveries) or RR (for C/S) with infant (or infant to SCN-special care nursery)

Dictation: (Resident or attending does dictation)

Post Partum Progress Note for a Cesarean Section:

S: Ask about pain control, diet (and if tolerating), nausea, vomiting, flatus, ambulation, voiding, vaginal bleeding (lochia), and breastfeeding (and how it is going and long-term plans). Ask about post partum birth control plans and circumcision for male neonates (for PAC and Winfield Moody patients only).

O: VS and I/O’s: Include UOP over 24hrs (calculate rate per hr).
CV: RRR. no m/r/g
LUNGS: CTAB, no wheezes/crackles
ABD: +/- BS. Soft. Appropriately tender. ND. Uterus firm @ 1-2cm above/below umbilicus. **Be sure to have pt lying flat for abdominal exam.
INCISION: C/D/I (clean, dry, intact), document if has steri strips or staples
EXT: Check edema/calf tenderness, SCDs in place and on? ** If not, please replace them/turn them on.

Labs: If POD #1. Typically CBC.

A/P: Age, G_P_ _ _ _ POD # s/p (type of C/S for (indication), doing well.
CVS/Heme: AFVSS. CBC appropriate for EBL (or pending)
GU: adequate UOP overnight, plan d/c foley, and await void
FEN/GI: HLIV (hep-lock IV); Advance diet to general (ADAT)
Neuro: transition to PO pain meds
Proph: SCDs, encourage ambulation
Breastfeeding: Lactation consultant PRN
PPBC: post partum birth control plan
** Include blood type and rubella status in your note- pt may need Rhogam or MMR postpartum

_Tip:_ Staples are usually removed on POD #3 for TRANSVERSE INCISIONS ONLY. Staples stay in vertical incisions for 7-10 days. DO NOT REMOVE STAPLES WITHOUT ASKING YOUR RESIDENT. Apply Benzoin and steri-strips perpendicular to incision.

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

**S:** Same as for C/S postop note

**O:** Same as for C/S postop note (except no incision)

**A/P:** Age, PPD #__ s/p NSVD (or LFVD/OFVD/VAVD), doing well.

Same as for C/S

_Tip:_ Some residents prefer a systems-based approach to the plan. Be sure to ASK!

### Gynecology H&P (Outpatient or Inpatient):

**HPI:** Start with age and G_P_ _, LMP _____ or PMP, followed by chief complaint (irregular vaginal bleeding, pelvic pain, vaginal discharge, etc). Write the HPI as you would for other rotations, asking about duration of symptoms, quality and characteristics of symptoms, aggravating/ameliorating factors. You will often need to include pertinent information such as menopausal status, menstrual cycle length and timing, history of other episodes of irregular bleeding, pain, discharge, etc. Include GI/GU complaints or pertinent positives/negatives here as well.

**PMHx:** (HTN, Obesity, etc)

**PSHx:** (Examples, D&C x 1 in 1980s, C/S in 1995)

**Meds:** ***

**Allergies:** ***

**OBHx:**
Include date of each pregnancy and outcome (Ex. FTSVD, FTC/S, TAB). Include gestational age of any miscarriage, abortion, preterm delivery. Include weight of
delivered infants, any pregnancy-related complications, and degree of lacerations if present.

**GynHx:**
- Menstrual history notation: (Date of last menstrual period) – cycle length/duration of bleeding. Age of menarche/ menopause.
- +/- History of STDs: which ones, dates, and whether they and their partner were treated; +/- History of PID
- +/- History of abnormal paps, date of last pap
- +/- History of fibroids or ovarian cysts

**Sexual Hx:**
- +/- sexually active, with (male/female) partners x (length of time)
  - # Lifetime partners
  - +/- use of birth control – which methods and when?
  - +/- condom use

**Social Hx:**
- Marital Status; with whom do they live?
- Tobacco/EtOH/Illicits
  - +/- Hx of Domestic Violence, +/- current Domestic Violence

**FamHx:** as usual (be certain to ask about breast/ovarian/uterine/colon CA and bleeding/clotting disorders)

**ROS:** as usual

**Physical Exam:**
- Vitals (Temp, HR, BP, RR, Pox)
  - General: ***
  - Neck: ***
  - CV: ***
  - Chest: ***
  - Abd: ***
  - Ext: ***

**Breasts:** +/- skin changes, dimpling/erythema, +/- masses or tenderness, +/- nipple discharge, +/- axillary lymphadenopathy

**Pelvic:**
- Ext Genitalia: B/U/S; normal pubic hair distribution, nontender, no masses, no lesions
- Vagina: no discharge, no lesions, normal rugation, +/- blood in vault (amount)
- Cervix: no gross lesions, +/- blood at os, smooth, no CMT
- Uterus: # of weeks size, position (anteverted, midline, retroverted?), smooth/irregular, nontender?, mobile?
- Adnexa: non-enlarged, any masses or fullness
- RV*: normal rectal tone, supple RV septum without fluid wave or nodularity, no masses, soft brown stool, hemoccult negative, * ask resident or attending before performing a rectal exam

**A/P:** Age, G_P____ with ___________
1. Evaluate pt's complaint and list your diagnosis with appropriate differential dx
2. Routine Health Screening and Management (pap smear, bilateral screening mammogram, fasting lipid panel, monthly SBE/SBE teaching)
3. Follow-up
Gynecology OP Note: (PowerChart has Power Note with checkboxes)

Pre-Op Dx: ***
Post-Op Dx: ***
Procedure: ***
Surgeon: ***
Assistant: Include resident(s) and medical student(s)
Anesthesia: Usually either GETA (general) or CLE (epidural) or MAC (monitored anesthesia care) with paracervical block
EBL: estimated blood loss; ask Anesthesiologist for amount
IVF: amount given during surgery; ask Anesthesiologist for amount (include crystalloid, colloid and any blood products administered intraop)
UOP: usually measured via foley; ask Anesthesiologist for amount
Findings: From both exam under anesthesia (EUA) and intra-op findings (liver, stomach, uterus, fallopian tubes, ovaries, etc)
Specimen: What you removed and where it went (for frozen section, routine pathology, etc.)
Complications: i.e. “None” – Ask attending/resident before putting down any complication other than “none”
Drains: Foley cath to gravity, subcutaneous JP drain, etc.
Disposition: Good condition, extubated, to PACU
Dictation: Resident or Attending will do the dictation.

Gynecology SOAP Note:

S: Ask about pain control, fever, nausea, vomiting, diet (and if tolerating), flatus, ambulation, voiding, vaginal bleeding, chest pain, SOB and calf pain.
O: **VS and UOP:** If not in computer, be sure to ask nurse/PCT. You must document UOP in cc/hr.
GEN: A&Ox3. NAD.
CV: RRR. no m/r/g
LUNGS: CTAB. No wheezes, crackles.
INCLUSION: C/D/I. No erythema or drainage. No fluctuance or ecchymosis. (Remove bandage on POD #1 unless specifically told not to, POD#2 for all ONC patients)
EXT: Note edema, calf tenderness, and +/- SCDs/TEDs
LABS/STUDIES: Usually will trend CBC every day, trend from pre-op hgb.
A/P: Age, POD # _ s/p (procedure) for (indication), doing well postop.
CVS/Heme: Afebrile, normal vitals. AM CBC pending (or result and its trend from pre-op). Include any perioperative heart meds here (beta blockers/other anti-hypertensives and if given or held).
Resp: Pt on (RA, NC, etc) and saturating well. Incentive spirometer by bedside and being used 10x/hr?

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FEN/GI: IVF and their rate, plan for TKO or HLIV, diet and ADAT
GU: adequate UOP; plan to d/c foley?
Pain/Neuro: How well is their pain controlled? Transition to PO meds?
Proph: SCDs, encourage ambulation, fragmin?
Other medical problems and their tx (e.g., endo for pts with thyroid issues, DM)
GYN: comment on vaginal bleeding or any need for hormone therapy
Path: Pending if not back yet
Dispo: continue hospital care or per attending

Duties on OR:

Daytime (Hours are typically 5:30AM to 7PM.)
1. Check in with residents. Pick up a student phone and write your name and number on the white board. Check the board for patients to pick up at the beginning of the day after signout. Always follow PAC and Winfield Moody patients.
2. Introduce yourself to the patients you are following as soon as possible. Write your name and phone number on the white board in the patient’s room. Introduce yourself to the nurse and ask them to call you when your patient starts pushing.
3. Write H&Ps on new patients throughout the day. (This is best done before or just as a resident is assigned to the patient – keep up with the board and ask chief if you may do an H&P if not yet assigned to a resident).
4. Check on your patients every 2 hours and write a labor progress note. (However, if pushing with another patient, that takes priority).
5. Work with nurse when patient is pushing (see above – never leave your patient if you have started pushing with her!)
6. Gown up promptly for delivery (always wear the blue-knee high boots and eye protection!) and be ready to be an active participant in the delivery (obviously attending and patient dependent).
7. Follow patients to C/S or be willing to go to a C/S at any time during the day.

Night Float (Hours are typically 6PM to 6AM.)
1. Largely the same as days in regards to picking up and following patients.
2. When on Gyn call, page your resident at the beginning of the shift. Plan to see consults in ER with the Gyn on-call resident. If nothing is going on then you will stay on L&D and see patients.
3. Always have something to read as nights can range from very busy to very slow.
4. If you prefer to attend the didactic sessions the following day, let your resident know you are allowed to leave at 10:30pm.

Duties on Gyn:

In The OR
1. Take bed out to the hallway, and help roll it back in after the surgery.
2. Write your name on the board and give your badge to the circulating nurse.
3. Introduce yourself to the circulating and scrub nurses.
4. Pull your gloves and a gown and give to scrub nurse or put on table in sterile fashion.
5. Put SCDs on the pt’s legs.
6. Exam under anesthesia with resident and/or attending.
7. Place foley catheter with resident assistance.

On The Floors
1. Daily SOAP notes and orders done and in chart by 6:15am (team dependent) so resident can add them.
2. Take off bandage in AM of POD #1 unless specifically told not to (POD#2 for oncology). If you are concerned about the appearance of the incision, please find your resident to examine it.
3. Check POD #1 CBC.
4. D/C instructions and scripts.
5. PostOp check and note (evening of surgery if patient gets to the floor prior to signout time).
7. Follow-up on pathology.

**Commonly Used OB/GYNE Abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ab – abortion</td>
<td>(includes elective (EAb), therapeutic)</td>
</tr>
<tr>
<td>(Tab), and miscarriages/spontaneous (SAb))</td>
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<tr>
<td>AFI – amniotic fluid index</td>
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<tr>
<td>APVSS – afebrile, vital signs stable</td>
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<tr>
<td>AMA – advanced maternal age</td>
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<tr>
<td>AROM – artificial rupture of the membranes</td>
<td></td>
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<tr>
<td>ASC-H – atypical squamous cells cannot exclude high-grade intraepithelial lesion</td>
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<tr>
<td>ASC-US – atypical squamous cells of undetermined significance</td>
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<tr>
<td>AUB – abnormal uterine bleeding</td>
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<tr>
<td>βHCG – beta human chorionic gonadotropin</td>
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<tr>
<td>BPP – biophysical profile</td>
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<tr>
<td>BSO/OR/O – bilateral/left/right salpingo-oophorectomy (removal of fallopian tubes/ovaries)</td>
<td></td>
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<tr>
<td>BSUS – bedside ultrasound</td>
<td></td>
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<tr>
<td>BV – bacterial vaginosis</td>
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<tr>
<td>C/D/I – clean/dry/intact</td>
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<tr>
<td>CI – cervical insufficiency</td>
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<tr>
<td>CLE – continuous lumbar epidural (epidural)</td>
<td></td>
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<tr>
<td>CPD – cephalopelvic disproportion</td>
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<tr>
<td>C/S – C-section</td>
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<tr>
<td>Cxs or Ucs – contractions</td>
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<tr>
<td>D&amp;c – dilatation &amp; curettage</td>
<td></td>
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<tr>
<td>D&amp;E – dilatation &amp; evacuation</td>
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<tr>
<td>DMPA – Depo-Provera</td>
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<tr>
<td>DUB – dysfunctional uterine bleeding</td>
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<tr>
<td>EAb – elective abortion</td>
<td></td>
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<tr>
<td>ECV – external cephalic version</td>
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<tr>
<td>EDC – est. date of confinement (same as EDD)</td>
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</tr>
<tr>
<td>EDD – est. date of delivery (same as EDC)</td>
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<tr>
<td>EFW – est. fetal weight</td>
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<tr>
<td>EUA – exam under anesthesia</td>
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<tr>
<td>FAS – fetal alcohol syndrome</td>
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<tr>
<td>FF – fundus firm</td>
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<tr>
<td>FHT – fetal heart tracing/tones</td>
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<td>FM – fetal movement</td>
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<tr>
<td>FSi – fetal scalp electrode</td>
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<tr>
<td>FT – full term</td>
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<tr>
<td>FTP – failure to progress</td>
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<tr>
<td>FWB – fetal well being</td>
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<tr>
<td>GA – gestational age</td>
<td></td>
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<tr>
<td>GBH/GBRS – group B β-hemolytic streptococcus</td>
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</tr>
<tr>
<td>GETA – general endotrachial anesthesia</td>
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<tr>
<td>GLIT – glucose loading test</td>
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<tr>
<td>Gs &amp; Ps – Gravida (number of pregnancies) and Para (number of births in this order: Term, Preterm, Abortions, Living)</td>
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<tr>
<td>GT T – glucose tolerance test</td>
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<tr>
<td>HDS – hemodynamically stable</td>
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<tr>
<td>HELLP – hemolysis, elevated LFTs, low platelets</td>
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<tr>
<td>HPL – human placental lactogen</td>
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<tr>
<td>ICSI – intracytoplasmic sperm injection</td>
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<tr>
<td>IUFD – intrauterine fetal demise</td>
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<tr>
<td>IUGR – intrauterine growth restriction</td>
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<tr>
<td>IUPO – intrauterine pregnancy</td>
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<tr>
<td>IUPC – intrauterine pressure catheter</td>
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<tr>
<td>LBW – low birth weight</td>
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<tr>
<td>LFTS – los transverse C-section tubes/ovaries</td>
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<tr>
<td>LTL – laparoscopic tubal ligation</td>
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<tr>
<td>MAC – monitored anesthesia care (type of anesthesia)</td>
<td></td>
</tr>
<tr>
<td>LG A – large for gestational age</td>
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<tr>
<td>LMP – last menstrual period (first day)</td>
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<tr>
<td>LOF – loss of fluids (water breaking)</td>
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<tr>
<td>LTOC – los transverse C-section</td>
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<tr>
<td>MAC – monitored anesthesia care (type of anesthesia)</td>
<td></td>
</tr>
<tr>
<td>MAC – monitored anesthesia care (type of anesthesia)</td>
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<tr>
<td>MSAFP – maternal serum AFP</td>
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<tr>
<td>MWB – maternal well being</td>
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<tr>
<td>NT – mucus translucency</td>
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<tr>
<td>NSVD – normal spontaneous vaginal delivery</td>
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<tr>
<td>OCT – oxytocin challenge test</td>
<td></td>
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<tr>
<td>PCOD – polycystic ovarian disease</td>
<td></td>
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<tr>
<td>PCOS – polycystic ovarian syndrome</td>
<td></td>
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<tr>
<td>PCHS – past GYNE history</td>
<td></td>
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<tr>
<td>PDIOL – post dates induction of labor</td>
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<tr>
<td>PIMH – pregnancy induced HTN</td>
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<tr>
<td>Pit – pitocin</td>
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<tr>
<td>PMP – post-menopausal</td>
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<tr>
<td>POB – past OB history</td>
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<tr>
<td>POD – post op day (=day of surgery)</td>
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<tr>
<td>PP – post partum</td>
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<tr>
<td>PPROM – preterm premature rupture of membranes</td>
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<tr>
<td>PREX – pre-eclampsia</td>
<td></td>
</tr>
<tr>
<td>PROM – premature rupture of membranes</td>
<td></td>
</tr>
<tr>
<td>ROM – rupture of membranes</td>
<td></td>
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<tr>
<td>RPR – rapid plasma reagin</td>
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<tr>
<td>SBd – spontaneous abortion</td>
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<tr>
<td>SERM – selective estrogen receptor modulator</td>
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<tr>
<td>SG A – small for gestational age</td>
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<tr>
<td>SROM – spontaneous rupture of membranes</td>
<td></td>
</tr>
<tr>
<td>SUI – stress urinary incontinence</td>
<td></td>
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<tr>
<td>SVD – spontaneous vaginal delivery</td>
<td></td>
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<tr>
<td>TAH – total abdominal hysterectomy</td>
<td></td>
</tr>
<tr>
<td>TAH – total abdominal hysterectomy</td>
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</tbody>
</table>

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Being Helpful: while on L&D, look on the back whiteboard to see if there are any post-partum patients who need staples removed. Have a resident show you the first time, then you can offer to do this on your own. In the OR, ask a resident to show you how to put in a foley, once you’re comfortable, volunteer to take the lead on this. Volunteer to write the operative note following surgery. Always write post-op progress notes on your patient if you performed surgery on them in the morning (typically ~6 hours after the surgery).

Recommended References, Textbooks, and Pocketbooks:

- **Case Files: OB/GYN**: Excellent preparation for Shelf and OSCE. For many students a must read. Case based, so easy to work through.
- **BluePrints: OB/GYN**: Excellent review book, great preparation for Shelf and OSCE. Less extensive detail than Beckmann.
- **APGO questions**: Check Blackboard under OB/GYN -> Learning Resources. An excellent review for the shelf. You will be given a password during orientation.
- **USMLE World questions**: A good batch of ~200 supplemental questions, good shelf preparation.

Testing:

**SHELF**: 100 question shelf exam.

**OSCE**: Typically 6 stations:

- OB exam: evaluate a pregnant pt (fundal height, FHT, due date, pregnancy related question/concern)
- Gyne exam (know how to use speculum and find the cervix)
- Oral exam question with an attending/resident
- Information literacy: answer a clinical question using online resources, similar to PBL
- Chart review: Review a pt chart and write A/P
- Visual identification: evaluate clinical pictures, imaging or heart rate tracings and write A/P
The pediatrics rotation is a 6-week rotation consisting of 2 weeks of general pediatrics (either general inpatient or infectious disease), 2 weeks of outpatient pediatrics, 1 week of specialty (endocrine, neurology, or pulmonology), and 1 week of urgent care and newborn nursery.

**Pediatric H&P:**

**CC:** As in medicine, but might have to use parental quote.

**HPI:** "4mo boy/girl with PMH significant for *** presents with _________."
- Drinking/eating/peeing/pooping – quantify in bottles/dirty diapers? Last bowel movement and consistency?
- Feeding history - breast milk/formula type; how much and how often? Is this normal for him?
- How much is he sleeping? More/less than usual? Is he easily arousable? Is he more fussy than usual? Is he consolable?
- How high of fever? What dosages of meds?

**PMH/SurgHx:** Hospitalizations/ER visits? Who is his PMD? Hx of asthma/allergies/eczema? If hx of asthma: any intubations, times albuterol needed/wk? Immunizations up to date (UTD)?

**Meds:** As usual.

**Allergies:** Be specific about rxns to determine intolerance vs. allergy.

**BirthHx (generally relevant only if pt <1-2yo):**
- Pregnancy: Term length, method of delivery, APGARs, complications
- Prenatal hx: Care, weight gain, complications
- Birth: Birth weight, gestational age, GBS status, fevers/abs, length of stay in hospital
- Maternal hx: GP and age of mom, drugs/EtOH/tobacco, STDs

**Diet:** Breast milk/Type of formula/Normal milk (and type)? How much, how often? Any solid foods (if age-appropriate)?

**Social Hx:** Who lives at home? Environment? Apt/house? Pets? Smokers(both inside and outside the house)? Who does he spend time with during the day (care taker, day care, school, etc)? Recent travel? Recent sick contacts?
- School: type, grade, time spent on hmwk, clubs/sports, friends/bullies
- Activities: exercise, TV/comp/videogames, reading
- Sleep: bedtime, snoring/OSA, nocturesis
- Elimination: amt of each, # of diapers, potty trained?
- Oral hygiene: brushing teeth? With assistance? Going to dentist? Cavities?
- Misc: changes in mood, vision/hearing test, safety

**Developmental Hx:** Assess milestones: social & emotional, fine motor, gross motor, language, cognitive (see below)

**Family Hx:** Hx of asthma/allergies/eczema? Childhood diseases, genetic disorders, cancer, SIDS, inbreeding, miscarriages, early deaths, congenital anomalies, dev delay, sickle cell, seizures?

**ROS:** As usual.

**PEX:**

**VS:** T/HR/RR/BP
**GROWTH:** height/weight/head circumference (if<2yo) and %iles, BMI
**GEN:** alertness, playfulness, consolability, hydration status, respiratory status, social interactions, responsiveness, nutritional status
**HEAD:** NCAT, AFOSF. If less than 2yo, assess anterior and posterior fontanelles.
**EYES:** PERRL, EOMI, tear production, corneal light reflex, red reflex, strabismus.
**EARS:** TM pearly-gray? Red? Intact?
**NOSE:** nares patent, nasal polyps, nasal flaring
**THROAT:** Oropharynx clear? MMM? Erythema or exudates?
**NECK:** soft, supple, no LAD
**CV:** RRR, nml S1S2, no m/r/g
**LUNGS:** CTAB, no wheezes (nasal flaring, tracheal tugging, substernal 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 or WWP (warm and well-perfused), no c/c/e.
**SKIN:** no rashes, angiomas, jaundice, acrocyanosis, mottling, birthmarks
**NEURO:** CNII-XII grossly intact, “appropriate”, MAEW (moves all extremities well).

Tone/strength/reflexes (root, suck, grasp, Moro, stepping).

* Above PE (and history) 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 presenting with ***. Discuss differential diagnosis and then break down plan by system (may only have main issue and FEN depending on level of complexity of patient).

**Pediatric SOAP:**

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

**O:** VS:

- Tmax for last 24hr - note fever spikes (and when, what was done for it)
- 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. E.g. 500 in (300 PO, 200 IV)/600 out = -100 down.
- UOP: Look specifically at urine output (record as cc/kg/hr, >1 is normal) and stool output (record as cc/kg/day, <20 is normal).

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

**Labs:** As above.

**A/P:** As above.

**Well Child Check Up (Uptown Clinic):**

CC/Any new hospitalizations/ER visits

PMH/PSH: Hx of asthma/allergies/eczema? If asthma, any intubations?

Medications and immunizations (don’t forget multivitamin!)

Allergies: (rash, anaphylaxis)
FH:
Social Hx: Who lives at home? Apt/house? Pets? Smokers? How spends time during the day (day care, care taker, school)?
Sleep: Bedtime and wake up? Own room? Snore? Accidents?
Chips/cookies/candy? Fast food? Seconds?
Teeth: Brush how often? Last appointment? Problems?
Age Appropriate Development: see below

Adolescents: Home life/Education, Employ/Activities/Drugs (alcohol, tobacco, illicit)/Depression, suicide/Safety (seat belts, guns, abuse)/Sexual activity/SAFETY: Car, smoke detector, helmet

Tips for Examining Kids:

- Always start with the heart and lungs first. This way, if he/she starts crying, you’ve already gotten a chance to listen.
- Don’t be afraid of asking the mom and dad to help you hold the child. Chances are, they’ve been to the doctor’s before, and know how to help you look in the ears, etc.
- Let the kids play with your stethoscope, penlight, etc., while you’re examining them. This way, they won’t be afraid when you use them!
- For toddlers, try to get down to their level when you’re talking to them. Literally.
- CAUTION: Parents tend to throw around the words “lethargic” and “irritable,” when they mean “sleepy” or “irritable.” When we say a child is lethargic (and not easily arousable) or irritable (and not consolable), those can be clue words for meningitis...so just be careful when you use those words!
- When examining adolescents-talk with your preceptor about when it is appropriate to ask questions to the patient with and without the parent in the room

Commonly Used Peds Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC</td>
<td>apnea, bradycardia, cyanosis</td>
</tr>
<tr>
<td>AFOF</td>
<td>anterior fontanelle open and flat</td>
</tr>
<tr>
<td>AGA</td>
<td>appropriate for gestational age</td>
</tr>
<tr>
<td>BPD</td>
<td>bronchopulmonary dysplasia</td>
</tr>
<tr>
<td>CBG</td>
<td>capillary blood gases</td>
</tr>
<tr>
<td>CLD</td>
<td>chronic lung disease</td>
</tr>
<tr>
<td>CPS</td>
<td>Child Protective Services</td>
</tr>
<tr>
<td>ECMO</td>
<td>extracorporeal membrane oxygenation</td>
</tr>
<tr>
<td>FAS</td>
<td>fetal alcohol syndrome</td>
</tr>
<tr>
<td>GBS</td>
<td>group B streptococcus</td>
</tr>
<tr>
<td>HMD</td>
<td>hyaline membrane disease</td>
</tr>
<tr>
<td>HMF</td>
<td>human milk fortifier</td>
</tr>
<tr>
<td>ICH</td>
<td>intracranial hemorrhage</td>
</tr>
<tr>
<td>IDM</td>
<td>infant of a diabetic mother</td>
</tr>
<tr>
<td>IHCU</td>
<td>Infant Intensive Care Unit</td>
</tr>
<tr>
<td>IRDS</td>
<td>idiopathic respiratory distress syndrome</td>
</tr>
<tr>
<td>IVH</td>
<td>intraventricular hemorrhage</td>
</tr>
<tr>
<td>LGA</td>
<td>large for gestational age</td>
</tr>
<tr>
<td>MAS</td>
<td>meconium aspiration syndrome</td>
</tr>
<tr>
<td>MR</td>
<td>mental retardation</td>
</tr>
<tr>
<td>NB</td>
<td>newborn</td>
</tr>
<tr>
<td>NICU</td>
<td>Neonatal Intensive Care Unit</td>
</tr>
<tr>
<td>NNB</td>
<td>normal newborn</td>
</tr>
<tr>
<td>OPC</td>
<td>Occipitofrontal circumference</td>
</tr>
<tr>
<td>PAL</td>
<td>Peripheral Alimentation Line</td>
</tr>
<tr>
<td>PDA</td>
<td>patent ductus arteriosus</td>
</tr>
<tr>
<td>PIE</td>
<td>pulmonary interstitial emphysema</td>
</tr>
<tr>
<td>PKU</td>
<td>phenylketonuria</td>
</tr>
<tr>
<td>POMAL</td>
<td>PO ad lib</td>
</tr>
<tr>
<td>PTD</td>
<td>prior to delivery</td>
</tr>
<tr>
<td>PVL</td>
<td>periventricular leukomalacia</td>
</tr>
<tr>
<td>ROP</td>
<td>retinopathy of prematurity</td>
</tr>
</tbody>
</table>
Commonly Used Medications:

Acetaminophen 10-15mg/kg/dose PO q4-6
Ibuprofen 10mg/kg/dose PO q6-8 (for >6 mo old)
Amoxicillin 80-90 mg/kg/d PO divided BID
Omnicef 14 mg/kg PO daily
Clindamycin 15 mg/kg/dose IV q8
Clindamycin 10 mg/kg/dose PO q8
Orapred 1-2 mg/kg/day PO (for asthma exacerbation)

Pediatric Vital Signs:

<table>
<thead>
<tr>
<th>Age</th>
<th>RR</th>
<th>HR</th>
<th>BP</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1 mo</td>
<td>30-80</td>
<td>110-190</td>
<td>52-95/25-72</td>
</tr>
<tr>
<td>1 mo</td>
<td>30-50</td>
<td>100-170</td>
<td>64-105/30-68</td>
</tr>
<tr>
<td>6 mo</td>
<td>30-50</td>
<td>100-170</td>
<td>60-110/40-72</td>
</tr>
<tr>
<td>1 yr</td>
<td>20-40</td>
<td>100-160</td>
<td>66-110/40-72</td>
</tr>
<tr>
<td>2 yrs</td>
<td>20-30</td>
<td>100-160</td>
<td>74-110/40-72</td>
</tr>
<tr>
<td>4 yrs</td>
<td>20-25</td>
<td>80-130</td>
<td>79-112/45-75</td>
</tr>
<tr>
<td>8 yrs</td>
<td>15-25</td>
<td>70-100</td>
<td>85-118/48-75</td>
</tr>
<tr>
<td>12+ yrs</td>
<td>15-20</td>
<td>60-100</td>
<td>95-125/50-84</td>
</tr>
</tbody>
</table>

Reference p. 447 Nelson’s Essential of Pediatrics

Urine output >1 ml/kg/hr
Stool output <20 g/kg/d (<20 g/kg/d = diarrhea)

Developmental Milestones:

<table>
<thead>
<tr>
<th>Year</th>
<th>Gross Motor</th>
<th>Fine Motor</th>
<th>Speech</th>
<th>Social/Cognitive</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 mo</td>
<td>Lifts head when prone</td>
<td>Palmar grasp</td>
<td>Startles to noise</td>
<td>Social smile</td>
</tr>
<tr>
<td>2 mo</td>
<td>Up on hands during tummy time, no head lag, rolls from front to back</td>
<td>Puts objects in mouth</td>
<td>Responds to human voice, “converses”</td>
<td></td>
</tr>
<tr>
<td>4 mo</td>
<td>Pulls to stand, crawls</td>
<td>Immature pincer grasp (aka can feed themselves); holds 2 objects at once</td>
<td>Waves “bye bye,” understands no, stranger/separation anxiety, plays peek-a-boo, explores cause and effect</td>
<td></td>
</tr>
<tr>
<td>6 mo</td>
<td>Sits with support;</td>
<td></td>
<td>Searches for dropped objects</td>
<td></td>
</tr>
<tr>
<td>9 mo</td>
<td>Pulls to stand, crawls</td>
<td>Immature pincer grasp (aka can feed themselves); holds 2 objects at once</td>
<td>Waves “bye bye,” understands no, stranger/separation anxiety, plays peek-a-boo, explores cause and effect</td>
<td></td>
</tr>
<tr>
<td>12 mo</td>
<td>Stands alone</td>
<td>Mature pincer grasp (can hold all the Cheerios),</td>
<td>Finds fully hidden objects (object permanence), puts objects in containers, simple pretend play,</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Activity</td>
<td>Two Words Description</td>
<td>Three Words Description</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------------------------------------------</td>
<td>--------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>15 mo</td>
<td>Walks forward and backward</td>
<td>3-6 words</td>
<td>Temper tantrums, gestures, follows simple commands</td>
<td></td>
</tr>
<tr>
<td>18 mo</td>
<td>Climbs stairs, runs</td>
<td>10-25 words</td>
<td>Less stranger anxiety, Pretends, complete object permanence, joint attention</td>
<td></td>
</tr>
<tr>
<td>24 mo</td>
<td>Walks down steps, Jumps</td>
<td>2-4 word phrases</td>
<td>Parallel play</td>
<td></td>
</tr>
<tr>
<td>3 yrs</td>
<td>Copies a circle, Tricycle, Understand 2 or 3 part commands</td>
<td>Understand ¾ speech, Lots of questions</td>
<td>Likes to make others laugh and play with others, Pretend play, Gender roles</td>
<td></td>
</tr>
<tr>
<td>4 yrs</td>
<td>Dresses/undresses self, Copies square R or L handed</td>
<td>Tells stories</td>
<td>Pretend and fantasy play, Friends; knows colors</td>
<td></td>
</tr>
<tr>
<td>5 yrs</td>
<td>Pencil grasp, Copies triangle, Ties shoes, Prints letters</td>
<td>Future tense, Counts to 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Remember Shapes (Alphabetical Order):
Circle (3 yrs), Cross (4 yrs), Square (5 yrs), Triangle (6 yrs)

**Standard Immunizations (Note: can change based on outpatient office/check the CDC annual regulations):**

Birth: Hep B
2 mo: Hep B, DTaP, Hib, IPV, PCV13, Rota
4 mo: DTaP, Hib, IPV, PCV13, Rota
6 mo: Hep B, DTaP, Hib, IPV, PCV13, Rota
12 mo: MMR, Varicella, PCV13
15 mo- DTaP, Hib
18 mo- Hep A
2 yr- Hep A
4-6 yr- DTaP, IPV, MMR, Varicella
Adolescents- Tdap, Meningococcal, Gardisil (3 doses needed)
Pentacel= DTaP, IPV, Hib
Kinrix= DTaP, IPV
MMRV= MMR, Varicella
- Flu Shot yearly after age 6 mo (if getting for first time and < age 9- need 2 doses 1 month apart)
- Hemoglobin and Lead at 1 yr
- Vision and hearing screen at 4-6 yrs

**Being Helpful:** Pediatric residents LOVE teaching. Enthusiasm to learn cannot be emphasized enough on this rotation! It goes both ways though. Try to bring in interesting articles and teach your residents something during your oral presentations. The AAP journal is great for this. You can also help your team by obtaining outside hospital records. You can proactively call the OSH and request follow-up on blood and urine cultures (if they were drawn) and report the information back to your team.

**Recommended References, Textbooks, and Pocketbooks:**
- **CLIPP Cases:** You are required to do at least 20 of them. Accessible via Blackboard. Covers peds topics in a case-based manner. Printable summary pages included at the end of each case are helpful for studying. Students have had mixed responses on the helpfulness of these cases.
- **Case Files Pediatrics:** Pediatrics is a very broad field and the cases in this book will help touch on the main topics that are tested on the shelf exam. Most students have found this book very beneficial.
- **Pretest Pediatrics:** Most students have found this book helpful for practice questions spanning the field of pediatrics. It is especially helpful for the subspecialties that you are not able to rotate on during the clerkship.
- **Blueprints Pediatrics:** Not necessary for all students, but about half of the students surveyed have found it helpful for a general overview of peds.

**Testing / Grading (subject to change):**

**SHELF:** 100 question shelf exam.

**OSCE:** Consists of talking to “parents” about their children. The physical exam is given on a card. Involves counseling parents both on medical and advocacy-related issues, some after encounter questions, and an admission order set.

**GRADING:** Clinical: 60%, Shelf: 20%, OSCE: 15%, Professionalism/Nutrition: 5%
PSYCHIATRY

Psychiatry H&P:

CC: Describe CC, as you would do with any H&P-often using patient’s own words

HPI: Include age, sex, and both past medical and past psychiatric history. Include symptom onset, course and duration, as well as significance (why presented now?). Include living situation, employment, recent stressors and funding status if pertinent. Also include presence of any suicidal/homicidal ideation, and auditory/visual hallucinations.

Psych ROS:

- Think: DAMPS = depression, anxiety, mania, psychosis, substance abuse
- Assess mood (depression screen ask SIGECAPS; mania/hypomania/mixed episodes ask DIGFAST) – see below for meaning of mnemonics.
- 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)

All psych encounters include a suicidality screen. If there is any potential suicidality contact the nurse to implement precautions immediately.

Past Psych Hx:

- Previous inpatient hospitalizations – when, where, why
- Previous outpatient tx – therapist/psychiatrist and when last seen, meds used, ?ECT, how long tx lasted, and if it was beneficial (if possible obtain name/number of psychiatrist for collateral-written consent to speak with therapist/collateral)
- Previous suicide attempts/aborted attempts/self-destructive behavior (such as cutting)

PMH/PSH: List PMH as you would for any patient. Ask specifically about seizure d/o, h/o head trauma and LOC, stroke, and in women with children ask about post-partum depression and relationship of symptoms to menstrual cycle

Meds: List meds prior to admission and while in hospital. List use of PRN meds. Don’t forget herbal, over the counter meds and birth control. Make sure to ask if pt is actually taking meds.

Allergies: Document medication and reaction.

Chem Dependency:

- Current use of EtOH (CAGE screen-Cut down; Annoyed; Guilty; Eye opener), illicit drugs (ask about specific drugs), and tobacco – quantity, frequency, pattern of use, last use, triggers. If positive history ask about h/o DTs, withdrawal seizures, blackouts, treatment (AA, NA)
- If positive drug abuse, ask about history of withdrawal seizures, DTs, blackouts
- Be sure to ask when first used, if there have been periods of sobriety, rehab/detox/AA/NA programs attended.
- Smoking, caffeine

Family Hx: h/o depression, bipolar d/o, anxiety, “nervous breakdowns,” psychosis, suicide, 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, developmental history/family of origin
MENTAL STATUS EXAM (MSE): This is the equivalent of the PEX for psych!

APPEARANCE/BEHAVIOR: appearance relative to age, race, dress, hygiene, behavior, eye contact, cooperativeness, alertness, orientation, involuntary movements/tics

SPEECH: rate (accelerated/slowed/normal), rhythm (halting/hesitancy/stuttering), volume (loud/soft/normal), lack of spontaneity? Hypervocal? Poverty of speech?

MOOD: (patient’s subjective description of inner state)-use pt’s own words.

AFFECT: (observed) objective sense of pt’s mood: range (constricted/full/labile), intensity, mood congruent/incongruent with affect?

THOUGHT CONTENT: (asked directly) passive or active SI, intent, plan, attempt; HI, A/VH, paranoia, delusions, obsessions, ruminations, etc.

THOUGHT PROCESS: (the way one puts ideas together-observed)-rate (thought blocking or flight of ideas), goal directedness-linear/goal directed or circumstantial, tangential, loose associations, thought blocking, flight of ideas, echolalia, neologisms, perseveration, word salad.

COGNITION: MMSE (mini mental) score and mistakes

INSIGHT: (ability to understand and appreciate facts and significance of their psychiatric, medical and social circumstances) poor/fair/good/excellent as evidenced by..... (ie do they understand why they have been admitted to the psych unit?)

JUDGMENT: ability to draw from facts and significance of their circumstances conclusions, including their process of reasoning and basis for their decision and ability to act when required based on their opinion. Poor/fair/good/excellent. The classic question is to ask the patient “if you found an addressed and stamped envelope on the street, what would you do with it?”

Labs/Studies: Usually includes urine tox, +/- CBC, chem, HIV, RPR, etc.

Assessment: Brief statement of overall impression. Should include reiteration of basic patient information, description of symptoms, predisposing factors and precipitating factors contributing to current presentation.

- **Axis I:** Primary psychiatric dx-may include your differential diagnosis here (major depressive d/o, somatization d/o, panic d/o, schizophrenia, bipolar d/o, autism spectrum disorders, conduct disorder)

- **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, write “DEFERRED”.)

- **Axis III:** List any purely medical problems here.

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

- **Axis V:** Global Assessment of Functioning – Found in DSM IV; can also find online [30-60 describes severe symptoms that may be managed as an outpatient; <30 usually warrants hospitalization]

Plan: level of care (inpatient for these reasons...); workup recommended (collateral, blood work, imaging, etc), recommend psychosocial and biological treatments (therapy, medications, other psychosocial interventions)
Psychiatry SOAP:

S: Events o/n. Use of PRN meds (found in MAR view)
O: VS:
   Mental Status Exam: as above
A/P: Brief Impression
   Med suggestions, placement suggestions, suggestions of additional consults, f/u on outpatient treatment options.

Safety: Safety is a priority when interviewing psychiatry patients. Most students do not have any problems when interviewing patients. However, keep in mind the following before every encounter.
- Interview patients in common areas or with the door open
- Position yourself between the patient and the door
- Do not touch patients
- If a patient becomes angry or asks you to leave, leave the patient room

Being Helpful: Students are especially helpful at obtaining ‘collateral’ information on their patients. This means obtaining outside hospital records, contacting family members, talking to outpatient psychiatrists, etc. Sometimes you may help the team by clarifying a patient’s medications and doses by calling their pharmacy. [Note-when obtaining collateral in psychiatry you will legally need the patient to fill out two release of records forms and place these in the patient’s paper chart]

References/Textbooks:

- First-Aid for Psychiatry: Many students find this concise book a useful summary of important points, similar format as First-Aid USMLE Step 1.
- Casefiles Psychiatry: Presentation of a case and discussion, similar to others in Casefiles series.
- Pretest Psychiatry: High yield psychiatry questions many find helpful for shelf studying.

Testing / Grading (subject to change):

SHELF: 100 questions. This exam is traditionally difficult to finish due to long question stems.

OSCE: 2 standardized patients presenting with common psychiatric diseases. You will conduct and document a thorough mental status exam and formulate management plans. You should also be able to perform and document a mini-mental status exam. Students must ask about suicidal ideation.
**GRADING**: Clinical: 55%, Shelf: 20%, OSCE: 25%

**Commonly Used Psych Abbreviations:**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADL</td>
<td>activities of daily living</td>
</tr>
<tr>
<td>A/VH</td>
<td>auditory or visual hallucinations</td>
</tr>
<tr>
<td>BPD</td>
<td>borderline personality disorder</td>
</tr>
<tr>
<td>Chem Dep</td>
<td>chemical dependency</td>
</tr>
<tr>
<td>DIGFAST</td>
<td>mnemonic for mania</td>
</tr>
<tr>
<td>MDD</td>
<td>major depressive disorder</td>
</tr>
<tr>
<td>MDE</td>
<td>major depressive episode</td>
</tr>
<tr>
<td>MR</td>
<td>mental retardation</td>
</tr>
<tr>
<td>MSE</td>
<td>Mental Status Exam (see above)</td>
</tr>
<tr>
<td>MMSE</td>
<td>Mini-mental Status Exam, aka Folstein test</td>
</tr>
<tr>
<td>NA</td>
<td>narcotics anonymous</td>
</tr>
<tr>
<td>SI</td>
<td>suicidal ideation</td>
</tr>
<tr>
<td>SIGECAPS</td>
<td>mnemonic for depression</td>
</tr>
</tbody>
</table>

**DIGFAST: >= 3 for mania**
- Distractibility
- Irritability
- Grandiosity
- Flight of ideas
- Activity (Inc, goal-directed)
- Speech (Pressured)/Sleep (decr need)
- Thoughtlessness/Talkativeness
- Suicidality

**SIGECAPS: >=4 for depression**
- Sleep (Inc or Dec)
- Interests (Dec)
- Guilt
- Energy (Dec)
- Concentration (Dec)
- Appetite (Inc or Dec)
- Psychomotor retardation/agitation
What to Expect

During the neurology rotation you will spend two weeks on one of the inpatient services and two weeks working with an outpatient preceptor. For the two inpatient weeks you will spend time on the general service, the consult service, the ER service, or the stroke service.

**General Service:** This service runs much like the general medicine inpatient months. You will work with an attending, residents, and other medical students. You will encounter a diverse array of neurologic diseases including myasthenia gravis, Guillain Barre, epilepsy, brain tumors, etc.

**ER Service:** You will work directly with another medical student and a senior resident. Typically you will go see consults in the ED when they first present. You will often go as a team to evaluate the patient but if the service becomes busier you will see the patient on your own and present to your resident. You should become proficient at conducting a thorough yet efficient neurology exam as you will be evaluating patients in a more imminent setting.

**Stroke service:** Every morning you should check on the “stroke labs” and be prepared to present these. These labs include: CXR, EKG, TSH and reflex T4, CBC, Chem7, coags, ESR, homocysteine, B12, Folate, lipid risk profile, UA, Utox, HIV, RPR/FTA, TTE, MRI/MRA. You can quickly find these labs in Powerchart by creating a new note and free-texting ".stroke." Report only the abnormal labs unless asked to do otherwise. Also look up any new studies (MRI, MRA, CT, CTA, Duplex) and know their findings. The best way to address new findings is to announce if a new study is available in PACS and to have the image pulled up so the attending may look at it.

**Consult Service:** You will be working with 2 to 3 junior and senior neurology residents, another medical student and possibly rotating residents from other services and a faculty member. Your service will be seeing patients in the hospital that need consultations on acute neurological issues. The team may see 4 to 10 patients in a day. Be proactive in trying to see new patients. When you are assigned to see a new patient, make sure you understand the question you are being consulted for (e.g. headache, mental status changes, hand tingling etc.). If you know the question, then you can do a targeted chart review and perform a focused evaluation. This is a busy service, so be organized when you present your cases. Follow up on your patient daily and try to be helpful to your team.

**Neurology H&P:**

While similar to a medicine note, the following are differences:

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

**Physical Exam:**

- **Gen:** NAD
- **Neck:** no carotid bruits
- **Lung:** CTAB
- **CV:** rrr, no m/r/g

**Neuro Exam:** more detailed than the documentation of a neuro exam for medicine. For cranial nerves write down specific results.

- **Mental Status Exam:** Alert and oriented to person, place and time.
- **Higher Intellectual Functions (HIF):** e.g. Mini mental 24/30 unable to recall 3 objects at 5 min and unable to spell "world" backwards (describing the deficits is very important to properly communicating the exam)
**Language:** Comprehension/fluency/naming and repetition intact, talk about reading and writing if pertinent

**CN I:** not routinely tested

**CN II:** Visual fields full to confrontation. If visual acuity is tested say what it is eg. 20/20. Pupils equal round and reactive to light and accommodation.

**CN III, IV, VI:** EOMI w/o 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:** Uvula is midline and palate elevates equally

**CN XI:** Sternocleidomastoid and trapezius muscles 5/5 strength bilaterally.

**CN XII:** Tongue protrudes midline without atrophy or fasciculations.

**Motor:** Strength 5/5 in upper and lower extremities bilaterally (mention atrophy and fasciculations if present). No pronator drift. Tone is normal (mention tremor: resting or intentional if present, also mention cogwheeling or rigidity if present).

- Grade 0: No muscle movement
- Grade 1: Muscle movement without joint motion (fasciculations)
- Grade 2: Moves with gravity eliminated
- Grade 3: Moves against gravity but not resistance
- Grade 4: Moves against gravity and light resistance
- Grade 5: Normal strength

**Reflexes:** Symmetrical reflex in upper and lower extremities in following tested reflexes: biceps, triceps, brachioradialis, patellar and achilles. Plantar reflexes (Babinski) downgoing bilaterally. 2+ is normal, 1+ decreased, 3+ brisk.

**Sensation:** Sensation intact to pinprick, light touch, vibration, proprioception.

**Coordination:** No finger-to-nose or heel-to-shin dysmetria. Rapid alternating movements are normal.

**Gait and Stance:** Normal gait and stance. Able to walk on heels, toes, and in tandem. Romberg negative; stance maintained without sway.

**A/P:** It is important to bring everything together in your assessment. Talk about the significant symptoms, exam findings labs and images that led you to think one way or another.

*Remember:* The most important thing in neurology is to localize the lesion.

**Neurology SOAP:**

**S:** Similar to medicine SOAP

**O:** Similar to medicine SOAP. Should include a full neurological exam:

**MSE:**
- 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:**
- Always document all CN as shown above in the H&P. NOT acceptable to write “II-XII intact” for a neuro note.

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

**Reflexes:**
- 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 light touch, pinprick, proprioception and temp.

**Gait:** Describe their gait. Can they walk on the toes? Heels? In tandem?

**A/P:** Similar to medicine SOAP in terms of format.

The **“SOAP Note” neuro exam in 5 minutes or less!**

You may find it difficult to pre-round on patients if you aren’t efficient and regimented about your physical exam. Here is some advice about how you can keep it short and sweet.

**Systems (1 min):** Carotid bruits, Cardiac exam, Lung exam, Brief abdominal exam

**MSE: (15s)** Ask for name, date, time, place, current president and save MOCA \_/_30 for later in the day or for patients you are concerned about.

**CN: (1 min)**

**I:** routinely not tested

**II:**

-- **acuity:** have patients read their breakfast menu and the white board,

--check pupillary constriction

-- **Visual fields:** have the patient stare at you at the foot of the bed. Have them cover one eye. You will hold up 1, 2, or 5 fingers (3 or 4 fingers are confusing to distinguish) 30-45 ° off center in each of the 4 visual fields. Repeat with the other eye.

**III, IV, VI: EOM**

**V:**

-- **Sensory:** Have patient close their eyes and gently touch their face in the 3 trigeminal dermatomes and ask if it is symmetrical. Then test temperature with the end of your tuning fork (which is cold to touch). Done! Remember that temperature and pain are on the same nerve tract!

**--Masseter strength.**

**VII:** is the face symmetric? If not, mention abnormality.

**VIII:** Rub fingers together by ears and verify that each side is just as loud.

**XI, X: Tongue/uvula midline**

**XI:** Shoulder elevation

**XII:** Head rotation

**UE: 1 min-1min 15s**

**Sensation:** 15 s: Test bilaterally at arm, forearm, and hand by gently touching for touch and with the tuning fork for temperature/pain.

**Strength** 5s: Have the patient squeeze your fingers. Ask them to pull you towards and push you away.

**Pronator Drift** 10s: Ask the patient to hold their arms in front of them with the hands facing the ceiling and their eyes closed. Now look for pronation of the arms.

**Reflexes:** 15-30s: Test brachioradialis, biceps, and triceps

**Cerebellar** 10s: Rapid alternating movement (several styles, ask your resident to demonstrate and pick your favorite)

**LE: 1min s**

**Sensation** 10s : Tough at outer thigh, outer leg, and dorsum of foot (remember, you already tested pinprick and touch at the toes during your H&P. It’s unlikely they’ll develop diabetic neuropathy during the hospital stay, so skip intensive testing unless you are worried about a changing exam)

**Strength** 10s: If lying down, have the patient elevate the foot to touch your hand and push down at the knee. Test dorsiflexion later.

**Reflexes** 10s: Have the patient sit up and test patellar and achilles

**Cerebellar** 10s: Heel to shin (may also do while lying down in bed)

**Pathologic reflexes** 10-20s: Babinski (easier when sitting up, but may be done lying down) and record as downgoing, neutral/silent, or upgoing

**Standing tests:** 30s

**Normal gait away:** 5s

**Tandem gait back:** 5s

**Tip-toe gait away:** 5s (Plantarflexors: strength 5/5 if completes)
Heel walk back: 5s (Dorsiflexors: strength 5/5 if completes)
Rhomberg: 5-10s stand with ARMS TO SIDE

Definitions you should know:
States of Normal and Impaired Consciousness: (From Adams & Victor’s Principles of Neurology, 9 edition.)

**Normal Consciousness:** This is the condition of the normal person when awake.
Aware of self and environment.

**Confusion:** Inattentive, disoriented. Unable to think clearly, and coherently. Could only follow the simplest commands inconsistently and briefly.

**Drowsiness and Stupor:** Physical activity and speech are reduced.

**Drowsiness:** unable to stay awake without external stimuli.

**Stupor:** patient can be aroused only by repeated strong external stimuli and cannot sustain such state without repeated external stimulation.

**Coma:** Pt. appears asleep and is not aroused by external or inner stimuli.

Being Helpful: Keep on top of imaging and pathology results and report to your team when they become available on PACS. If it is the middle of the afternoon on general or stroke service and the official read of a study seems to be dragging, consider calling radiology, finding out who is reading the study, and go down and ask “when would be a good time for them to read it with you”. Usually they will finish their dictation and pull up your study. You can use your position as a medical student to move your patient’s read to the front of the queue, and you can report the findings to your team!

References/Textbooks:
- See Neurology Curriculum
- Clinical Neurology by Gelb: This is the recommended textbook by the clerkship director. It is an easy read and covers what you need to know for the floors and shelf.
- Casefiles Neurology: Cases and discussions of common neurological presentations. Easy read and many find it very helpful for the shelf.
- Pretest Neurology: High yield practice questions, helpful for shelf preparation.
- High Yield Neuroanatomy: Great review of neuroanatomy! Good basis for neurological principles. Not always a necessary book, but can definitely help with the basics.

Grading/Testing:
Clinical (45%): Your attendings and senior residents on in-patient and outpatient will submit evaluations of you.

SHELF (20%): 100 questions, with some long question stems. Also like other shelf exams, this is thought to be a challenging test. There may also be a decent medicine representation on the exam since it is difficult to isolate solely neurology questions.

OSCE (35%): The OSCE consists of two patient cases with follow-up questions afterward. There are also question-based stations without standardized patients. The cases on the OSCE will be based on the cases reviewed Fridays in group sessions, so it is to your benefit to pay attention to those discussions.
PRIMARY CARE

What to Expect

You will have the option of working in a family medicine, internal medicine, or occasionally pediatric clinic, all of which will provide a different experience, but with the same underlying principles of outpatient primary care. You may be expected to travel, so be prepared to factor in commuting time. If you have this rotation in the beginning of the year, use it as a refresher course for honing your PEX skills, as they may be a little rusty after studying for Boards. 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.

The format of your day will vary from clinic to clinic. You may shadow your preceptor for the first day or so, but make sure you express your wish to see patients on your own. Make sure to take note of any interesting patients, as you can present them during Weekly Report (see below).

There is an OSCE that mimics the USMLE Step 2 CS format at the 2 week mark but it does not contribute towards your grade. There is no formal 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). Remember, for outpatient medicine, a patient will more likely have an uncommon presentation of a common diagnosis rather than a common presentation of an uncommon diagnosis.

You will get to know your attending very well during this clerkship. Be as helpful and interested as possible. Your attending could be an excellent source for a letter of recommendation!

Weekly Report and LCLG:

- Weekly Report: 10 minute presentation (H&P) of an interesting case and discussion of important learning points. Make sure to have read up on the relevant topics and be prepared to be asked questions by your colleagues or group facilitator. Students often have a primary research article to help illustrate teaching points. When you are not presenting, be engaged, contribute ideas, and ask relevant questions.

- LCLG: 8 minute presentation of any topic of your choice relevant to primary care during the third week. You choose two topics to create concise handouts and pick one to present on LCLG day; most students utilize powerpoint for the presentation. Start early and work hard on this. Ask your preceptor for feedback. Not only is it a great learning opportunity for a topic you’re interested in, but it is also a large portion of your final grade.
**Primary Care H&P:** essentially the same as medicine; include preventive medicine section at end.

**Primary Care SOAP:** use your preceptor’s notes as a guide unless they ask you to use a general soap (essentially the same as medicine with the addition of preventive medicine). For annual check-up visits—some preceptors use the subjective section to detail each of the patient’s chronic problems and how the patient has been feeling/managing these issues (example—Htn: measuring BPs at home—b/w 120-140 SBP. Taking ** meds regularly. Hyperlipidemia: denies rest or exertional chest pain, SOB, etc.)

**Being Helpful:** Because primary care clinics are often busy; finding the balance between doing a thorough history and practicing your PEX skills and being efficient (aka focused histories and physicals) is key. Become familiar with the patient’s chart beforehand (look in EPIC for a previous note listing their chronic health problems), confirm their current medications, and be aware of the preventive medicine issues that pertain to the patient (ie osteoporosis screening, vaccinations up to date, mammograms, colonoscopy etc).

**References/Textbooks:**
- **Primary Care Medicine:** Excellent reference for the clerkship as well as recommended reading. Available online on the Galter website.
- **Primary Care Mentor:** Brief overview of common presentations, will be lent to you on the first day of the clerkship.
- **Objectives Checklist:** Given to you on the first day of the clerkship. Use this during class to take notes or reference the outline after. The checklist serves as a great launching point for studying for the in-house exam.
- **Step Up to Medicine:** Chapter on ambulatory medicine is helpful for understanding basic primary care principles
- **MKSAP Question Book:** General Internal Medicine Section-good practice questions covering many high yield primary care principles

**Pearls for Primary Care:**
- Commonly used risk scores: Framingham Risk Score (calculator online), CHADS2, FRAX (calculator online)
- NCEP Guidelines for management of hyperlipidemia
- Vaccinations for adults
- US Preventative Health Services Task Force Recommendations (search for phone application)—breast cancer, prostate cancer, cervical cancer, colorectal cancer, skin cancer, osteoporosis
- Other screening: abdominal aortic aneurysm, hyperlipidemia
- Diabetes diagnosis: Fasting glucose >126; random plasma glucose >200 in person with DM symptoms, 2hr post-prandial glucose >200 (after 75g glucose load), HbA1C >6.5
Third Year Timeline

**July '12 – June '13**
- Attend monthly career development sessions in IDM
- Complete personal profile at the Careers in Medicine (CiM) website at: http://www.aamc.org/students/cim/start.htm

**November '12**
- 1st draft of CV due in AWOME

**Jan '13/Feb '13**
- Find an advisor by contacting the Career Advising Coordinator in the departments you are interested in: http://www.feinberg.northwestern.edu/AWOME/Current_Students/Counseling/Career/Specialties/index.html
- If uncertain about specialty, contact Dr. Sandy Sanguino, Dr. Marianne Green or Dr. Thomas for assistance
- Can begin requesting letters of recommendation from faculty, but not necessary yet (due in October 1)
- Attend department specialty information sessions
- Curriculum vita should be in good shape to share with advisors and letter writers as needed
- Investigate M4 electives and begin applying (program deadlines range from January through May)
- Schedule Step 2

**March '13**
- Schedule M4 Year (specifics will be discussed in IDM)

**May '13/June '13**
- Work on Personal Statement
- Research residency programs of interest through FREIDA website

**July '13/Aug '13**
- Receive ERAS token and begin ERAS application
- Sign up for application and matching services (ERAS, NRMP, SF match, AUA, military)
- Submit MSPE worksheet
- Letters of Recommendation should be requested and submitted
Patient Privacy

Respect the privacy of patients at all times.

Failing to protect the confidentiality of health information is:

- Against the law (placing the medical school, hospital, and yourself in legal jeopardy)
- Unethical and undermining to the patient-physician relationship

Reminders regarding the basics:

- It is the patient’s right to have confidential medical records. 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.
- You are only allowed to look at charts or printed/electronic medical records of patients with whom you are involved in their care. Example: if your friend is in the hospital and you are curious as to how he/she is doing, it is a violation for you to look at their records if you are not involved in their care. The hospital tracks who is looking at the charts and the reason they are looking.
- Regarding your own medical record within NMH. The nursing staff claims it is a HIPAA violation. It is inappropriate to access your own medical records at NMH. You do have the right to the information, but you should follow the established process, which requires completing an authorization form and presenting it to the NMH Medical Records Department. When you obtained your login, you agreed to this. All access to electronic records is recorded and can be audited at any time.
- Never disclose patient information without the patient’s permission. Do not talk about a case to those not involved in the case. If you are ever unsure if disclosure is appropriate check with a more senior member on your care team beforehand.
- NEVER talk about patients in public places like elevators, hallways, cafeterias, or anywhere else where somebody might overhear the conversation. You don’t know who is listening and it could be very damaging to a patient’s privacy. It is unprofessional in the eyes of your superiors and may result in a formal reprimand.
- Don’t throw papers with identifiable patient information into unlocked trash bins or other containers. Special containers for such disposal confidential materials are available and are marked as “confidential” or “HIPAA” and are typically located at nursing stations on every floor. Do not dispose of this information at home.
- Turn off computer screens and log off programs that contain patient information when you are finished. Don’t leave any source containing patient information where others might be able to look at them.
Safety Issues

Needle Sticks

If stuck with a contaminated needle, or otherwise subjected to contamination by bodily fluids from a patient, there is a small but very real risk of acquiring a serious infection from the host. **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 can 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.*

- **Children’s Lurie:** [pending new numbers]

- **VA** Employee Health (Room 1480) 312-569-7159
  *Needle Stick Hotline or ER report immediately to VA Employee Health (> North Damen) during regular work hours (Mon-Fri 8 AM - 4PM) and to the Emergency Department at all other times.*

- **MacNeal** Report the incident to your chief resident or Dr. Zawacki. Proceed to Employee Health ext. 3427 (before 4 PM) or to the ED ext. 6000 (after 4 PM).

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.

**Remember:** 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. NEVER recap needles, and dispose of all sharp objects immediately after use. If you follow standard precautions 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
E-mail: cljohnson@northwestern.edu

If you become aware of an error (wrong order, medication, technical problem with a procedure, etc) you need to make sure it is reported for appropriate follow up. NETS (Northwestern Event Tracking System) is available on every NMH computer from the home page. It takes about 2 minutes to enter an event. Good Catch or Near Miss reports are also very welcome and will be followed up. You can report anonymously or provide your name. You can also report by phone to 6-RISK at any time, and for serious events you should use the phone rather than the online system.

If you are involved in a medical error you should reach out for support. Your resident, attending or clerkship director are good resources. If you are part of the team involved in a devastating event such as a patient suicide, be sure to ask for and accept support.

Security

As medical students, we can have difficult hours: early mornings and late nights. These are the logical times you should be aware of your surroundings, but remember crimes can occur at any time.

To further reduce your risk of becoming 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. Many times you will be asked to travel to different locations around the city and surrounding suburbs. Remember to always use caution when using public transit and attempt to travel in groups. Incidents can occur anywhere, recently there has been an increase in crimes located in the Gold Coast area, so always be prepared. Don’t every carry laptops (you will never need them). Limit your use of smart phones or iPads during transit as these have become targeted devices in thefts. Avoid public transportation during strange hours. When in doubt, a cab might be the safest bet, especially when taking call from MacNeal. If you have questions about the general safety of an area, talk to hospital personnel. Most likely, they have been working at the hospital or office for several years and know the places you should avoid.

Safety in the hospital has also been a concern. Although most patients don’t appear to be hostile or capable of inflicting physical harm, you should always be conscious of your surroundings and when in doubt immediately vacate the area. Although these events are rare, care should always be taken.
Student Code of Conduct

The 1999–2000 Medical Student Senate developed the following “Code of Conduct” (revised in 2011) to emphasize students’ commitment to certain principles. The Code of Conduct now serves as a guide for continuing discussion and reflection among students and faculty members regarding the nature of honor and integrity, professional responsibility, and respect.

Honor and Integrity

- I will neither give nor receive impermissible assistance on academic examinations and assignments.
- I will abide by the Feinberg School of Medicine’s policies and procedures, including those regarding plagiarism, use and distribution of controlled substances, and downloading copyrighted material, as outlined in the Student Handbook.

Professional Responsibility

- I will commit myself to life-long learning, and pledge to contribute to the advancement of medicine.
- I will be a patient advocate and speak up on behalf of my patients.
- I will keep all information that I receive about patients in confidence from anyone outside of the medical team.
- I will not engage in inappropriate relationships with patients or members of my medical team.
- I will not give a false impression of my medical knowledge and skill, and will not falsify medical records.
- I will ask for academic and personal support from my peers and superiors when necessary, and offer similar help as needed.

Respect

- I will treat all people equitably without regard to age, race, gender, religion, ethnicity, disability, socioeconomic status, disease status, sexual orientation, or political ideology.
- I will collaborate with members of the medical school community to promote an environment that supports teamwork.

By signing this Code of Conduct, I pledge to abide by the Code and to report any infraction. I understand that failure to do so is itself a violation of the Code of Conduct.
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. All clerkships outline a clear plan of action for abusive behavior. Furthermore, the incident(s) should be reported as soon as possible, so that corrective actions can be made.

In addition, 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.

NMH has a Physician Health Committee, chaired by Joan Anzia MD, which addresses abusive behavior. You can contact her confidentially if needed.

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.
Medical Student Duty Hours Policy

Background
- During the clinical years, Feinberg medical students should assume an increasing level of professional responsibility, learning to care for patients with dedication, integrity, and compassion. One of the challenges of becoming a physician is learning to fulfill one’s clinical responsibilities without sacrificing one’s own physical and mental health. The clinical years should provide an environment in which students can attend both to their education and to their personal well-being as they develop into physicians.

Policy
- Medical students must not be required to work more than resident physicians, whose duty hours are regulated by the ACGME.
- Duty hours are defined as any clinical work or required educational experiences (e.g. conference, lectures, exams); they do not include time at home to study or travel time to and from clinical sites.
- Medical students must not work more than 80 hours per week.
- Medical students must not work more than 24 consecutive hours caring for patients. After 24 hours, they may continue to work for up to 6 hours for continuity of care or classroom experiences, but may not assume care for new patients during this time.
- Medical students must not be scheduled for call the night before an exam.
- Medical students are dismissed from ward duties by midnight before IDM. Students on call the same day/night of IDM are to report immediately after IDM has concluded to their medical teams. Students not on call are dismissed after IDM.
- At minimum, medical students must receive an average of one day off per week over a four week rotation.
- With the exception of Thanksgiving, University holidays (e.g. Independence Day, Labor Day, Memorial Day, Martin Luther King Day) shall be treated like weekend days, on which students may be on call. For all rotations except sub-internships, the Thanksgiving Holiday shall be observed beginning at 6pm on the Wednesday before Thanksgiving and ending on Sunday evening; these count as days off. During sub-internship rotations, medical students may be required to work during the Thanksgiving holiday.

Monitoring
- Within the limitations above, the clerkship directors are responsible for setting medical student schedules on each individual rotation. All scheduling shall be done with the students’ best educational interests in mind.
- Any concerns about duty hours should be discussed with the clerkship director. Students should report any violations of this duty-hours policy to Dr. John X. Thomas; student grades shall not be affected by such reporting.
Professionalism

- At times, it might seem like a good idea to attend that extra meeting the morning before IDM or to show up early in order to carry that extra patient. However, respecting the medical student hour policy also shows respect towards your fellow colleagues and classmates.

- Intentionally disregarding the medical student hour policy has a tendency to backfire—attendings and residents can tell if you’re trying to look better than the other students on your team. It can also negatively impact the working relationship you have with your fellow teammates.

- On the other hand, if you’re carrying more patients than you can handle, or are finding that you have to come in far earlier than other students to write notes, you might want to think about talking with your team. You can ask how to become more efficient with your time, or simply let them know that you feel overwhelmed. Your team will generally appreciate your honesty.
Clerkship Transportation Reimbursement Policy

As part of their required clerkship curriculum, students may be assigned to a clinic or hospital site outside of the Chicago Campus. When students must travel off campus, they are expected to take University shuttles, mass public transportation or their own vehicle.

In specific situations, students traveling off campus may be reimbursed for travel via Metra, personal car or, in unusual circumstances, taxi. Please note that some clerkships provide transportation options at little or no cost to students. Students should utilize these options. In cases where the clerkship does not provide transportation options, a student may qualify for travel reimbursement to their primary assigned site.

Whether traveling by taxi or Metra (counter ticket purchase price only) reimbursement will consist of the one-way cost minus the cost of CTA public transportation. For personal vehicles there is a $5 deduction. Please note students will be reimbursed from the Chicago campus or home, whichever is shortest, up to a maximum of $30 each way.

Reimbursements may be issued when:

• A student is **required** to start clerkship work before 6 AM.

• A student is **required** to work later than 9:30 PM or, for those at the Jesse Brown VA, after the last shuttle.

• A student traveling to an outpatient facility or MacNeal Hospital that is readily accessible by public transportation (Metra, CTA) will be reimbursed for Metra travel less the cost of CTA public transportation. If traveling by car or taxi students are expected to travel together whenever possible.

All requests will be reviewed by the appropriate clerkship coordinator/director for validation and the AWOME for adherence to department and Northwestern University policies and guidelines.

**Please Note:** This policy is subject to change without notice. Please consult [http://www.feinberg.northwestern.edu/AWOME/Current_Students/ClerkshipReimbursement/index.html](http://www.feinberg.northwestern.edu/AWOME/Current_Students/ClerkshipReimbursement/index.html) for the most current and detailed version.
Conclusion

Your junior year will be fascinating beyond your wildest imagination and will test you at every corner. You will see and do many things that you may never have the chance to do again—deliver a baby, replace a knee, comfort a terminally ill patient in palliative care, have a real difficult conversation with a real patient, observe and diagnose mental and psychiatric disorders, operate on an ill patient, participate in a code, hold someone’s life in your hand and help to save it.

The student’s experience is team-dependent. Unfortunately, there is no standard of resident teaching as there is a standard of medical care, so rise to the challenge and 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.

Remember that you are here to learn. Never forget that it is a privilege to be here and you should utilize every day and value every experience. If your resident is able to finish all the floor work because you helped, there will be more time for teaching. Teamwork allows for a more enjoyable working atmosphere.

Towards the end of your third year, you may feel compelled to declare your future profession. Your mind will likely change many times throughout this year, as you become encouraged by some experiences, evaluations, and teachers (and occasionally discouraged by others). Whatever the challenges, you will succeed.

Have a fantastic year and welcome to the wards!

—The Class of 2013
Appendix

Abbreviations

The following represents a very extensive list of commonly and uncommonly used abbreviations. The use of abbreviations is strongly discouraged for diagnoses or procedures, and we would like to see much less use of abbreviations overall. Some of these are EXPLICITLY prohibited by The Joint Commission and others are just bad practice which has led to medical error and patient harm. For example:

GBS – can mean gallbladder series, gastric bypass surgery, group B streptococci, Guillain-Barre Syndrome
HSG – can mean herpes simplex genitalis or hysterosalpingography
OCP – can mean ocular cicatricial pemphigoid, oral contraceptive pills or ova, cysts, parasites
MR – can mean mitral regurgitation or mental retardation
PE – has been used by some to mean physical exam, pulmonary embolism, or pulmonary effusion

We have put a line through the abbreviations that should absolutely NOT be used, but have still included them below because you may run into them on the wards.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/2</td>
<td>secondary to</td>
</tr>
<tr>
<td>T</td>
<td>one (used to substitute for numerical digit)</td>
</tr>
<tr>
<td>TTT</td>
<td>three (used to substitute for numerical digit)</td>
</tr>
<tr>
<td>AAA</td>
<td>abdominal aortic aneurysm</td>
</tr>
<tr>
<td>Ab</td>
<td>antibodies</td>
</tr>
<tr>
<td>Abd</td>
<td>abdomen</td>
</tr>
<tr>
<td>ABG</td>
<td>arterial blood gas</td>
</tr>
<tr>
<td>ABI</td>
<td>ankle brachial index</td>
</tr>
<tr>
<td>a.c.</td>
<td>before meals (Latin: ante cibum)</td>
</tr>
<tr>
<td>AC &amp; BC</td>
<td>air conduction and bone conduction of ear</td>
</tr>
<tr>
<td>ACS</td>
<td>acute coronary syndrome</td>
</tr>
<tr>
<td>ACTH</td>
<td>adrenocorticotropic hormone</td>
</tr>
<tr>
<td>ADA diet</td>
<td>American Diabetic Association diet</td>
</tr>
<tr>
<td>ADH</td>
<td>anti-diuretic hormone (vasopressin)</td>
</tr>
<tr>
<td>ADLS</td>
<td>activities of daily living skills</td>
</tr>
<tr>
<td>ad lib</td>
<td>at liberty</td>
</tr>
<tr>
<td>AFB</td>
<td>acid fast bacilli (think tuberculosis)</td>
</tr>
<tr>
<td>Afib</td>
<td>atrial fibrillation</td>
</tr>
<tr>
<td>AFP</td>
<td>alpha fetoprotein</td>
</tr>
<tr>
<td>AFVSS</td>
<td>afebrile, vital signs stable</td>
</tr>
<tr>
<td>AI</td>
<td>aortic insufficiency</td>
</tr>
<tr>
<td>AIN</td>
<td>acute interstitial nephritis</td>
</tr>
<tr>
<td>AKA</td>
<td>above the knee amputation</td>
</tr>
<tr>
<td>AKI</td>
<td>acute kidney injury</td>
</tr>
<tr>
<td>ALL</td>
<td>allergies; also acute lymphocytic leukemia</td>
</tr>
<tr>
<td>AMA</td>
<td>against medical advice (signing out of hospital); advanced maternal age</td>
</tr>
<tr>
<td>AML</td>
<td>acute myelocytic (or myelogenous) leukemia</td>
</tr>
<tr>
<td>ANA</td>
<td>anti-nuclear antibody</td>
</tr>
<tr>
<td>ANC</td>
<td>absolute neutrophil count</td>
</tr>
<tr>
<td>AOX3</td>
<td>alert and orient to time, place, and person</td>
</tr>
<tr>
<td>AP</td>
<td>anteroposterior</td>
</tr>
<tr>
<td>A+P</td>
<td>auscultation and percussion</td>
</tr>
<tr>
<td>A/P</td>
<td>assessment/plan</td>
</tr>
<tr>
<td>aPTT</td>
<td>activated partial thromboplastin time (PTT)</td>
</tr>
<tr>
<td>AR</td>
<td>aortic regurgitation</td>
</tr>
<tr>
<td>ARDS</td>
<td>adult respiratory distress syndrome</td>
</tr>
<tr>
<td>ARF</td>
<td>acute renal failure</td>
</tr>
<tr>
<td>AROM</td>
<td>artificial rupture of membranes; active range of motion</td>
</tr>
<tr>
<td>AS</td>
<td>aortic stenosis</td>
</tr>
<tr>
<td>ASA</td>
<td>acetylsalicyclic acid (aspirin)</td>
</tr>
<tr>
<td>ASAP</td>
<td>as soon as possible</td>
</tr>
<tr>
<td>ASD</td>
<td>atrial septal defect</td>
</tr>
<tr>
<td>ATN</td>
<td>acute tubular necrosis</td>
</tr>
<tr>
<td>AXR</td>
<td>abdominal x-ray</td>
</tr>
<tr>
<td>BAL</td>
<td>bronchoalveolar lavage</td>
</tr>
<tr>
<td>BID</td>
<td>twice per day</td>
</tr>
<tr>
<td>B/L</td>
<td>bilateral</td>
</tr>
<tr>
<td>BRRPR</td>
<td>bright red blood per rectum</td>
</tr>
<tr>
<td>Bx</td>
<td>biopsy</td>
</tr>
<tr>
<td>CA</td>
<td>cancer</td>
</tr>
<tr>
<td>CABG</td>
<td>coronary artery bypass</td>
</tr>
<tr>
<td>CAP</td>
<td>community acquired pneumonia</td>
</tr>
<tr>
<td>c/b</td>
<td>complicated by</td>
</tr>
<tr>
<td>C/D/I</td>
<td>clean/dry/intact (in regard to incisions)</td>
</tr>
<tr>
<td>CHF</td>
<td>congestive heart failure</td>
</tr>
<tr>
<td>CBS</td>
<td>carcinoma in situ</td>
</tr>
<tr>
<td>CKD</td>
<td>chronic kidney disease</td>
</tr>
<tr>
<td>CM</td>
<td>costal margin or cardiomegaly</td>
</tr>
<tr>
<td>CMV</td>
<td>cytomegalovirus</td>
</tr>
<tr>
<td>CN</td>
<td>cranial nerve</td>
</tr>
<tr>
<td>c/o</td>
<td>complaints of</td>
</tr>
<tr>
<td>coag</td>
<td>coagulation factors (tested with PT/PTT)</td>
</tr>
<tr>
<td>COPD</td>
<td>chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>CP</td>
<td>chest pain or cerebral palsy</td>
</tr>
<tr>
<td>CPAP</td>
<td>continuous positive airway pressure</td>
</tr>
<tr>
<td>CS</td>
<td>chemstrips (measures serum glucose)</td>
</tr>
<tr>
<td>CSF</td>
<td>cerebrospinal fluid</td>
</tr>
<tr>
<td>CSOM</td>
<td>chronic suppurative otitis media</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>CT</td>
<td>computerized tomography (CT scan)</td>
</tr>
<tr>
<td>CTA</td>
<td>computerized tomography-angiography (CT angiogram)</td>
</tr>
<tr>
<td>CV</td>
<td>cardiovascular</td>
</tr>
<tr>
<td>CVA</td>
<td>cerebrovascular accident (stroke)</td>
</tr>
<tr>
<td>CVAT</td>
<td>costovertebral angle tenderness</td>
</tr>
<tr>
<td>CVP</td>
<td>central venous pressure</td>
</tr>
<tr>
<td>c/u</td>
<td>consistent with</td>
</tr>
<tr>
<td>Cs</td>
<td>culture</td>
</tr>
<tr>
<td>CXR</td>
<td>chest x-ray</td>
</tr>
<tr>
<td>D5</td>
<td>5% dextrose in saline solution</td>
</tr>
<tr>
<td>D5LR</td>
<td>5% dextrose in lactated Ringer's solution</td>
</tr>
<tr>
<td>D5W</td>
<td>5% dextrose in water</td>
</tr>
<tr>
<td>D+C</td>
<td>dilatation and curettage</td>
</tr>
<tr>
<td>D/C</td>
<td>discontinue or discharge</td>
</tr>
<tr>
<td>DCG</td>
<td>Department of Children and Family Services</td>
</tr>
<tr>
<td>D+E</td>
<td>dilatation and evacuation</td>
</tr>
<tr>
<td>DI</td>
<td>diabetes insipidus</td>
</tr>
<tr>
<td>DIC</td>
<td>disseminated intravascular coagulation</td>
</tr>
<tr>
<td>DKA</td>
<td>diabetic ketoacidosis</td>
</tr>
<tr>
<td>DM</td>
<td>diabetes mellitus</td>
</tr>
<tr>
<td>DNR</td>
<td>do not resuscitate (supportive measures only)</td>
</tr>
<tr>
<td>DOE</td>
<td>diaphragm on exertion</td>
</tr>
<tr>
<td>DM</td>
<td>diabetes mellitus</td>
</tr>
<tr>
<td>DP</td>
<td>dorsalis pedis artery</td>
</tr>
<tr>
<td>DPT</td>
<td>diphtheria, pertussis, tetanus immunization</td>
</tr>
<tr>
<td>DTs</td>
<td>delirium tremens</td>
</tr>
<tr>
<td>DTR</td>
<td>deep tendon reflexes</td>
</tr>
<tr>
<td>DUB</td>
<td>dysfunctional uterine bleeding</td>
</tr>
<tr>
<td>DVT</td>
<td>deep vein thrombosis</td>
</tr>
<tr>
<td>Dx</td>
<td>diagnosis</td>
</tr>
<tr>
<td>EBL</td>
<td>estimated blood loss</td>
</tr>
<tr>
<td>ECT</td>
<td>electroconvulsive therapy</td>
</tr>
<tr>
<td>ECG</td>
<td>electrocardiogram</td>
</tr>
<tr>
<td>ED</td>
<td>estimated date of confinement (referring to pregnancy)</td>
</tr>
<tr>
<td>EEC</td>
<td>electronencephalogram</td>
</tr>
<tr>
<td>EFM</td>
<td>external fetal monitor</td>
</tr>
<tr>
<td>EPW</td>
<td>estimated fetal weight</td>
</tr>
<tr>
<td>EGD</td>
<td>esophagogastroduodenoscopy</td>
</tr>
<tr>
<td>EKG</td>
<td>electrocardiogram</td>
</tr>
<tr>
<td>ELISA</td>
<td>enzyme-linked immunosorbent assay</td>
</tr>
<tr>
<td>EMG</td>
<td>electromyogram</td>
</tr>
<tr>
<td>ENT</td>
<td>ear, nose, and throat</td>
</tr>
<tr>
<td>EOM</td>
<td>extracranial movements</td>
</tr>
<tr>
<td>EOMI</td>
<td>extracranial movements intact</td>
</tr>
<tr>
<td>EPS</td>
<td>electrophysiological study/services</td>
</tr>
<tr>
<td>ERCP</td>
<td>endoscopic retrograde cholangiopancreatogram</td>
</tr>
<tr>
<td>ESRD</td>
<td>end stage renal disease</td>
</tr>
<tr>
<td>ESRR</td>
<td>esrhythmofterestivation rate</td>
</tr>
<tr>
<td>ESWL</td>
<td>extracorporeal shock wave lithotripsy</td>
</tr>
<tr>
<td>ETT</td>
<td>endotracheal tube</td>
</tr>
<tr>
<td>EXT</td>
<td>extremities</td>
</tr>
<tr>
<td>FB</td>
<td>foreign body</td>
</tr>
<tr>
<td>FBS</td>
<td>fasting blood sugar</td>
</tr>
<tr>
<td>F/Us</td>
<td>fevers/chills/sweats</td>
</tr>
<tr>
<td>FDP</td>
<td>fibrin degradation products (same as FSP)</td>
</tr>
<tr>
<td>FDLMP</td>
<td>first day last menstrual period</td>
</tr>
<tr>
<td>FEN</td>
<td>fluids, electrolytes, and nutrition</td>
</tr>
<tr>
<td>FFP</td>
<td>fresh frozen plasma</td>
</tr>
<tr>
<td>FLK</td>
<td>funny looking kid (<strong>not very professional</strong>)</td>
</tr>
<tr>
<td>FMI</td>
<td>face mask</td>
</tr>
<tr>
<td>FNA</td>
<td>fine needle aspiration</td>
</tr>
<tr>
<td>FOB</td>
<td>foot of bed</td>
</tr>
<tr>
<td>FOPP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>FSH</td>
<td>follicle stimulating hormone</td>
</tr>
<tr>
<td>FSP</td>
<td>fibrin split products (same as FDP)</td>
</tr>
<tr>
<td>FTA-Ah</td>
<td>fluorescent treponemal antibody absorption</td>
</tr>
<tr>
<td>FTT</td>
<td>failure to thrive</td>
</tr>
<tr>
<td>f/u</td>
<td>follow up</td>
</tr>
<tr>
<td>FUD</td>
<td>fever of unknown duration</td>
</tr>
<tr>
<td>Fx</td>
<td>fracture</td>
</tr>
<tr>
<td>gb</td>
<td>gallbladder</td>
</tr>
<tr>
<td>GMB</td>
<td>glioblastoma multiforme</td>
</tr>
<tr>
<td>GC</td>
<td>gonococcus</td>
</tr>
<tr>
<td>GDM</td>
<td>gestational diabetes mellitus</td>
</tr>
<tr>
<td>GERD</td>
<td>gastroesophageal reflux disease</td>
</tr>
<tr>
<td>GGO</td>
<td>ground glass opacity</td>
</tr>
<tr>
<td>GI</td>
<td>gastrointestinal, gastroenterology</td>
</tr>
<tr>
<td>g/m%</td>
<td>grams per hundred milliliters of serum</td>
</tr>
<tr>
<td>GNB</td>
<td>gram-negative bacilli</td>
</tr>
<tr>
<td>GOTT</td>
<td>general oral endotracheal tube</td>
</tr>
<tr>
<td>GP</td>
<td>gravidity (# pregnancies), parity (# births categorized as TPAL - term, preterm, abortions, living children)</td>
</tr>
<tr>
<td>GPC</td>
<td>gram-positive cocci</td>
</tr>
<tr>
<td>GSTW</td>
<td>gunshot wound</td>
</tr>
<tr>
<td>gt. or gtt.</td>
<td>drop or drops (Latin: gutta)</td>
</tr>
<tr>
<td>GTT</td>
<td>glucose tolerance test</td>
</tr>
<tr>
<td>GU</td>
<td>genitourinary</td>
</tr>
<tr>
<td>GYN</td>
<td>gynecology</td>
</tr>
<tr>
<td>HA or h/a</td>
<td>headache</td>
</tr>
<tr>
<td>HAL</td>
<td>hyperalimentation</td>
</tr>
<tr>
<td>HAV</td>
<td>hepatitis A virus</td>
</tr>
<tr>
<td>Hb</td>
<td>hemoglobin</td>
</tr>
<tr>
<td>HBV</td>
<td>Hepatitis B virus</td>
</tr>
<tr>
<td>HCG</td>
<td>human chorionic gonadotropin</td>
</tr>
<tr>
<td>Hct</td>
<td>hematocrit</td>
</tr>
<tr>
<td>HD</td>
<td>hemodialysis; hospital day (followed by a number)</td>
</tr>
<tr>
<td>HDSS</td>
<td>hemodynamically stable</td>
</tr>
<tr>
<td>HEENT</td>
<td>head, ears, nose, throat</td>
</tr>
<tr>
<td>HEU</td>
<td>Health Evaluation Unit (the VA's ER)</td>
</tr>
<tr>
<td>Hg/h</td>
<td>hemoglobin</td>
</tr>
<tr>
<td>Hmg/h</td>
<td>hemoglobin/hematocrit</td>
</tr>
<tr>
<td>HJT</td>
<td>heparin-induced thrombocytopenia</td>
</tr>
<tr>
<td>H-j</td>
<td>Hepatitis J virus</td>
</tr>
<tr>
<td>HL</td>
<td>hyperlipidemia</td>
</tr>
<tr>
<td>h/o</td>
<td>history of</td>
</tr>
<tr>
<td>H/O</td>
<td>hospital of</td>
</tr>
<tr>
<td>H.O.</td>
<td>house officer</td>
</tr>
<tr>
<td>HOB</td>
<td>head of bed</td>
</tr>
<tr>
<td>HOP</td>
<td>hard of hearing</td>
</tr>
<tr>
<td>hpf</td>
<td>high power field (referring to microscope)</td>
</tr>
<tr>
<td>HPI</td>
<td>history of present illness</td>
</tr>
</tbody>
</table>
PDR  Physician's Desk Reference
PE  physical examination; pulmonary embolus
PEEP  positive end expiratory pressure
PERL  pupils equal and react to light
PERLs  pupils equal, round, and reactive to light and accommodation
PFC  persistent fetal circulation
PFT  pulmonary function tests
PG  prostaglandins
PHx  past history
PID  pelvic inflammatory disease
PKU  phenylketonuria
Ph  platelets
PM  primary care physician
PMH  past medical history
PMP  postmenopausal
PMI  point of maximum impulse (referring to heart)
PMNs  polymorphonuclear leukocytes
PM&R  Physical Medicine & Rehabilitation
PND  paroxysmal nocturnal dyspnea
P.O.  by mouth (Latin: per os)
POD  postoperative day (followed by a number)
polys  polymorphonuclear leukocytes
post-op  post-operative
PP  post-partum
PPTL  post-partum tubal ligation
PFD  purified protein derivative (for tuberculin test)
.q  per rectum (suppository)
PRBC's  packed red blood cells
prn  when necessary (Latin: pro re nata)
ROM  range of motion
PM&R  Physical Medicine & Rehabilitation
PNUT  paroxysmal uncontrolled tachycardia
PROM  premature rupture of membrane or passive range of motion
PSH  past surgical history
PSVT  paroxysmal supraventricular tachycardia
pH  patient
PT  prothrombin time; posterior tibial artery; physical therapy
PTA  prior to admission
PTCA  percutaneous transluminal coronary angioplasty
PTH  parathyroid hormone
PTT  partial thromboplastin time
PUD  peptic ulcer disease
PVC  premature ventricular contraction
PVD  peripheral vascular disease
PWH  Prentice Women's Hospital
q  every (Latin: quaque)
qAM  every morning
qhs  at hour of sleep
qid  four times per day
qMWF  every Monday, Wednesday, and Friday
qod  every other day
R  right
RA  rheumatoid arthritis
RAI  radioactive iodine
Rx  prescription, treatment, or therapy
S1S2  first and second heart sounds
SBE  subacute bacterial endocarditis
SBFT  small bowel follow-through
SH  social history
SICU  surgical intensive care unit
SL  sublingual (e.g. for nitroglycerin)
SLE  systemic lupus erythematosus
SOB  shortness of breath
SOM  somatic otitis media
s.p.  status post
SP  speech pathology
sq  specific gravity
SQ  subcutaneous
SROM  spontaneous rupture of membranes
SSCP  substernal chest pain
STAT  immediately (Latin: statim)
SVT  supraventricular tachycardia
T  temperature
T3  triiodothyronine
T4  thyroxine
T4-RU  triiodothyronine resin uptake
TSH  thyroid stimulating hormone
THA  transient hypothyroidism
THP  thiazide diuretics
THV  right ventricular hyperthrophy
TM  thoracotomy
TMJ  temporomandibular joint
TMT  transmembrane transport
TNA  total parenteral nutrition
TV  tracheostomy
UCC  urine cortisol
UDL  upper digestive lumen
UC  upper cutaneous
UGI  upper gastrointestinal
UNIT  unit of measure
UO  urinalysis
UPE  upper pulmonary embolus
UPV  upper peripheral vascular disease
UR  urinalysis
USG  ultrasonogram
USP  United States Pharmacopeia
USP  universal surgical plane
USU  useful surgical unit
UPS  upper part of spine
URCA  upper respiratory tract infection
V  volume
V3V4  upper chest leads
VAR  variance
VCM  ventriculocerebral mass
VM  ventral midline
VMS  voluntary muscle spasm
WBC  white blood cells
WNL  within normal limits
WNP  women's night program
WPW  Wolff-Parkinson-White syndrome
XS  xiphoid process
Xr  x-ray
XRT  x-ray therapy
Xylo  xylazine
XyL  xylocaine
Y  year
Y-IRBI  Y-iodinated radiopharmaceutical
Y-IRI  Y-iodinated radiopharmaceutical
YBO  Yielding bone oil
YCT  yellow card
YR  yellow rubber
YRBA  yellow rubber bag application
YRBS  yellow rubber bag suction
YRLV  yellow rubber lung
YSO  yellow sodium obturator
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>T4</td>
<td>serum thyroxine</td>
</tr>
<tr>
<td>T+A</td>
<td>tonsillectomy and adenoidectomy</td>
</tr>
<tr>
<td>tab</td>
<td>tablet (Latin: tabella)</td>
</tr>
<tr>
<td>TAH-BSO</td>
<td>total abdominal hysterectomy with bilateral salpingo-oophorectomy</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis (think isolation)</td>
</tr>
<tr>
<td>TBG</td>
<td>thyroxine binding globulin</td>
</tr>
<tr>
<td>TBSA</td>
<td>total body surface area</td>
</tr>
<tr>
<td>T+C</td>
<td>type and crossmatch</td>
</tr>
<tr>
<td>TCA</td>
<td>tricyclic antidepressant</td>
</tr>
<tr>
<td>TED</td>
<td>thromboembolic device</td>
</tr>
<tr>
<td>TENS</td>
<td>transcutaneous electrical nerve stimulator</td>
</tr>
<tr>
<td>TFT</td>
<td>thyroid function tests</td>
</tr>
<tr>
<td>TIA</td>
<td>transient ischemic attack</td>
</tr>
<tr>
<td>tid</td>
<td>three times a day (Latin: ter in die)</td>
</tr>
<tr>
<td>TKO</td>
<td>to keep open (referring to IV rates)</td>
</tr>
<tr>
<td>TL</td>
<td>tubal ligation</td>
</tr>
<tr>
<td>TLC</td>
<td>therapeutic lifestyle change</td>
</tr>
<tr>
<td>TM</td>
<td>tympanic membrane</td>
</tr>
<tr>
<td>TMJ</td>
<td>temporal mandibular joint</td>
</tr>
<tr>
<td>TOA</td>
<td>tubal ovarian abscess</td>
</tr>
<tr>
<td>TORCH</td>
<td>toxoplasmosis, other (syphilis), rubella, CMV, herpes</td>
</tr>
<tr>
<td>TPA</td>
<td>tissue plasminogen activator</td>
</tr>
<tr>
<td>TPN</td>
<td>total parenteral nutrition</td>
</tr>
<tr>
<td>T+S</td>
<td>type and screen</td>
</tr>
<tr>
<td>TSH</td>
<td>thyroid stimulating hormone</td>
</tr>
<tr>
<td>TTP</td>
<td>thrombotic thromboembolic purpura</td>
</tr>
<tr>
<td>TUR</td>
<td>transurethral resection</td>
</tr>
<tr>
<td>TURP</td>
<td>transurethral resection of the prostate</td>
</tr>
<tr>
<td>Tx</td>
<td>treatment</td>
</tr>
<tr>
<td>UA or U/A</td>
<td>urinalysis</td>
</tr>
<tr>
<td>UE</td>
<td>upper extremity (arm)</td>
</tr>
<tr>
<td>U/O</td>
<td>urine output</td>
</tr>
<tr>
<td>URI</td>
<td>upper respiratory infection</td>
</tr>
<tr>
<td>U/S</td>
<td>ultrasound</td>
</tr>
<tr>
<td>UTC</td>
<td>up to chair (referring to activity)</td>
</tr>
<tr>
<td>UTI</td>
<td>urinary tract infection</td>
</tr>
<tr>
<td>VAB</td>
<td>Veterans Administration</td>
</tr>
<tr>
<td>VATS</td>
<td>video-assisted thoracoscopic surgery</td>
</tr>
<tr>
<td>VDRL</td>
<td>serologic syphilis test</td>
</tr>
<tr>
<td>VF</td>
<td>visual field</td>
</tr>
<tr>
<td>VFFTC</td>
<td>visual field full to confrontation</td>
</tr>
<tr>
<td>Vfib</td>
<td>ventricular fibillation</td>
</tr>
<tr>
<td>VNA</td>
<td>Visiting Nurse Association</td>
</tr>
<tr>
<td>V/Q</td>
<td>ventilation/perfusion</td>
</tr>
<tr>
<td>VRE</td>
<td>vancomycin-resistant enterococcus (think isolation)</td>
</tr>
<tr>
<td>VS</td>
<td>vital signs</td>
</tr>
<tr>
<td>VSD</td>
<td>ventricular septal defect</td>
</tr>
<tr>
<td>VSS</td>
<td>vital signs stable</td>
</tr>
<tr>
<td>VT</td>
<td>ventricular tachycardia</td>
</tr>
<tr>
<td>V-tach</td>
<td>ventricular tachycardia</td>
</tr>
<tr>
<td>WBC</td>
<td>white blood count</td>
</tr>
<tr>
<td>WDWN</td>
<td>well developed, well nourished</td>
</tr>
<tr>
<td>WNL</td>
<td>within normal limits</td>
</tr>
<tr>
<td>w/c</td>
<td>wheelchair</td>
</tr>
<tr>
<td>w/e/e</td>
<td>warmth/erythema/edema (on extremities exam)</td>
</tr>
<tr>
<td>W/E</td>
<td>work up</td>
</tr>
<tr>
<td>XRT</td>
<td>radiation therapy</td>
</tr>
<tr>
<td>ZE</td>
<td>Zollinger-Ellison</td>
</tr>
</tbody>
</table>
**Hospital Slang (we don’t condone using some of these)**

**Bounceback** – after a discharge, the patient is re-admitted back to your service

**Crumping/Crashing** – patient condition suddenly deteriorates. May also be a noun:
“Did you hear about the crump on the 12th floor?”

**COW** – computer on wheels

**Curbside** – getting a specialist’s opinion without a formal consult

**To “gas” someone** – to draw an ABG on them

**Getting burned** – any future problems with a patient that you should have been able to prevent

**Getting numbers** – writing down vitals, I/O’s and labs for overnight patients, usually in the surgery rotation

**Laying some eyes** – checking up on your patient without spending much time talking to them

**Prerounding** – getting vital/labs/test results, then doing a brief overnight history and PE before “rounds”

**PIMPed** – Put In My Place

**Rescue page** – sending a pretend page to somebody to ‘rescue’ them out of an arduous task

**Run the list (RTL)** – going through the list of patients on your service, updating everyone on new information

**Scut work** – the work that no one wants to do; usually the work of the third year med student (just kidding; Abuse Policy Violated...)

**Sign out** – done at the end of the shift, passing pertinent information to the overnight team

**Snowed/Snowballed** – receiving too much narcotics or benzos, leaving the patient in an altered state

**Tuck’em in** – checking on your patients before you leave for the day

**Update the list** – filling in the pertinent info from the day, or adding new patients to the list; sometimes AdHoc in Powerchart, sometimes an excel file on the NMH server

**Zebras** – rare and/or obscure diseases
NMH Helpful Phone Numbers

All numbers starting with a 5; outside line is 312-695-xxxx
All numbers starting with a 6; outside line is 312-926-xxxx

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

General
Cardiac arrest: 5-5555
LISTEN to dictations: 6-1199
EPIC helpdesk: 5-HELP

Patient Services
Case Management: 6-2272
Social Work: 6-2060
PT: 3229
OT: 6-2526

Pharmacy
Analgesic Dosing Service:
5-7246 (pager), 6-3382 (office)
Anticoagulation Dosing Service:
5-6548, 6-8670 (office)

Clinic
NMFF GMC: 5-8630
GMC resident line: 5-8211
Physician Referral Svcs: 6-8400
Direct Admission PTC: 5-4600

Imaging Locations
Echo Reading – Rm 8-216
XR Viewing – Rm 4-328
CT Body Viewing – Rm 4-546
MR Viewing – Rm 4-525
Nuclear Cardiology – 8-140
** After 5PM, go to ED viewing to review
films with radiologists

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
After hours Reading 1st Fl 6-7038
Cardiac Cath 8th Fl 6-5135
Cardiac Stress 8th Fl 6-7486
CT ordering/protocol 4th Fl 6-5314
CT Body Reading 4th Fl 6-5894
CT Head Reading 4th Fl
ECHO/Nuclear Cardio 8th Fl 6-2629
General Radiology 4th Fl 6-5150
Interventional Radiology 4th Fl 6-5200
MR Protocol/Read Triage 4th Fl 6-4333
MR Fax 6-6452
Nuclear 6-2320
Ultrasound ordering 4th Fl 6-7032
Ultrasound Reading 4th Fl 6-2761
Vascular 8th Floor 6-2746

Labs
Specimen Receiving 7th Fl 6-7970
ABG 8th Fl 6-5174
Autopsy Olson 6-3212
Blood Bank 7th Fl 6-2513
Chemistry 7th Fl 6-7536
Cytopathology 7th Fl 6-7008
Flow Cytometry 7th Fl 6-7360
Heme/Cell Count 7th Fl 6-3200
Hemostasis 7th Fl 6-2428
Micro 7th Fl 6-3202
Specimen receiving: 6-7970
Surgical Path: 6-3211
Pathology 7th Fl
Send Out 7th Fl 6-1200
**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

**Psych**
Chem Dep Inpt Consult: 6-8411
Psych Consult: 6-8411

**GI/Renal**
GI Lab: 6-2425
Dialysis (inpatient): 6-1696

**Miscellaneous**
Ethics consult: 5-ETHX (5-3849)
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
15 E Nursing Station: 6-2362
15 W Nursing Station: 6-3099
MICU 9E: 6-5140
CCU 8E: 6-5172
OR desk: 6-5150/6
Pharmacy: 6-2552
ER 1st Fl: 6-4588
Dialysis 9th Fl: 6-1696

**Available Consults By Web Paging**
Allergy/Immunology
Anesthesia
Cardiology – Floor Consults
Cardiology ICU Consults – CCU Fellow
Cardiology – EP/Heart Failure/ Cath Separate
Cardiac Surgery
Dermatology
Endocrine
ENT
Ethics
General Surgery
GI – Gen or Interventional
Heme/Onc – Benign or Malignant
Heme/Onc – ER/Transfer/Triage
Hepatology
Hospitalist
Infectious Disease – Med/Neuro
ID – Surg/HemeOnc
ID – Transplant
IR MD on-call – (Emergencies)
Neurology
Neurosurgery
Orthopedic Surgery
Pain Service (Anesthesia - Interventional)
Palliative Care (End of Life and Analgesic C/S)
Plastic Surgery
Pulmonary
Pulmonary HTN
Rad Oncology (Emergencies only)
Nephrology – Acute, Chronic, Transplant
Rheumatology
Thoracic Surgery
Urology
Vascular Surgery

**Handouts with Lurie Children’s and VA phone numbers will be given to you at each specific hospital.**

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