

3rd Year Tips

Adam and Mandy Gleason

Typical Day on the Floor

- Pre-Rounding
 - When starting a rotation, give yourself at least 45 min - 1 hour per patient, before the start of rounding
 - adjust time as needed
 - It is MUCH better to only carry 1 or 2 patients and nail it, than to spread yourself thin with 3+ (you'll practice pt volume on your AI)
- Rounding (~8:00AM-12:00PM)
- Noon Lecture (12:00PM-1:00PM)
- Work time (1:00-Signout)
 - Writing notes
 - Helping Intern
 - Admitting New Patients
 - Attending/Resident Education
 - Go Home (can be as early as 4:00PM or as late as 11:00PM)

Pre-Rounding

- Get off the elevator and head to work room/area
- Use EMR/paper chart to check vitals, ins & outs (I&Os), labs, imaging, consult notes, etc for each of your patients
 - Record these on your “blank sheet”
- Talk to nurse, talk to pt, examine pt
- Fill in the rest of your “blank sheet”
 - Focus on creating an amazing tagline and assessment/plan
- **Check in with intern/senior to verify plan before rounds**

Don't go see a patient without a blank sheet of paper

ID:

Hosp Day:

Subjective:

Yesterday:

OverNight:

Objective:

PE: vitals:

CV:

Lungs:

(etc)

Labs: --/--/--< >-----<

Imaging:

Assessment:

Plan:

1)

2)

3)

Don't go see a patient without a blank sheet of paper

ID Statement: Mr. ___ is a ___ y/o man with (*relevant medical history*) who was admitted ___ days ago for (*reason of admission*) and (*found to have*) or (*has been treated with _____ in order to _____*)

-----Space for Updates (biopsy results, imaging findings, etc) -----

Subjective: *Write down what you want to ask the patient/nurse*

Objective:

Physical Exam: *Write down what systems you want to check*

Labs: ---/---/---< >-----<

- *Remember, if it was pressing you wouldn't wait until labs to say it*
- *Include trends from admission/yesterday if team is concerned with a particular value*

Imaging:

- *Summarize findings from radiology report. Don't say the report word-for-word.*

Don't go see a patient with a blank sheet of paper

Summary:

- *often can just say a shortened version of "Mr. ___ is a...", as above.*
- *Include update on current status, eg. "doing well after being weaned off O2"*

Plan

1. Problem 1 (*Usually why they were admitted*)

- *Give an assessment statement about the current state of this problem*
 - *eg. "Problem 1 is hypercalcemia. His calcium is now in the normal range"*

PLAN: say what you want to continue doing, and what you want to change/add

2. Problem 2 (*often times, these problems are chronic problems (like diabetes or HTN) that require hospital administration of meds*)

PLAN:

3. Disposition (*when/where is the patient going when they leave the hospital (home vs. SNF) and what needs to happen in the hospital before he/she can be discharged*)

PLAN:

Don't go see a patient without a blank sheet of paper

ID:

Hosp Day:

Subjective:

Yesterday:

OverNight:

Objective:

PE: vitals:

CV:

Lungs:

(etc)

Labs: --/--/--< >-----<

Imaging:

Assessment:

Plan:

1)

2)

3)

The Presentation

- *When is it given?*
 - *To the attending and team on rounds in the morning*
- *What is my goal?*
 - Clear, Concise, **argument**
- How much does the attending want to know?
 - Only what you feel is pertinent to this hospitalization. Better to have the attending ask if they have more questions and you can explain then
 - For example, don't go on about a patient's background of gout if they are admitted for COPD exacerbation
- Why does my attending look bored/frustrated/angry?
 - You didn't say your **hook sentence (tagline)** clearly and confidently

Presenting: New Admission H&P

- **TAGLINE**
- **HPI**
 - Past Medical History
 - Past Surgical History
 - Medications/Allergies
 - Physical Exam findings
 - Labs obtained
 - Imaging obtained
- **Summary**
- **Assessment**
- **Plan**

Breaking Down the Presentation

Tagline

- do not include the full PMH/PSH in the intro sentence for complicated patients, just the history pertinent to this hospitalization. You can briefly mention other history later.
- you should include dates of diagnosis/surgeries (eg. “with history of aortic stenosis, status-post valve replacement in 2006”), or severity of the problem (eg. “with CHF with ejection fraction of 35%”)
- *Template:* Mrs. _____ is a _____ year old woman with (relevant PMH, PSH) who presented to the ED/her PCP with (chief complaint: put it in the patient’s words/layman’s terms) for _____ hours/days/weeks.
- *Example:* “Mrs. B is a 34 year old woman with PMH significant for asthma, diagnosed at age 9, and which is well-controlled with albuterol inhaler as needed for symptoms. She presented to the UH ED yesterday with worsening cough and shortness of breath for 1 day.”

Breaking Down the Presentation

HPI

- Chronological story that includes background chronic diseases and leads the listener to current moment
- Should push the listener towards the diagnoses you are considering. Leave out background information that does not relate to your differential
- Include relevant positive and negative ROS, risk factors and social history here, family history, (that either support or don't support the diagnoses in your differential) not later in a separate section. Unlike your H&P note, do not present your ROS as a separate section

Breaking Down the Presentation

HPI Template:

- **1. What is the chief complaint?**
 - “The (chief complaint) started when”... OR “the patient was in her normal state of health until...”
- **2. Why did the patient seek medical help?**
 - “The problem worsened/did not resolve/etc so she went to the ED/her PCP.”
- **3. ED course:**
 - “In the ED...patient was tachypnic to 40, sating 86% on room air. Patient was placed on 2L O2 via nasal cannula but sats remained below 90%. CXR was unremarkable. Patient was transferred to the floor for further management.”
- **4. What was done when the patient arrived on the floor?**
 - “On the floor...patient was weaned to 1L O2 and was placed on the asthma care path.”
- **5. What state is the patient in now?**
 - “Overnight...patient did well with no complaints. She states that her breathing is much improved and feels like the albuterol treatments really helped.”

The Hard Part of the HPI

- Hard part = converting the story from the patients words to how you would want to hear it as an attending
 - **Example:** a patient may recount that “On Monday I felt short of breath while watching Oprah, then started coughing an hour later. I used my inhaler which made me feel a little better but then I felt short of breath again that evening. I used my inhaler 3 more times. I called my sister and she brought me to the emergency room the next morning...”
 - **Your translation:** “She was in her normal state of health until 1 day prior to admission when she experienced shortness of breath and dry cough while at rest. She tried using her albuterol inhaler four times, without relief, so she came to the ED yesterday morning...”

Breaking Down the Presentation

PMH/PSH/meds not related to presenting problem

- Some attendings will want to “hear everything” and some will rush you through this part. Tailor accordingly
- If you mention a disease, state its severity and what meds/interventions they’ve had for it right afterwards. It’s much cleaner than separate PMH and meds list
- Remember, any pertinent family and social history went into your HPI. Do not repeat it again
 - “The patient’s PMH also includes...Type 2 diabetes for which she takes metformin. Her A1c was 7.2, taken 2 months ago. PSH only includes shoulder surgery in 2009, which is non-contributory. Medications include metformin twice daily, and albuterol inhaler as needed for asthma symptoms. Social history and family history are non-contributory”

Physical Exam

- Always state morning VITALS, general appearance, and pertinent systems related to complaint (ie lungs for asthma)
- Some attendings like you to state your morning CV and lung exams for every patient
- If a system is unremarkable, it is ok to say so. Save the “CTAB, w/r/r” for your note

Breaking Down the Presentation

Labs

- write them all down (in case you get asked), only say which ones apply to your patient
- note trends since admission, where relevant (e.g. Na of __, down from __ yesterday)
- know a patient's baseline lab values if you're going to report that something is high or low
 - "For labs...BMP is remarkable for BUN of ___ and Cr of ___. Her baseline is around ___ and ___ respectively. Sputum culture was sent, results are pending."

Imaging

- summarize imaging findings for this hospitalization based on the rads report. Don't read the whole report to the attending
- also describe old comparison images, if relevant (ie. If there is a mass noted on CXR, check for old images to see if the mass is new or changing)
 - "CXR shows only perihilar peribronchial thickening. No focal consolidation is present."

Breaking Down the Presentation

Summary and Assessment

- *Template:*
 - So in summary, this is a ___ year old ___ who presented with ____. (summarize current state and current interventions). On Assessment, the patient's presentation is most consistent with a diagnosis of _____, but _____ and _____ are also possible. The most likely diagnosis is _____ given that _____, _____, and _____. It is also possible that the diagnosis is _____ or _____ given _____, but these are less likely given _____.
- *Example:*
 - “So in summary, this is a 34 year old woman who presented with cough and shortness of breath for 1 day, currently stable on 1L O2 and with sputum culture pending. Since admission, her O2 saturation has improved to the high 90s and she denies shortness of breath. Her presentation is most consistent with asthma exacerbation, but pneumonia and bronchitis are also possible. Asthma exacerbation is most likely, given her long history of asthma, and recent exposure to mold and tobacco smoke. Pneumonia is possible, given.... But....”

Breaking Down the Presentation

Plan

- Always have some plan. There is almost always a change that should be made to a patient's plan every day.
- Keep in mind what needs to be done to discharge the patient! This is always on the attending's mind
- the main reason a patient is in the hospital is because he/she needs oxygen, an IV, or may crash. If your patient don't need these things, get them out of the hospital and finish the workup as an outpatient
- when stating your plan, say "I want to..." or "we should...". Attendings hate when med students/residents waffle and say "I think that maybe we should..."
 - *Template:*
 - For my plan, I **want to address** 3 problems. Her first problem is _____, and I want to do/order _____, _____, and _____. Her second problem is _____ so I've ordered _____. Finally, her third problem is _____ and I want to _____.
 - *Example:*
 - "For my plan, I want to address 3 problems. Her first problem is asthma exacerbation, for which I want to continue the asthma care path, try weaning her off of oxygen this afternoon, and order a consultation with the hospital asthma educator before discharge so that she can learn ways to limit exposure to asthma triggers. Her second problem is diabetes, for which she is getting a diabetic diet and sliding-scale insulin dosing. If we are able to wean her off oxygen and her sats remain in the high 90s, we should consider discharge this afternoon."

Disclaimer: The asthma workup in this document was written quickly and incompletely, and should in no way be used as a template for how to work up an asthma patient in real life!

Presenting: New Admission

- **TAGLINE**
- **HPI**
 - Past Medical History
 - Past Surgical History
 - Medications/Allergies
 - Physical Exam findings
 - Labs obtained
 - Imaging obtained
- **Summary**
- **Assessment**
- **Plan**

Presenting: SOAP

- TAGLINE
- What's New
 - labs, biopsy results you've been waiting on, etc
- What Happened yesterday/overnight
 - Per patient/EMR/nursing, as needed
- Physical exam findings
- Daily Labs/Imaging
- Summary
- Plan

Studying at home

- Study diseases your patients have (**your attending will expect you to know information cold**), if you are comfortable with this information then study other topics for Shelf
- Attending favorites for patient pimping
 - Stages of disease (eg. gold stages for COPD)
 - Criteria (eg. Well's criteria for DVT/PE)
 - Pathophysiology and how medications alter it (Why are we giving the patient this medication?)

Shelf Study Materials

- Core 1
 - Internal Medicine
 - UWORLD Step 2
 - Step 2 Secrets
 - Step Up to Medicine
 - Great resource, tough to read cover to cover

DON'T use MKSAP. Too basic and costly.

- Family Medicine
 - Family Med module pdfs
 - The FM Shelf is based on the required modules. It is not given by NBME like the other Shelves
 - You can download summary pdfs after completing each family med module
 - Focus on studying OB/GYN/Peds. Everything else is covered by studying for IM Shelf except screening guidelines

Shelf Study Materials

- Core 2
 - Pediatrics
 - UWORLD Step 2
 - Step 2 secrets
 - +/- Pretest
 - Ob/Gyn
 - ACOG Guidelines!
 - You might have to ask a resident for access or Google the pdfs
 - UWORLD Step 2
 - Blueprints
 - For charts/tables/chapter summaries
 - Its lower yield to read it cover to cover
 - +/- Pretest

Shelf Study Materials

- Core 3
 - Neurology
 - UWORLD Step 2
 - +/- Pretest
 - Psychiatry
 - UWORLD Step 2
 - First Aid for Psych
 - +/- Pretest

Shelf Study Materials

- Core 4
 - Surgery
 - Pestana Surgery Notes
 - Find the free pdf online
 - Oral Exam study guides
 - UWORLD Step 2
 - also brush up on medicine questions!

DON'T use Pretest! It is riddled with errors.

What you need to bring to each rotation

For all rotations:

- Folding clipboard
 - <http://mdpocket.com/Clipboards/medical-clipboards-category/medical-clipboards>
 - Bright colors are best so you can spot them when you leave them lying around
- Stethoscope
- Kleenex-for a patient if they start crying
- Penlight
 - Disposable are best, you'll lose them
- Pens, highlighter
 - Many!

What you need to bring to each rotation

- Core 1
 - Internal Medicine
 - Neuro tools
 - Family Medicine
 - Child immunization schedule
 - Cards/papers with history questions on it
- Core 2
 - Pediatrics
 - List of normal vitals for each age range
 - List of milestones
 - Stuffed toy
 - Ob/Gyn
 - Pregnancy wheel
 - They'll give it to you on the first day

What you need to bring to each rotation

- Core 3
 - Neurology
 - Neuro tools
 - H&P interview sheet
 - Make your own using Bates
 - Psychiatry
 - H&P interview sheet
 - Make your own using Bates

What you need to bring to each rotation

- Core 4
 - Surgery
 - Surgical Recall book
 - Use before every OR case to tackle pimp questions
 - Buy a cheap messenger bag
 - Go to the supply room on the first day and load your bag with:
 - 4x4 gauze
 - Large gauze pads
 - Staple remover
 - Kerlix rolls
 - Bottle of saline
 - Scissors
 - Whatever else your patients may need
 - Replenish daily

CAS Feedback tips

- Ask Attending and Senior on first day for expectations on feedback
- Ask for oral feedback (weekly) and send CAS **that day**
- Explain CAS to the attending/resident when you submit it
 - “Hi Dr. Smith. Thanks for a great week and for your verbal feedback. I am not sure how familiar you are with CAS, but you will receive two evaluation forms from me. The system requires that you submit two forms before a third form is auto-generated. It is the third form that the clerkship director uses for grading. To make it easier, feel free to copy and paste your evaluation into all 3 forms.”

What questions do you have?