3rd Year Tips

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

ID:
HospDay:

Yesterday:
OverNight

PE: vitals:
CV:
Lungs:
(etc)

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1)
2)
3)

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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)----------

Write down what you want to ask the patient/nurse

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.*

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- *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”*

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:

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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

- 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

- 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

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
  - 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…”
  - “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

- *Template*

Breaking Down the Presentation

- Always have some plan. There is almost always a change that should be made to a patient's plan every day.
- Keep

Theasthma 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!

Studying at home

- Study diseases your patients have 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)

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 Shelfs
      - You can download summary pdfs after completing each family med module like the y NBME

Shelf Study Materials

- Core 2
  - Pediatrics
    - UWORLD Step 2
    - Step 2 secrets
    - +/- Pretest
  - Ob/Gyn
    - Pretes ÉÍé65,x– ,Ú¯¬ªÎÛ1×€9P)Tj E

Shelf Study Materials

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

What you need to bring to each rotation

For all rotations:

- Foldingclipboard

What you need to bring to each rotation

- Core 1
  - Internal Medicine
    - Neurotools
  - 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
    - Neurotools
    - 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
        - Kerlixrolls
        - 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?