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Dear Class of 2017,

I would like to start by welcoming you to the Wichita campus on behalf of the 2016 class. It has been a tough journey through the first two years and Step 1 but you have finally made it to the clinical years. I hope you will find your time in Wichita to be the most fruitful of your medical school career. This city has allowed us to expand our medical knowledge and hopefully, it can do the same for you.

Beginning with Introphase, this year will seem like an uphill battle. You have spent your time having all of the information taught to you and being able to review the podcast ad nauseam. Third year is more about interacting with actual patients and learning about the diseases that ail them. All the while you will have to find time to study other diseases and ready yourself for the shelf exams. Feel free to ask anyone around the school for advice as all of the fourth years will have been in your position.

Everyone asks me how to study for the Shelf test and how to get good grades. The best technique is to read about the diseases of your patients and understand the management of them. The required texts and UpToDate will give you adequate information but there will always be more on the internet. If you do this every day, you will have learned a great deal of information by the last day of the rotation. Questions are always your friend whether they are in a textbook or UWorld.

Here is some advice that will give you a solid foundation:

1. “If you are early, you are on time. If you are on time, you are late.” Remember these words for rounding, lectures, and surgeries. This will be your first sign of professionalism and many doctors start working earlier than what the time says.
2. Always dress professionally. If you do not know what it is, ask on your first day of the rotation. Bring your white coat, even when wearing scrubs. The best gauge is to dress like your attending.
3. Side note on your white coat: always keep it stocked. With pens, snacks, and a notebook. Everyone asks for a pen and often forget to give it back. Sometimes call or your shift may run late and a snack will come in handy. The notebook will be perfect for documenting patient information (while protecting PHI) and helping you remember what patients to log.
4. Always ask questions, but be prepared to look up an answer. The best idea is to first research your own question, then ask the attending if the question still remains. Many attendings will make your question a homework assignment if you show you have not looked into it. Reading UpToDate and the assigned texts will become your friend in this process.
5. Always check your email and texts. Many coordinators and ASA staff communicate by these manners and it will be essential to read these so you can keep on top of tasks. I would recommend a backup battery for your phone if yours likes to die quickly. No one wants to be on call with a dead phone and can’t receive pages.

Third year will be the most rewarding year, even if you may be anxious. It was designed to be challenging so you could learn information but you will also learn about the kind of doctor you want to be. The Class of 2016 is excited to have you here and would be willing to help with anything you need.

Sincerely,

Cole Gillenwater
President of the Class of 2016, KUSOM-Wichita
# Phone Numbers and General Information

**Academic and Student Affairs**

**Phone: 293-2603**

Garold O. Minns, MD, Dean of KUSM-W and Associate Dean of Academic and Student Affairs; Heather Van Buuren, Director; Karen Drake, Assistant Director; Lynnette Amey, Student Services Coordinator; Sue Kennedy, Fiscal Analyst; Cindy Olson, Administrative Assistant; Melanie Runge, Coordinator; and Sarah Strole, Student Services Coordinator.

## Clerkship Directors and Coordinators

<table>
<thead>
<tr>
<th>Department</th>
<th>Director (Coordinator)</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family and Community Medicine</td>
<td>Scott Moser, M.D., (Mary Hursey)</td>
<td>293-2607</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>Melissa Gaines, M.D., (Deb Dixon)</td>
<td>293-2607</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Samuel Akidiva, M.D., (Jean Olsen)</td>
<td>293-2650</td>
</tr>
<tr>
<td>Neurology</td>
<td>Jon Schrage, M.D., <em>interim</em> (Amanda Elmore)</td>
<td>293-2650</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>Michael Brown, M.D., (Margaret Santos)</td>
<td>962-7396</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Mark Harrison, M.D., (Donnita Pelser)</td>
<td>962-2250</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Cheryl A. Wehler, M.D., (Ronda Magness)</td>
<td>293-3508</td>
</tr>
<tr>
<td>Surgery</td>
<td>Teresa Cusick, M.D., (Katie Flessner)</td>
<td>268-5990</td>
</tr>
</tbody>
</table>
KU Bookstore Wichita Campus  
**Phone:** 293-2618  
Hours: 10 am - 5 pm Monday through Thursday  
Closed for lunch 1 - 1:30 pm daily

**Hospital Information and Pager Numbers**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Page Operator</th>
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</thead>
<tbody>
<tr>
<td>Robert J. Dole VA Medical Center</td>
<td>page through Wesley</td>
</tr>
<tr>
<td>5500 E. Kellogg</td>
<td></td>
</tr>
<tr>
<td>Via Christi – St. Francis</td>
<td>268-5000</td>
</tr>
<tr>
<td>929 N. St. Francis</td>
<td></td>
</tr>
<tr>
<td>Via Christi – St. Joseph</td>
<td>685-1111</td>
</tr>
<tr>
<td>3600 E. Harry</td>
<td></td>
</tr>
<tr>
<td>Wesley Medical Center</td>
<td>962-3030</td>
</tr>
<tr>
<td>550 N. Hillside</td>
<td></td>
</tr>
<tr>
<td>Physicians’ Exchange</td>
<td>262-6262</td>
</tr>
</tbody>
</table>

**Farha Medical Library**  
**Phone: 293-2629 (24-hour access with security card)**  
[http://wichita.kumc.edu/library/](http://wichita.kumc.edu/library/)  
Library staff members are available Monday through Friday (8:00 a.m. to 5:00 p.m.).  
Student privileges include free inter-library loans, literature searches, photocopying and printing. The library's main level features a computer lab, charging station, study tables, and houses the review book collection. The library's lower level features three private study rooms with computers, individual study carrels, study tables, charging station, as well as casual lounge seating.

**KU School of Medicine-Wichita After Hours Access**  
You will receive a security card that will give you access to the medical school after hours and on weekends. Each card is assigned to an individual and will record who has been in the building. You must report a lost card immediately to ASA (293-2603).
## Graduation Competencies

<table>
<thead>
<tr>
<th>Curriculum Objective:</th>
<th>Graduation Competency:</th>
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<tbody>
<tr>
<td><strong>Patient Care:</strong> Students will achieve the knowledge, skills, attitudes and behaviors to enable them, under supervision, to demonstrate increasing clinical capabilities as they progress towards residency education.</td>
<td><strong>PC1:</strong> Assess patients presenting with undifferentiated urgent, acute, or chronic health problems.</td>
</tr>
<tr>
<td><strong>Medical Knowledge:</strong> Students will use sound scientific principles to explain normal/abnormal human function at the molecular, biochemical, cellular, organ system, and societal level. They will apply scientific knowledge in the logical diagnosis and management of medical problems and promotion of health.</td>
<td><strong>PC2:</strong> Develop a prioritized differential diagnosis and/or problem list based on patient assessment.</td>
</tr>
<tr>
<td><strong>Practice-Based Learning/Improvement:</strong> Students will demonstrate critical and analytic thinking, awareness of the limitations of their knowledge and skills, and commitment to continuous learning and improvement.</td>
<td><strong>PC3:</strong> Select and interpret diagnostic tests based on scientific evidence and patient considerations.</td>
</tr>
</tbody>
</table>

**Before graduation from the School of Medicine, students will be able to:**

| **PC4:** Use sound problem solving strategies to propose initial patient management plans (see also PBL 1, SBP1-4). |
| **PC5:** Assess and address disease prevention/health promotion for individual patients. |
| **PC6:** Perform selected investigations and technical skills correctly and with attention to patient safety and comfort (Appendix C). |

| **MK1:** Access updated, reliable, high-quality scientific information in order to support clinical decisions. |
| **MK2:** Provide evidence for their diagnostic and management decisions based on application of medical knowledge and clinical reasoning. |
| **MK3:** Scientifically appraise innovative concepts and practices for potential value in patient care. |

| **PBL1:** Refine diagnoses, management strategies, and prognosis as conditions evolve as active participants in the ongoing care of patients. |
| **PBL2:** Accept and provide constructive feedback. |
| **PBL3:** Critically reflect on patient care activities, using analysis of experiences to improve performance. |
| **PBL4:** Set personal learning objectives and describe strategies to achieve them. |

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1 See objectives of individual modules, courses and clerkships for specific types of patients (e.g. children, elderly), medical conditions, diagnostic investigations, and procedures.

2 See objectives of individual modules, courses and clerkships for requirements to master specific domains of knowledge of normal and abnormal functioning across spectrum from molecular to societal aspects of health.
### Interpersonal and Communication Skills:

Students will communicate effectively and appropriately with patients, family members of patients, colleagues, other health professionals, and relevant others as a basis for trusting, collaborative relationships to promote optimal health outcomes.

| ICS1: | Communicate effectively with patients and families, including situations involving sensitive, technically complex, or distressing information. |
| ICS2: | Conduct a culturally-competent clinical encounter. |
| ICS3: | Provide a concise, accurate, verbal summary of a patient situation to a faculty member, resident, peer, or other member of the health care team prioritizing the most clinically significant factors. |
| ICS4: | Create, maintain and use appropriate confidential records of clinical encounters using standard terminology and formats. |

### Professionalism:

Students will integrate the concepts of altruism, accountability, excellence, duty, service, honor, integrity, and respect for others into all aspects of their professional lives.

| P1: | Demonstrate appropriate professional attitudes and behaviors (altruism, respect, accountability, duty, honor, integrity and commitment to excellence) in their clinical and educational activities. |
| P2: | Demonstrate sensitivity and responsiveness to patient individuality in health practices and decisions by demonstrating the ability to form appropriate professional relationships with patients from diverse backgrounds. |
| P3: | Recognize and address personal limitations, attributes or behaviors that might affect their effectiveness as a physician. |
| P4: | Recognize and address ethical concerns in the practice of medicine. |

### Systems-Based Practice:

Students will prepare to function effectively in teams and within organizations. They will be aware of and responsive to community health issues and will be able to apply community and other resources to medical problems for individual patients and groups.

| SBP1: | Demonstrate effective participation in a health care team. |
| SBP2: | Appropriately adapt to participate in patient care in a variety of settings, each with different priorities, opportunities, and constraints. |
| SBP3: | Describe the organizational, financial and health systems factors that affect patient well-being and incorporate them appropriately in clinical decision-making, prioritizing patient well-being. |
| SBP4: | Discuss the causes of medical error: Act to anticipate, prevent, and respond appropriately to threats to patient safety. |
| SBP5: | Identify, analyze, and propose solutions for a health problem in the community. |
Family Medicine

In Brief
Length: 8 weeks
Setting: Private Physician's Office (Wichita area or rural at student request)
Schedule: 8 a.m. – 5 p.m.
Setting: JayDoc Community Clinic
Schedule: Saturday 8:30 a.m. – 1:00 p.m.
Call: 3 overnight calls with residents & maternity care experience
Clerkship Director: Scott Moser, M.D.
Clerkship Coordinator: Mary Hursey (293-2607) mhursey@kumc.edu
Website: http://wichita.kumc.edu/fcm/

General Information
This 8 week rotation is generally a good experience for getting to know your way around an outpatient clinic. The faculty who volunteer to take students are no less than excellent, and make a big commitment to having a student in their offices for eight weeks.

Before you get started
1. Complete the survey you receive in the mail asking what kinds of experiences you would like to see. If you are interested in being assigned to a rural site for the rotation, please notify Mary Hursey as early as possible.
2. Books—The FCM Department loans copies of the required text. The rotation has an excellent syllabus that covers most things you will need to know. Several people have suggested using the Family Practice Review by Swanson for studying for the shelf exam; however, it is a large book to tackle so start early if you plan to cover it.

Example of a Typical Week
Monday 8 a.m.-5 p.m.—Seminars and Workshops
Tuesday 8 a.m.-5 p.m.—Clinic, if on call, plan for 5pm-noon the next day
Wednesday 8 a.m.-5 p.m.—Clinic or off post call
Thursday 8 a.m.-4 p.m.—Clinic
Friday 8 a.m.-5 p.m.—Clinic
Saturday Jaydoc Clinic 8:30 a.m.-1:00 p.m. Scheduled for two Saturdays during the eight-week rotation
Sunday Off

Clinic
You will usually be able to see a patient alone, get a history, formulate a diagnosis, present to your attending, then suggest a treatment plan. Depending on when in the third year you take this, you will be at varying degrees of comfort with a differential diagnosis, but be sure to stretch your comfort zone.

Most doctors are also willing to talk business with you—take advantage of this! Their real-world experience with malpractice, nurse practitioners, call schedules, and a myriad of other things are more enlightening than any textbook.
Lectures
Lectures and workshops are on Mondays. For the most part, these are excellent and applicable to what you will see in clinic. You ARE evaluated on your participation; so do your homework and do not sleep in class! Do not rely on the lectures to prepare you for the shelf exam. The workshops are also an excellent hands-on approach. You get to splint, suture, pretend to deliver a baby, etc.

Standardized Patients
These consist of two afternoons where each student meets with two actors who have been given a patient role to play. These patient encounters were given both positive and negative reviews. However, given that they will appear on National Boards, you can’t complain too much. Just try to forget the camera is there, and don’t be too anxious—you’re not graded on them, and it is one of the only chances you will have to personally review your interview technique. There is a post-interview session where the faculty reviews the cases with you so you know what the appropriate questions/plan of action should have been, etc. I think these were helpful sessions.

Patient Centered Project
A portion of your grade will come from a project in which you explore the impact of the patient centered medical home (PCMH) on patients, physicians, and healthcare teams. Pay attention to the directions because the project specifics change along with this dynamic aspect of patient care.

Subject Exam
This is a case-based exam that includes much of what you will find in all the other rotations, such as psychiatric problems, pediatric issues, and even some trauma or surgical questions. Many people find a Q&A book such as Appleton and Lange or Swanson’s Family Practice Review helpful.

If you’re crunched for time, just read the Adult Medicine section of Swanson. Most of the test focuses on adults. You really aren’t at a disadvantage if you haven’t had pediatrics or OB/GYN yet.

Call
You will be on call 3 times during the rotation. Family Medicine residents are famous for letting students do tons on call, so take advantage of this!

1. Wesley call (2)—these are usually very broad and busy; don’t plan on much sleep. You will be primarily assigned to the resident on call for obstetrical deliveries but may also admit patients and do other inpatient care. Follow your resident closely; even though you may be craving sleep, these experiences are valuable. Even if the FP doesn’t do the C-section, you can still attend.

2. St. Joseph (1)—One night of call is with the house officer for medical and pediatric inpatients.

3. Continuity Maternity Care Experience – You will be assigned an OB patient with a family medicine resident at the Via Christi Family Medicine Residency Program. You will be expected to attend the prenatal care appointments, the delivery, and follow up appointments for mom and baby. This experience took the place of one night of on-call at St. Joseph.
**Grades**
The grading method on the clerkship takes into account input from the preceptor, residents on call, the National Board subject exam, an Objective Structured Clinical Exam (OSCE), a written case presentation, and seminar participation. Achieving a superior grade requires an overall score of 90/100 plus good performance on both the preceptor grade and the NBME subject exam.
Geriatric Medicine

In Brief
Length of Course: 4 Weeks
Clinical Schedule: Normally 8:00-5:00 p.m. M-F; Sat & Sun Off
Call: None
Clerkship Director: Melissa Gaines, M.D. mgaines@kumc.edu
Assistant Director: John Dorsch, M.D. jdorsch@kumc.edu
Clerkship Coordinator: Deb Dixon (293-2607); ddixon@kumc.edu
Website: http://wichita.kumc.edu/fcm/

General Information
This clerkship is designed to help students become comfortable with the knowledge base and philosophy in caring for the geriatric patient as well as becoming familiar with the many social services available to complement medical care. A complete syllabus is on “Jaydocs,” and should be reviewed for a good understanding of what is important in this course. Since there is no call, self-study reading assignments are expected. The preceptor comes from either the Family Medicine or Internal Medicine department, so contact Deb Dixon at least a month before the rotation begins, if you have a preference.

Example of a Typical Week
Monday 8 a.m.-5 p.m.—Didactics/Workshops
(1 p.m.-5 p.m. - Last Monday of Clerkship = Standardized patients)
Tuesday 8 a.m.-5 p.m.—Clinic or Hospice or Community Agency
Wednesday 8 a.m.-noon—Dementia Rounds/Nursing Home Rounds or Hospice
1 p.m.-5 p.m.—Clinic
Thursday 8 a.m.-noon—Clinic
1 p.m.-5 p.m.—Clinic
Friday 8 a.m.-noon—Clinic or Nursing Home Rounds
1 p.m.-5 p.m. - Clinic
Saturday Off
Sunday Off

Teaching Methods
More than half of the time will be spent with community faculty in private clinics, out-patient KU clinics or KU-Midtown. Here the student will participate as a member of the healthcare team.

Other experiences include:
- Long Term Care rounds
- Visit to Community Agency—Write-up and presentation on the agency you visit
- Hospice—in-patient and out-patient visits
- Seminars
- Workshops
- Standardized Patients
- Specific self-study reading assignments
- Patient presentations
- Case based discussions
Textbooks
The following textbook is required and available for loan from the Department of Community and Family Medicine at no cost. It must be returned in good condition at the end of the course.

1. Old & Swagerty, A Practical Guide to Palliative Care

Grades
Grades calculation is the same on both Campuses.

The following shows how grades are weighted:
Clinical Performance (Preceptor 40%; Nursing Home Faculty 10%) 50%
Standardized Patients, Hospice, Community assignments 10%
Case-Based Discussion, Patient Case Presentations 10%
Geriatrics Final exam 30%
(Must have 60% on Final to pass course)

Grading Scale is as follows:
92-100% Superior
82-91.9 High Satisfactory
70-81.9 Satisfactory
<70 Unsatisfactory
General Surgery

In Brief
Length: 8 weeks – divided into two 4-week blocks between two panels
Setting: St. Francis, Wesley, Founders Circle and the Center for Same Day Surgery (CSDS) just across the circle entryway from St. Francis (South entrance).
Schedule: 4-6 a.m. until 6-9 p.m. depending on your panel
Call: 5-6 calls during the 8-week rotation
Clerkship Director: Terri Cusick, M.D.
Clerkship Coordinator: Katie Flessner (268-5990)
katie.flessner@viachristi.org
Website: http://wichita.kumc.edu/surgery/

General Information
Students find surgery to be a valuable educational experience. The hours may be long, but the education you can receive from faculty, residents, and patients is worth it. Some find the OR environment intimidating, but you will learn quickly. Just remember that the scrub nurses can be very helpful and can be a good friend in the OR. The operative word is “respect”.

Before you get started
The gunners among you could go over First Aid for Wards or parts of Surgical Recall. Most students would recommend just catching up on rest. It’s helpful to review fluids and electrolytes early on because you will be exposed to IV fluids extensively. Also, some students recommend asking a fourth year student ahead of time to show you the basic knot, how to instrument tie, and possibly a subcuticular suture so if you are asked to tie or close it’s not completely foreign to you. This isn’t a requirement though because you will have a suture lab during the first few weeks with good information and practice.

Example of a Typical Week
The times are highly dependent on your panel. Generally M-F looks like this:
5 a.m. or before: Pre-round on your assigned patients
6 -7 a.m.: Round with residents and/or faculty
7 a.m. - 5 p.m.: Surgery, lectures, conferences
Tuesday 5-6 p.m.: Conference at Wesley
Wednesday 7-9 a.m.: Morbidity and Mortality conference with following Surgery Grand Rounds conference. Dress clothes are required for Tuesday and Wednesday conferences (no scrubs).
Weekends: The weekends also vary considerably between panels. You will have to round Saturday, but have Sunday off. You will have the weekend entirely off between the 4th and 5th week.

The Panels
All panels are all general surgery, vascular or trauma, but have their own unique slants. The resident(s) assigned to each panel will make your patient assignments and OR responsibilities.
- Vascular: General surgery, vascular surgery, and dialysis support (i.e. central lines, vascular access, and declots).
- Trauma: A great intro to critical care. Take advantage of the opportunity to get familiar with ventilators, fluid management, TPN, and the SICU. If you are on the trauma service let the residents know when you have class so they know why you aren’t able to come to the trauma. Lectures and conferences are your first priority at all times.
• **General and Sub-Specialties:** General surgery, colorectal surgery, hepatobiliary, and minimally invasive surgery. Reading before cases is imperative. This service is well received by students, just stay on the ball.

**Grades**

Cognitive Skills (Final Exam 35%; Oral Exam 10% + Case Presentation 5%) = 50%

Clinical Management Abilities (Interpersonal skills, data gathering and problem solving skills) = 50%

The student is expected to successfully complete both the clinical and didactic portions of the clerkship. In addition, he/she is expected to receive a score of **58 or greater** on the final exam – the NBME subject examination. A minimum score of 58 is required for the NBME subject examination given at the completion of the clerkship. When this minimum score is not attained, the grade will be reported as “incomplete” for the clerkship. A second attempt will be required to meet the minimum score for this examination and the final grade, after receiving a passing score, will be a satisfactory. If the student does not receive the minimum score required on the second attempt, he/she will be required to repeat the junior surgery clerkship.

Expectations are high and they are very up-front about working hard to get the grade. The textbooks provided by the department are as follows:

**TEAM**-Trauma Evaluation and Management  
**NMS**-National Medical Series for Independent Study  
**Essentials of Surgical Specialties** by Peter Lawrence  
**Essentials of General Surgery** by Peter Lawrence

**Call**

The frequency of call depends on how many students are on your rotation, but it averages to about 5 times in 8 weeks; one student is on call every night except for Sunday. Call may be busy or not, depending on ER patients. Your job is to attend every trauma and write out the H&P as the team obtains it. The expectations are very well explained. If the trauma form seems difficult, ask a classmate on the trauma service. Keep your head in the game and don’t be afraid to ask the nurses for help. You may be excused from answering a trauma call if you are in the operating room and the surgeon requests that you stay. Otherwise, get to each one quickly. **You will have no excuse for arriving late.** The trauma page will identify an ETA and you should arrive 5 to 10 minutes before the ETA. If you sleep through a page or screw up somehow, be apologetic and honest.

**How to Excel**

- Ask your residents to orally quiz you and give you practice orals on different topics each day, even if it’s only for a few minutes.
- Be a team player.
- Keep your resident informed and help get the work done.
- Know **Surgical Recall**.
- The shelf exam places a lot of emphasis on basic science information, in particular, internal medicine and some physiology. Do not spend time memorizing in-depth surgical techniques. Do look over the statistics on prevalence, prognosis, etc. for major surgical diseases (e.g. appendicitis, cholecystitis, colon cancer, breast cancer, etc.). Finally, there is some material on the shelf exam from surgical subspecialties. Some say the best brief review of these is the Wiley series review on surgery.
- **Check the surgery schedule for the following day and review the anatomy and physiology for your assigned cases.** Questions will generally be asked. Be sure you have read the H&P for the patients, and ask your residents if they want you to do any of the preop H&P. Your residents may want to quiz you before the case or before the oral exam. Keep checking
the operating room schedule throughout the day as things may change quickly, and it's not acceptable to miss or be late to an assigned case just because it started early. Take responsibility for yourself, not depending on the resident to keep you informed. Keep a small book or note cards with you so you can easily study or review before or between cases when you are waiting.

**How to know when the scheduled operation is going to start**

Follow these steps to save some time. If the patient from the previous case is still in the room or the patient is in preop, you may have 30 minutes. If the patient has just arrived in the room, you have about 15 minutes. Alternatively, politely ask one of the nurses when your case might begin.

**Hints**

- Never talk without discretion in the locker rooms or anywhere else in the hospital.
- Be on time to the OR. Better to be early than sorry. And *always* meet the patient beforehand.
- Study the anatomy of your assigned cases the night before the surgery. You will be asked to identify structures. (Use Netter).
- Spend every free minute you have studying, sleeping, or eating.
- Carry a granola bar or other snack in your coat pocket, sometimes things can be busy and you don’t have time to get lunch.
- Ask your resident to help you prepare for the oral exam. If you can get them to give you case scenarios, that’s best.
- *Lectures and Conferences Always Take Precedence Over Anything Else.*
- Never wear the scrubs from CSDS outside the Center. You are not to wear hospital scrubs outside the hospital, with the exception of going to CSDS. It has been recommended to always have a set of dress clothes in your locker. You may be invited to clinic or lunch with an attending.
- Never eat food from the surgeons’ lounge unless you get permission.

**Helpful Books**

- **Surgical Recall** – Probably the most popular book. It is arranged in a self-quizz format and a lot of the questions will come up in “pimping” sessions. Try to read this book before each case.
- NMS series – a very good book for the surgery board exam.
- **Current Surgical Diagnosis and Treatment** (Way) - loaned to you by the surgery department. Probably too large to read from front to back, but it is a good reference for basic principles and specific cases.
- **Current Surgical Therapy** (Cameron) - popular book among residents. It is a good book for the more in depth review of the main cases you will see.
- **Surgical Secrets** – not unlike Surgical Recall, but often goes into more detail.
- **Schwartz** - the surgery bible, but you don’t necessarily have to own one now. It is probably too in-depth, unless you are preparing for a big case.
- **Ferri - Care of the Medical Patient**. Good for differential diagnoses (especially G.I. bleeds).
- **Mont-Reid Surgical Handbook** – This is an excellent book. It covers all you could want to know in a concise manner. Also, it fits in your pocket so you can have it on your person at all times. Great review for orals.
Internal Medicine

In Brief
Length of Course: Two 4 week sections
Setting: 4 weeks at the VA and 4 weeks at one of the other hospitals, Via Christi or Wesley. (The VA is not a guarantee, based on student numbers.)
Schedule: 6 a.m. – 5 p.m.
(This varies by number of patients and your residents.)
Call: 3 per month (1 weekend day and 2 week days.) Calls at VA end at 9 p.m.
Clerkship Director: Samuel Akidiva, M.D.
Clerkship Coordinator: Jean Olsen (293-2650)
Website: http://wichita.kumc.edu/im/

General Information
The main emphasis of Internal Medicine is learning to take a history and perform a physical examination. Also important is learning how to write and present an H&P in a well-organized manner.

Before you get started
1. Go over your H&P database such as order of the Review of Systems and PE. Be sure to include the social, family, allergy and immunizations (you’d be surprised how easy it is to forget this stuff when under pressure).
2. Review some of the disease processes you are sure to see such as COPD, DM, CHF, renal failure, Asthma, and HTN. Look over the common medications, labs that might be associated with them, and a little pathophysiology.
3. Go over PE technique. The inspection, palpation, percussion, and auscultation sequence is likely to be forgotten with your first patient.

Example of a Typical Week
Monday-Friday:
6:00 a.m.-7:30 a.m. Round and write your notes
8:00 a.m.-8:45 a.m. Morning case conference: Attendings, residents, and students work through a patient presentation. Students are asked to participate in answering questions with the residents.
8:45 a.m. Attending rounds
After rounds–Noon Polish off any other business, study, lectures, noon conference
1:00 p.m.-5:00 p.m. Handle new admits, do your H&Ps, study, lectures
Weekends Usually you will cover only one of the weekend days per week; you will round, write notes, then do attending rounds. Typically, you are free after that. The weekend between the 4-week blocks is free.

Lectures – lectures on this rotation are typically in the afternoon, and they can be any day of the week. Most are on Fridays.

The H&P
The department gives you an electronic form to use as a template when doing your required write-ups. The more complete and detailed the better, with emphasis on the HPI and problem list. One to two H&Ps per week are required, but this will depend on the service and the availability of patients. Use this time to work on H&P skills, as you won’t get as much opportunity in other clerkships.
How to Excel

A key to this clerkship is the presentation of patients and writing a daily progress note. The SOAP note format is most often used, although some attendings prefer problem-oriented-progress-notes. Ask your resident for some hints on the best way to present to your attending. Also, try to touch base with your resident before rounds to go over your patient. They often know things not in the chart. What one attending wants will be different from what another will expect; however, the basics are the same. Be concise, but thorough. (Which means don’t take too much time, but give all pertinent information.) You will probably be presenting patients the rest of your career, so practice and take advantage of every opportunity to present patients. Offer to present at morning report if you have worked up a patient on call. Attendings will not expect perfection; they are more interested in your improvement. You will be expected to read extensively, emphasizing your interesting patients on the service. Try to focus this reading on differential diagnosis, pathology, and therapeutic options. You will also find it helpful to read about the medications your patient is taking. It is important to know your patient and the contents of his/her chart.

Call

You will help work up any admits overnight. This means assisting with the H&P and orders. The interns run codes at all hospitals and you will be expected to go along. At the private hospitals you will be on call all night. Call at the VA ends at 9 pm.

Grading

RIME: Physician Developmental Scale (used by faculty to evaluate students)

Reporter: Student has obtained, knows, and can accurately report every available fact about his/her patients, including a comprehensive history, physical examination, and all lab data, consultants’ opinions etc--every piece of information in the chart. This is first task in physician development. Junior students should master this skill by end of the junior internal medicine rotation. Includes two major components: 1) skill in obtaining an accurate and thorough history and physical examination, and developing good rapport with patients while doing so (physician-patient relationships); and 2) reporting or communicating this information accurately and succinctly to others (in written form as progress notes; and orally as case presentations). Reporting derives from comprehensive data collection and assumes that the information has been accurately collected. Professional attitudes are assumed to be fundamental to the conduct and character of a physician, and are therefore described as "R" functions.

Interpreter: All "R" functions, plus skill in interpreting the findings. The term, “interpret” refers to the ability to “interpret” all data (especially history) in an integrative way, and diagnose the patient’s case or aspects of it. In general, skill in "interpretation" is a progression: junior students should be able to generate a simple DDX for a specific aspect of the case (e.g. hypokalemia); senior students and interns should consider and show increasing skill in developing a DDX for the unifying presenting diagnosis (e.g. cause of recent SOA/fever); 2nd and 3rd year residents should show increasing skill in pattern recognition, and be able to narrow and prioritize a broad DDX to an accurate presumptive diagnosis. All "I" functions are contingent on an accurate and growing fund of basic information.

Manager/Interpreter: "R" skills + "I" skills appropriate for level of training (see above) + ability to manage or treat the resulting condition. Junior students should not be focused on "M" skills except very generally. Senior students should begin to show significant development in this skill. 1st year residents should know how to manage most common conditions by end of their 1st year; R2’s and R3’s should be developing evidence-based advanced therapeutic practice. All should also demonstrate ongoing growth and skill in “Interpreter” or diagnostic skills. Note: "Managing" (treatment) should always derive from skill in diagnosis. Watch for learners who skip or are underdeveloped in
stage "I", and who may have learned how to treat symptoms but are unable to generate an adequate DDX.

Educator/Expert: "R" + "I" + "M" above, + is able to teach ("educate") or consult ("expert") for others. This implies a broad systematized fund of knowledge and skill in its appropriate application.

1. **Attendings' evaluations (Clinical and Interpersonal Skills):** You will be evaluated by your attending on each 4-week rotation. This is subjective, but is based on performance on rounds, daily progress notes, H&Ps, etc. Residents are usually asked for their input. This will account for 60% of your grade.

2. **Oral examination:** You will be given an oral examination during the seventh week of the clerkship. This is to gauge how well you can apply internal medicine theory to the actual care of patients. Attendance at all oral examination preparation sessions (usually one per week) is mandatory. Absences are covered by the same rules as the rest of your clerkship. Come to oral examination preparations prepared to attack patient care problems in front of your classmates. The exam will consist of you choosing from one of two cases (drawn by random number generation) and working through a case in 10-15 minutes. You will then repeat the exercise for a second case. If you don’t do well enough to pass the examination you’ll have a chance to remediate with a faculty member. The focus of these coaching sessions will be to address whatever weaknesses were noted by the initial examiner. After two coaching sessions, you’ll be given the opportunity to be re-examined. If you fail the second oral examination, you will be required to repeat the clerkship.

3. **Faculty-observed H&P exam:** An assigned physician will introduce you to a patient about whom you know nothing. You will have approximately 60 minutes to do a history and physical while being observed by that physician. **Be thorough and emphasize in your physical exam what you learned in the history.** Another good piece of advice: whenever doing an H&P, limit yourself to 60 minutes so that you will not be intimidated by the time limit of this exercise. Also, neither you, the patient nor the attending has the attention span to go much longer. One other idea to help reduce the stress of the situation: ask a resident to sit through and watch you do an H&P or two sometime during your clerkship. The resident can give advice on your technique and you will become comfortable with having an observer present. Sometimes you will be asked to present the patient to the observing physician. This exam is pass/fail. It can be repeated until a passing grade is obtained.

4. **Written examination (mini boards):** This is a very difficult test, which focuses on differential diagnosis, therapeutics and pathology. There is no good way to study for this; just read throughout your clerkship. In addition to reading about your patients in detail, find a good review book that you like, such as MKSAP for Students, and use that to augment your studying. You will have one hour per week of MKSAP review with an attending. If the only reading you do is on your patients, you will have difficulty with the boards. Journal articles are too detailed for what you need to know, but a good article can be impressive if asked to give an impromptu mini-lecture on a topic. This exam counts toward 40% of your final grade.

**Final Grade Determination**

<table>
<thead>
<tr>
<th>Clinical Performance Rating</th>
<th>60%</th>
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</thead>
<tbody>
<tr>
<td>Oral Examination (1)</td>
<td>pass/fail</td>
</tr>
<tr>
<td>Faculty-Observed History &amp; Physical Examination (1)</td>
<td>pass/fail</td>
</tr>
</tbody>
</table>
MINIMAL PASSING INTERNAL MEDICINE REQUIREMENTS

1. Satisfactory or better for each ward rotation.
2. Pass for the Faculty-Observed History & Physical Examination.
4. Satisfactory or better overall.
5. Completion of all assigned tasks.
6. Raw score of 63 or better on NBME subject exam.
7. Completion of patient data logging as required by clerkships.

Failing either ward rotation will result in a failing grade for the clerkship, and the clerkship will need to be repeated. A raw score of less than 63 on NBME subject exam requires the student to repeat the exam. If the repeat score is less than 63 points the student will fail the clerkship and must repeat the clerkship. If the repeat score is 63 or better, the student will be awarded a clerkship grade of Satisfactory if the overall performance rating is Satisfactory or better.

Helpful Books

- Pocket Medicine 4th Edition, Marc Sabatine
- MKSAP for Students (checked out to you by the department)
- Current Medical Diagnosis and Therapy – available on Accessmedicine.com
- Harrison’s Internal Medicine Text (You don’t need to buy a big medicine text yet as you can find them in all libraries and various other places.)
- Cecil’s Internal Medicine Text  (ditto)
- Dubin’s EKG Programmed Course of Instruction on EKG Reading (This is a nice, basic book that has been used with success for a long time.)
Neurology

In Brief
Length of Course: 4-weeks with 1 weekend off (usually last weekend)
Setting: 4 weeks inpatient consults at Via Christi-St. Francis Hospital, Outpatient Neurology Clinics, and neurophysiology labs
Schedule: Monday-Friday:
7:00-9:00 a.m.: Inpatient work rounds (VC-SFH)
9:00-11:00 a.m.: Inpatient teaching rounds (VC-SFH)
12:00-1:00 p.m.: Conference or didactics (VC-SFH)
1:30-4:30 p.m.: Inpatient consults (VC-SFH), or outpatient clinics (locations to be determined later)
Saturday, Sunday or Holiday:
7:00 a.m. through ?: Inpatient work rounds
Call: Every 4th to 5th night; may take call from home
Clerkship Director: Jon Schrage, M.D., Interim (IM Office).
Clerkship Coordinator: Jean Olsen/Amanda Elmore (293-2604)
jolsen@kumc.edu
aelmore3@kumc.edu
Website: http://wichita.kumc.edu/im/

General Information
It is anticipated that upon satisfactory completion of the clerkship you will be competent interviewing and examining patients with a wide variety of neurologic symptoms, have a general understanding of common neurologic disorders, and be capable of recognizing and responding appropriately to neurologic emergencies. Though one purpose of the clerkship is to learn about neurologic disorders and how they affect patients acutely and chronically, emphasis will be placed on how to solve medical problems of which you most likely will have had little or no experience. By using what you have been taught in your first two years of basic sciences, improving upon your clinical skills at collecting useful historical information, learning to perform a valid neurologic examination while at the same time reinforcing clinical knowledge and skills acquired from previous clerkships, problem solving abilities will be encouraged.

Before you get started
Review the neurosciences, especially neuroanatomy. The first step in diagnosis is to know the location of the lesion based partly upon the symptoms, but confirmed by the neurologic examination.

Example of a Typical Week
See “Quick & Dirty” for the schedule outline. On weekdays after the noon conference, some students will attend outpatient clinics while the other students on the service will see inpatient consultations.

Clinics
General Neurology Clinics (KU Wichita Center for Healthcare, KU Midtown Clinic, outpatient offices of KU Clinical Neurology Faculty); Specialty Clinics (VC Pediatric Specialty Clinic; VC-SF MD Specialty Clinic).

Lectures/Conferences
Neuroanatomy, Neuroradiology, Neurologic Emergencies, Epilepsy, Neuromuscular, Neurophysiology, Movement Disorders, Cognitive Disorders, Ethical Issues in Neurology, and Problem Based Learning sessions.
**Requirements**

Tools to perform a detailed neurologic examination are necessary and should include: reflex hammer, eye chart (e.g., Rosenbaum Pocket Eye Chart) for visual acuity, tuning fork (128 Hz) for vibratory sensation, penlight, sensory tools (single-use pins, cotton swab, tongue depressor), stethoscope. An ophthalmoscope (with otoscope attachment) is not required.

Requirements justifying an acceptable performance that meets expectations for the Clinical Inpatient portion of the Neurology Clerkship include, but are not necessarily limited to:

1. **KNOW YOUR PATIENTS!** Obtain a COMPLETE, ACCURATE, DETAILED DATABASE and perform a full neurologic and general physical examination for each of your patients.
2. Know what medications, IV fluids, tube feedings, respirator settings, oxygen, etc., your patient is receiving.
3. Know the results of all laboratory and other clinical studies (e.g., CT, MRI, EEG, CXR, EKG, impressions of other consultants), what tests are pending, and when they are to be completed, before the houseofficer or attending.
4. Read about your patients’ diseases, read the required neurology text chapters, and if you do not understand something, ask.
5. Treat your colleagues, other medical staff, and especially your patients with utmost respect and dignity regardless of any difficult circumstances.

**Exams**

**Practical Exam** during which the student demonstrates skill and understanding in the performance of a detailed neurologic examination. **National Board of Medical Examiners (NBME) Subject Examination for Clinical Neurology** taken on the last day of the clerkship.

**Call**

From 5:00 p.m. through 7:00 a.m. weekdays, and 7:00 a.m. through 7:00 a.m. weekends or holidays; may take call from home but expected to see new emergency consults and be prepared to present the patient the next day. Students are required to use the in-house call room for sleep if too exhausted to safely return home after seeing a consult.

**Sites**

Via Christi-St. Francis Campus, General Neurology Clinics (KU Wichita Center for Healthcare, KU Midtown Clinic, outpatient offices of KU Clinical Neurology Faculty); Specialty Clinics (VC Pediatric Specialty Clinic; VC-SF MD Specialty Clinic).

**Grading**

<table>
<thead>
<tr>
<th>Clerkship Grade</th>
<th>Total Percentage Points</th>
<th>Supplemental Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Consultation Service</td>
<td>35%</td>
<td>+ minimum CPR grade of 85%, minimum shelf exam score of 40th%, and satisfactory completion of ALL required assignments</td>
</tr>
<tr>
<td>Outpatient Clinics/Neurophysiology Lab</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Practical Exam</td>
<td>Pass/Do Again</td>
<td></td>
</tr>
<tr>
<td>Case Discussion Participation</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Case Discussion Attendance/Professionalism</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>NBME Subject Exam for Clinical Neurology</td>
<td>40%</td>
<td></td>
</tr>
</tbody>
</table>

Assignment of clerkship grade will be based upon the aggregate (sum) of these scores plus additional criteria listed below:
<table>
<thead>
<tr>
<th>High Satisfactory</th>
<th>80% - 89.9%</th>
<th>+ meets all requirements for “Satisfactory” (below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory</td>
<td>70% - 79.9%</td>
<td>+ minimum CPR evaluation score of 70%, minimum shelf exam score of 5th%, and satisfactory completion of ALL required assignments</td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>&lt;70%</td>
<td></td>
</tr>
</tbody>
</table>

**Helpful Resources**

**Clinical Neurology**, Seventh Edition (LANGE Clinical Medicine) by Roger Simon, David Greenberg, and Michael Aminoff (Paperback - Mar 9, 2009); this text will be lent to you at the beginning of the clerkship, and could be completely read allowing 15-20 pages/day.


http://www.aan.com/go/education/students/medical/advice

American Academy of Neurology “Advice to Medical Students Studying
Psychiatry

In Brief
Length: Four weeks: Two weeks in adult inpatient and two weeks in one of three other subspecialties
Setting: Via Christi Behavioral Health and outpatient community preceptors
Schedule: Adult Inpatient Psychiatry morning report 7:30 a.m.; Outpatient Psychiatry in afternoons; schedules vary by preceptor
Call: One six-hour shift on a Saturday or Sunday
Clerkship Director: Cheryl A. Wehler, M.D.
Clerkship Coordinator: Ronda Magness (293-3508) rmagness@kumc.edu
Website: http://wichita.kumc.edu/psych/

Introduction
These four weeks of psychiatry can be professionally (and personally) enriching if you approach the experience with an open mind. You’ll see patients here that you won’t see anywhere else, but you’ll also learn about disorders and social problems that will be important features in patients you’ll see on other rotations and in your future practice of medicine.

Grading
Grading breakdown is as follows:

| Psychiatry Clinical Performance (totals 60%) | 30% |
| Subspecialty Performance                     | 30% |
| Subspecialty Performance                      | 30% |
| Subject Exam in Psychiatry                    | 30% |
| Comprehensive Patient Evaluation (oral exam)  | 10% |
| Psychiatry Interview and Mental Status Exam   | Pass/Fail |

Sites
Most of the time spent on this rotation is at Via Christi Behavioral Health Center. You’ll be given keys for unlocking doors, because you’ll be dealing with patients on locked wards.

Everyone completes two two-week electives; one in Adult Inpatient Psychiatry, and the other in either Consultation/Liaison, Geriatric Psychiatry or Adolescent Psychiatry based on personal interests and availability. There are also two afternoons spent at various outpatient settings. Other required outings include AA and one other community self-help meetings.

Requirements
As previously mentioned, there is a requirement to visit two community self-help meetings. Like other clerkships, attendance at lecture is required. Other assignments include patient and other logs (generally learn to document everything you do in this clerkship), structured patient interviews, and a comprehensive patient analysis and presentation. This last requirement is akin to an oral exam specific to one patient you will have seen (your choice) during your rotation. You’ll be doing yourself a favor if you choose to present a patient with only one defined psychiatric diagnosis. Residents and Attendings are good resources in preparation for this report.

Exams
National Board of Medical Examiners (NBME) Subject Examination for Psychiatry is taken on the last day of the clerkship.

Call
One six-hour call assignment is required during this four-week clerkship. Saturday and Sunday calls are located at Via Christi Hospital on Harry in the Assessment Center, located near the Emergency Room.
**How to Excel**
Be adaptable with your interviewing skills. An interviewing workshop is part of this clerkship, and it has value for clinician-patient encounters regardless of whether you go into psychiatry. Apply these skills when you see your patients, and strive to express genuine empathy for their plights. When it comes to the oral presentation, be able to differentiate your patient’s disorder from other, similar disorders; know the drugs used to treat your patient’s disorder; know the potential side effects of these drugs; know how the patient’s disorder is likely to impact their life and the lives of their family members.

**Books**
The department will check out several required texts to you:
- *Quick Reference to the Diagnostic Criteria from DSM-IV*
- *Psychiatry PreTest Self-Assessment and Review*. Klamen & Pan
- *National Medical Series for Independent Study: Psychiatry* (NMS Psychiatry)
- *Outpatient Management of Depression*. Preskorn. (yours to keep)
- *Psychiatry Clerkship Guide*. Manley

**Helpful Books**
- *Psychiatry for the House Officer* by Tombs
- *Pocket Handbook of Clinical Psychiatry* by Harold I. Kaplan, Benjamin J. Saddock, Adele Scheele. Lippincott, Williams & Wilkins; ISBN: 0-683045-83-0 (Popular with residents and some students, small enough to carry with you.)
- *NMS: Psychiatry Review Book*
Obstetrics and Gynecology

**In Brief**
Length: 6 weeks
Setting: Wesley – Labor and Delivery as well as the OR
Schedule: 5 a.m. until anywhere from Noon to 6 p.m.
Clerkship Director: Michael Brown, M.D.
Clerkship Coordinator: Margaret Santos (962-3181)
Websites: [http://wichita.kumc.edu/obgyn/](http://wichita.kumc.edu/obgyn/)
[http://wesleyobgyn.com](http://wesleyobgyn.com)

**Grading**
Your final grade for the clerkship is based on the following:

**50% Weekly Evaluations**
- Each week you will receive a grade 1-10 (total of 50 points for the first 5 weeks)
- The “Miscellaneous Week” can be a deciding factor, as points may be deducted if students skip activities, or a superior performance may also increase clinical grade
- The percentage from these points will be your clinical grade

**10% Midterm**
- Administered the third week of the clerkship
- Tests over all competencies of the clerkship
- Helps to determine what topics need to be mastered before the final exam

**40% NBME Final Exam (last Friday of the Clerkship)**
- Final exam based on National Board format
- Students have Thursday off for studying
- To be eligible for a Superior grade for the rotation, a student must obtain a seventy-fifth percentile on the Final Exam (National Board format)

**Requirements**

**Documentation**
- You must complete and review with your mentor 2 H&Ps by midterm
- You must complete and review with your mentor 2 additional H&Ps by the end of the rotation (total of 4 H&Ps by the end of the clerkship)
- Any patient you see you must write a note
- Pick one progress note/OP note/postpartum note/POD note to review with your mentor each week

**Weekend Call**
- All students must complete one weekend of call (total of 24 hrs)
- Can be a 24 hour shift or two 12 hour shifts
- Can be completed at any time during the rotation (Friday night-Sunday night)
- All patients still need to be rounded on during the weekend prior to 7am
- Only one student can work a shift at a time, sign up during clerkship orientation
**Mentoring Program**
- You will be paired with an Ob/Gyn Resident mentor during your clerkship
- Communicate with your mentor to determine if they prefer being paged, texted, or called to set up appointments
- It is your responsibility to set up times to meet with your mentor weekly
- If you have any clinical problems/concerns or questions, contact your mentor
- Mentors are assigned to students the first day of orientation

**Recommended Texts**

There is a binder in the Ob/Gyn medical student room with important papers/supplemental information that will be helpful with successful completion of this rotation.

**Clerkship Tips**
Here are some general tips to remember during your clerkship:
- Lectures/Simulations: **ALWAYS** top priority
- Wear your Wesley name badge at all times
- Appropriate times to page/call residents or the on-call phones **(6AM-6PM)**
- A resident/attending **MUST** be present for any exam you perform
- **Always** introduce yourself to the resident, patient, attending, nurse/scrub tech
- Logging patients: log your patients every 2 weeks at least. Must have a minimum of 100 logged patients during your six week clerkship
- **Show interest, even if you are not interested** (you will have a better experience)

**Absences**
If you need to be excused (examples: family death, medical school responsibility, medical emergency) from your scheduled responsibilities for any reason, **YOU MUST**:
1. Contact Margaret and let her know (in advance)
2. Let your mentor or appropriate senior resident know
3. Find a replacement for your responsibilities

Being accountable for your whereabouts is part of professionalism. We cannot excuse your absence without it reflecting in your grade and learning experience.

**It is expected that you will not be excused from holidays except for the following:**
1. New Year’s Day
2. Memorial Day
3. Labor Day
4. Thanksgiving Day
5. Christmas Day

*We look forward to having you on the Obstetrics and Gynecology clerkship and are excited to have you as part of our team!*
Pediatrics

In Brief

Length: 6 weeks
Setting: 4 weeks of inpatient are at Wesley Medical Center, 1 ½ weeks in PICU and 1 ½ weeks on the Pediatric Wards with 1 week on Newborn Service
1 week at KU Pediatric Faculty Clinic at 620 N. Carriage Pkwy
1 week of outpatient preceptor (assigned)
Schedule: 8 a.m.-5 p.m. on outpatient, 6 a.m.-5 p.m. inpatient
Call: 3 times while on inpatient at Wesley
Clerkship Director: Mark Harrison, M.D.
Clerkship Administrator: Donnita Pelser 962-2657 or 962-2250
Donnita.Pelser@wesleymc.com
Website: http://wichita.kumc.edu/pediatrics/

General Information

The clerkship orientation is presented at 7:15 a.m. the first day of the rotation. Scheduled faculty lectures are given at KU Pediatrics Administrative Office Classroom in the Wesley Medical Arts Tower on Wednesday afternoons. The pediatrics department loans each student a copy of Pediatric Case Files. Many students also use the NMS, Appleton and Lange’s question book, Pre Test or Blueprints review book, all of which are useful. A list of lecture topics is given to students at the start of the rotation to review before scheduled lectures. Students will be able to access their syllabus, lecturer materials and other course materials on JAYDOCS. The rotation is quite different each week, so this one is reviewed by location.

Wesley

Students are usually exposed to a wide variety of medical problems during the inpatient service at Wesley. The four weeks will be split between the PICU, Pediatric Wards and Newborn Service. On the wards there are two panels: one for teaching staff and one for private attendings. In the PICU you will work with Drs. Bajracharya, Smith, and/or Murphy. Take advantage of this time, as they are excellent teachers. On Newborn Service, you will round on your newborn baby patients in the morning, and then hang out during the afternoon to take new admissions directly from the stork! This week is a great opportunity to learn how to do physical exams, manage hyperbilirubinemia and group B strep issues, care for newborn babies in the special care unit, observe circumcisions, and much more.

Check the syllabus or JAYDOCS for the H&P format you will use typing up your notes. Students are required to round on their patients and have their presentations ready if called upon by the attending. If you were on call the night before, you are usually responsible for presenting the patients you worked up, including lab results from tests you ordered on admission. You should also gather any x-rays that were performed. After morning report, you may start rounding with your attending immediately if you are seeing regular floor patients, or you may have some free time before rounds start if you are seeing PICU patients. Rounds usually take most of the morning and may continue into the afternoon if you’re on PICU during a busy season (winter). The rest of the day is spent seeing patients, charting, participating in procedures, doing CLIPP Cases online and reading. Students are responsible for working up most new admissions assigned to their panel and providing complete patient presentations. Students are also required to attend Intro to NICU rounds, usually once a week. Call is from 5PM until 11:00 PM on week days and from noon until 5 PM on weekends. Students will be excused at that time, after pertinent clinical duties are finished. Students may stay longer if further learning opportunities are anticipated. Call rooms are located Bldg 1 6th floor. Conferences are held almost every noon hour at Wesley.
Outpatient Clinic
Two weeks are spent in the outpatient pediatrics setting. One week is spent in the KU Pediatric Faculty Clinic clinic at 620 N. Carriage Parkway. Here, the students see patients on their own under the supervision of a resident or faculty member and then report their findings. This is a great opportunity to practice well-child exams and to learn from some of the best. The hours are usually 8am - 5pm. The other outpatient week is spent with a volunteer pediatrician in a private practice setting. The amount you get to do with the private practice pediatrician is highly preceptor-dependent, but it is still a great experience to interact with kids and their parents and pick up good tips on examining them. Also, students will have the opportunity to tour Heartspring facility as a group; it is a unique program here in Wichita that cares for children with very challenging developmental and genetic conditions.

Exams
The pediatric subject exam is scheduled for the end of the sixth week. Many students highly recommend the Appleton and Lange question book to study for the boards test. The most current edition is in the early 1990s, so be careful and skeptical when going through material that might be updated. There are three review texts are typically used, Case Files, PreTest and Blueprints. Some sections are difficult, but they are reflective of the subject matter and the board questions you will face at the end of the clerkship. A Midterm Exam covering pediatric CLIPP cases online will be given the 4th week. This exam reviews cases done on the internet that students are assigned to do at the beginning of the clerkship. This exam accounts for 101 percent of the clerkship grade. Students will be tracked on how many cases they complete online. An oral exam is also required.

Standardized Patient
Students will be required to participate in a standardized patient exercise during their third week on the clerkship. The focus will be on “giving bad news.”

Grading
Final grades are based upon clinical evaluations (50%) the Pediatric Subject Exam (35%) and Midterm Exam (7.5%) or (Oral Exam) (7.5%). To pass Pediatrics:
1. You must earn a score of 5th percentile or higher on NBME Pediatric Subject Exam. If you receive a score less than the 5th percentile you are required to retake the examination. If you fail the NBME Subject Exam and then pass the examination when you retake it, the maximum grade you will receive for the clerkship is “Satisfactory”. If you again receive a score below the 5th percentile you will be required to retake the entire clerkship.
2. Both exam and clinical portions of the rotation must be satisfactorily completed. If any portion of the student’s clinical evaluations are unsatisfactory, the Department of Pediatrics may require one or all portions of their clinicals to be repeated at the discretion of the Pediatric Student Curriculum Committee. If any clinical experience needs to be repeated, the student will be required to repeat the failed portion of their clinicals at the beginning of their fourth academic year.
3. Forms completed and returned for documentation of observed history and physical, and immunizations procedures.
4. Maintaining patient logs a minimum of three times during the rotation and at the end of the rotation. If you fail to do so, this clerkship will withhold your grade.
Books
The *Harriet Lane Handbook* is a good quick and easy references book that is most often used by the residents to formulate treatment plans. It does have an excellent dosing guide for pediatrics as well as normal pediatric lab values.
Commonly Used Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA</td>
<td>abdominal aortic aneurysm</td>
</tr>
<tr>
<td>abd</td>
<td>abdomen</td>
</tr>
<tr>
<td>ABG's</td>
<td>arterial blood gases</td>
</tr>
<tr>
<td>a.c.</td>
<td>before meals</td>
</tr>
<tr>
<td>ACBE</td>
<td>air contrast barium enema</td>
</tr>
<tr>
<td>ACE</td>
<td>angiotension-converting enzyme</td>
</tr>
<tr>
<td>Accuο</td>
<td>finger glucose monitoring</td>
</tr>
<tr>
<td>ADA</td>
<td>American Diabetes Association (refers to diabetic diet)</td>
</tr>
<tr>
<td>ADL’s</td>
<td>activities of daily living</td>
</tr>
<tr>
<td>ad lib</td>
<td>as desired</td>
</tr>
<tr>
<td>AF</td>
<td>atrial fibrillation, ≠ afebrile</td>
</tr>
<tr>
<td>AFB</td>
<td>acid fast bacilli</td>
</tr>
<tr>
<td>AKA</td>
<td>above the knee amputation</td>
</tr>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
</tr>
<tr>
<td>AP</td>
<td>anterior-posterior</td>
</tr>
<tr>
<td>AS/AI</td>
<td>aortic stenosis/aortic insufficiency</td>
</tr>
<tr>
<td>ASHD/ASCVD</td>
<td>atherosclerotic heart disease/cardiovascular disease</td>
</tr>
<tr>
<td>ASA</td>
<td>acetylsalicylic acid; aspirin</td>
</tr>
<tr>
<td>ASAP</td>
<td>as soon as possible</td>
</tr>
<tr>
<td>BaE, BE</td>
<td>barium enema</td>
</tr>
<tr>
<td>BBB</td>
<td>bundle branch block</td>
</tr>
<tr>
<td>b.i.d.</td>
<td>twice daily</td>
</tr>
<tr>
<td>BKA</td>
<td>below the knee amputation</td>
</tr>
<tr>
<td>BM</td>
<td>bowel movement</td>
</tr>
<tr>
<td>BMP</td>
<td>basic metabolic panel</td>
</tr>
<tr>
<td>BP</td>
<td>blood pressure</td>
</tr>
<tr>
<td>BPH</td>
<td>benign prostatic hypertrophy</td>
</tr>
<tr>
<td>BR</td>
<td>bed rest</td>
</tr>
<tr>
<td>BRP</td>
<td>bathroom privileges</td>
</tr>
<tr>
<td>B.S.</td>
<td>bowel sounds (+ or -) can also mean breath sounds or blood sugar as well as in expletive.</td>
</tr>
<tr>
<td>BSO</td>
<td>bilateral salpingo-oophorectomy</td>
</tr>
<tr>
<td>BUN</td>
<td>blood urea nitrogen</td>
</tr>
<tr>
<td>BUS</td>
<td>Bartholin’s gland, urethra, Skene’s</td>
</tr>
<tr>
<td>Bx</td>
<td>biopsy</td>
</tr>
<tr>
<td>c/o</td>
<td>complains of</td>
</tr>
<tr>
<td>CA</td>
<td>cancer</td>
</tr>
<tr>
<td>CABG</td>
<td>pronounced “cabbage” - coronary artery bypass graft</td>
</tr>
<tr>
<td>CABG x_</td>
<td>coronary artery bypass graft times number of vessels bypassed</td>
</tr>
<tr>
<td>CAD</td>
<td>coronary artery disease</td>
</tr>
<tr>
<td>CBC</td>
<td>complete blood count</td>
</tr>
<tr>
<td>CC</td>
<td>chief complaint</td>
</tr>
<tr>
<td>CHF</td>
<td>congestive heart failure</td>
</tr>
<tr>
<td>CMP</td>
<td>comprehensive metabolic panel</td>
</tr>
<tr>
<td>CN</td>
<td>cranial nerves</td>
</tr>
<tr>
<td>CPE</td>
<td>complete physical exam</td>
</tr>
<tr>
<td>CPK</td>
<td>creatinine phosphokinase</td>
</tr>
<tr>
<td>CRF</td>
<td>chronic renal failure</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------</td>
<td>------------</td>
</tr>
<tr>
<td>C &amp; S</td>
<td>culture and sensitivity</td>
</tr>
<tr>
<td>CSF</td>
<td>cerebrospinal fluid</td>
</tr>
<tr>
<td>CT</td>
<td>computed tomography</td>
</tr>
<tr>
<td>CVP</td>
<td>central venous pressure</td>
</tr>
<tr>
<td>C.X.R.</td>
<td>chest X-ray</td>
</tr>
<tr>
<td>CMP</td>
<td>comprehensive metabolic panel</td>
</tr>
<tr>
<td>D/C</td>
<td>discontinue or discharge</td>
</tr>
<tr>
<td>DD</td>
<td>dependent drainage</td>
</tr>
<tr>
<td>DDX</td>
<td>differential diagnosis</td>
</tr>
<tr>
<td>Dx</td>
<td>diagnosis</td>
</tr>
<tr>
<td>D5NS</td>
<td>5% dextrose in 0.9% saline (W = water, LR = lactated ringers)</td>
</tr>
<tr>
<td>DJD</td>
<td>degenerative joint disease</td>
</tr>
<tr>
<td>DKA</td>
<td>diabetic ketoacidosis</td>
</tr>
<tr>
<td>DNR</td>
<td>do not resuscitate</td>
</tr>
<tr>
<td>DM</td>
<td>diabetes mellitus</td>
</tr>
<tr>
<td>DOE</td>
<td>dyspnea on exertion</td>
</tr>
<tr>
<td>DTR</td>
<td>deep tendon reflexes</td>
</tr>
<tr>
<td>EBL</td>
<td>estimated blood loss</td>
</tr>
<tr>
<td>EDD</td>
<td>estimated due date</td>
</tr>
<tr>
<td>EGD</td>
<td>esophagogastroduodenoscopy</td>
</tr>
<tr>
<td>EMD</td>
<td>electro-mechanical dissociation</td>
</tr>
<tr>
<td>EOMI</td>
<td>extraocular muscles intact</td>
</tr>
<tr>
<td>ETOH</td>
<td>ethanol</td>
</tr>
<tr>
<td>ESR</td>
<td>erythrocyte sedimentation rate</td>
</tr>
<tr>
<td>FB</td>
<td>foreign body</td>
</tr>
<tr>
<td>FBS</td>
<td>fasting blood sugar</td>
</tr>
<tr>
<td>FFP</td>
<td>fresh frozen plasma</td>
</tr>
<tr>
<td>FiO2</td>
<td>inspired oxygen tension, expressed a %</td>
</tr>
<tr>
<td>FMHx</td>
<td>family history</td>
</tr>
<tr>
<td>FR</td>
<td>french (a catheter size)</td>
</tr>
<tr>
<td>FROM</td>
<td>full range of motion</td>
</tr>
<tr>
<td>f/s/c</td>
<td>fever/sweats/chills</td>
</tr>
<tr>
<td>Fx</td>
<td>fracture</td>
</tr>
<tr>
<td>G</td>
<td>gallop</td>
</tr>
<tr>
<td>GB</td>
<td>gallbladder</td>
</tr>
<tr>
<td>G_P_A_</td>
<td>G = gravida, # of time pregnant; P = Paral # of viable infants; A = Aborted (s = spontaneous, t=therapeutic)</td>
</tr>
<tr>
<td>GSW</td>
<td>gunshot wound</td>
</tr>
<tr>
<td>gtt</td>
<td>drops</td>
</tr>
<tr>
<td>GTT</td>
<td>glucose tolerance test</td>
</tr>
<tr>
<td>HA</td>
<td>headache</td>
</tr>
<tr>
<td>HCTZ</td>
<td>hydrochlorothiazide</td>
</tr>
<tr>
<td>H/H</td>
<td>or H and H – hemoglobin (hgb) and hematocrit (HCT)</td>
</tr>
<tr>
<td>HEENT</td>
<td>head, eyes, ears, nose, and throat</td>
</tr>
<tr>
<td>HJR</td>
<td>hepatojugular reflux</td>
</tr>
<tr>
<td>HOB</td>
<td>head of bed</td>
</tr>
<tr>
<td>H&amp;P</td>
<td>history &amp; physical</td>
</tr>
<tr>
<td>HPI</td>
<td>history of present illness</td>
</tr>
<tr>
<td>HR</td>
<td>heart rate</td>
</tr>
</tbody>
</table>
h.s. bedtime
HSM hepatosplenomegaly
HTN hypertension
Hx history
I & D incision and drainage
I & O intake and output
IDDM insulin dependent diabetes mellitus
ICU intensive care unit
IM/IV intramuscular/intravenous
IVDU intravenous drug use
IVP intravenous pyelogram
JVD jugular venous distention
JVP jugular venous pulse
KUB kidneys-ureters-bladder
KVO keep vein open (TKO = to keep open) specifies minimal IV fluid
LAF low animal fat
LBBB left bundle branch block
LBP low back pain
L.E. lower extremity
LFT liver function test
LLQ/LLDq lower left quadrant/left lateral dequbitus
LLSB lower left sternal border
LMD local medical doctor
LMP/LNMP last menstrual period/last normal menstrual period
LOC level/loss of consciousness
LOS length of stay
LP lumbar puncture
LVH left ventricular hypertrophy
M murmur
M & M morbidity and mortality
MI myocardial infarction
MOM milk of magnesia
MRI magnetic resonance imaging
MRSA methicillin-resistant Staph aureus
MS morphine sulfate; mental status; mitral stenosis; multiple sclerosis. Medical student
MSE mental status exam
MVA motor vehicle accident
NAD no apparent stress
NAS no added salt
NG nasogastric
NHP nursing home placement
NIDDM non insulin dependent diabetes mellitus
NKMA no known medical allergies
N.P.O. nothing by mouth
NKA or NKDA or NKMA - no known (drug or medical) allergies
NSAID nonsteriodal anti-inflammatory drug
NSR normal sinus rhythm
NTG nitroglycerin
N/V nausea and vomiting
OBS organic brain syndrome (dementia)
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC</td>
<td>oral contraceptives (OPC) or BCP = birth control pills</td>
</tr>
<tr>
<td>ORIF</td>
<td>open reduction, internal fixature</td>
</tr>
<tr>
<td>OS/OD</td>
<td>left eye/right eye</td>
</tr>
<tr>
<td>OTC</td>
<td>over the counter</td>
</tr>
<tr>
<td>p</td>
<td>after</td>
</tr>
<tr>
<td>P&amp;A</td>
<td>percussion and auscultation</td>
</tr>
<tr>
<td>PAC/PVC</td>
<td>premature atrial contraction/ventricular contraction</td>
</tr>
<tr>
<td>PCN</td>
<td>penicillin</td>
</tr>
<tr>
<td>pc/pp</td>
<td>after meals/post prandial</td>
</tr>
<tr>
<td>PCW</td>
<td>pulmonary capillary wedge</td>
</tr>
<tr>
<td>PE</td>
<td>physical exam</td>
</tr>
<tr>
<td>PERRLA</td>
<td>pupils equally round to light and accommodation</td>
</tr>
<tr>
<td>PFT</td>
<td>pulmonary function tests</td>
</tr>
<tr>
<td>Plt</td>
<td>platelets</td>
</tr>
<tr>
<td>PO/PR/PV</td>
<td>by mouth/by rectum/by vagina</td>
</tr>
<tr>
<td>PMHx</td>
<td>past medical history</td>
</tr>
<tr>
<td>PND</td>
<td>paroxysmal nocturnal dyspnea</td>
</tr>
<tr>
<td>p.o.</td>
<td>orally</td>
</tr>
<tr>
<td>PRBC</td>
<td>packed red blood cells</td>
</tr>
<tr>
<td>p.r.n.</td>
<td>as needed</td>
</tr>
<tr>
<td>PT/pt</td>
<td>physical therapy/patient</td>
</tr>
<tr>
<td>PTCA</td>
<td>percutaneous transluminal coronary angioplasty (balloon)</td>
</tr>
<tr>
<td>PUD</td>
<td>peptic ulcer disease</td>
</tr>
<tr>
<td>PVD</td>
<td>peripheral vascular disease</td>
</tr>
<tr>
<td>Px</td>
<td>physical</td>
</tr>
<tr>
<td>q</td>
<td>every</td>
</tr>
<tr>
<td>qAM</td>
<td>every morning</td>
</tr>
<tr>
<td>qD</td>
<td>every day</td>
</tr>
<tr>
<td>qhs</td>
<td>at every bed time</td>
</tr>
<tr>
<td>qhc</td>
<td>at meals</td>
</tr>
<tr>
<td>q.i.d.</td>
<td>four times a day</td>
</tr>
<tr>
<td>q.o.d.</td>
<td>every other day</td>
</tr>
<tr>
<td>QNS</td>
<td>quantity not sufficient (for analysis)</td>
</tr>
<tr>
<td>R.A.</td>
<td>room air</td>
</tr>
<tr>
<td>RR</td>
<td>respiratory rate</td>
</tr>
<tr>
<td>RLE</td>
<td>right lower extremity</td>
</tr>
<tr>
<td>RML</td>
<td>right middle lobe</td>
</tr>
<tr>
<td>RRR</td>
<td>regular rate and rhythm</td>
</tr>
<tr>
<td>r/o</td>
<td>rule out</td>
</tr>
<tr>
<td>ROS</td>
<td>review of systems</td>
</tr>
<tr>
<td>RT</td>
<td>respiratory therapy</td>
</tr>
<tr>
<td>RTC</td>
<td>return to clinic</td>
</tr>
<tr>
<td>RUQ</td>
<td>right upper quadrant</td>
</tr>
<tr>
<td>Rx</td>
<td>prescription</td>
</tr>
<tr>
<td>s</td>
<td>without</td>
</tr>
<tr>
<td>SBE</td>
<td>self breast exam</td>
</tr>
<tr>
<td>SBFT</td>
<td>small bowel follow-through</td>
</tr>
<tr>
<td>SEM</td>
<td>systolic ejection murmur</td>
</tr>
<tr>
<td>sig</td>
<td>labeled directions; sigmoidoscopy</td>
</tr>
<tr>
<td>SLR</td>
<td>straight leg raises</td>
</tr>
</tbody>
</table>
SMAC  multichemistry blood test
SMD  small for dates
SOA  short/shortness of air
s/p  status post
SQ  subcutaneous
ss  sliding scale (insulin doses)
SS  social stresses
STD  sexually transmitted disease
STAT  emergently
Sx  symptoms
T  temperature
TAH  total abdominal hysterectomy
TCA  tricyclic antidepressant
TCN  tetracycline
t.i.d.  three times a day
TPN  total parenteral nutrition
TRA  to run at
TURP  transurethral prostatectomy
Tx  treatment
UA  urinalysis
U.E.  upper extremity
UGI  upper GI Xray
UGIB  upper gastrointestinal bleed
U/O  urine output
UTI  urinary tract infection
VA  visual acuity; Veterans Administration
VF  visual fields
VIP  very inappropriate personality
VS  vital signs
VSS  vital signs stable
WNWD  well nourished, well developed
WBC  white blood cells
WM  white male
WNL  within normal limits
_except
  one
two

There are many more abbreviations used and some of the above may be frowned upon by some attendings.

**Shorthand Notation for Lab Values**

Metabolic Panel, Basic:

<table>
<thead>
<tr>
<th>Na</th>
<th>Cl</th>
<th>BUN</th>
<th>Glucose</th>
</tr>
</thead>
<tbody>
<tr>
<td>K</td>
<td>HCO₃</td>
<td>Cr</td>
<td></td>
</tr>
</tbody>
</table>

There are many more abbreviations used and some of the above may be frowned upon by some attendings.
Complete Blood Count (CBC):

- Hgb
- WBC
- Hct
- 6B/56S/30L/3M/3E/2B
  (bands/segs/lymphs/monos/eos/basos)

ABG:

- pH
- pCO₂
- pO₂

@specify oxygen (i.e. 2l NC-2l nasal cannula; 50% FM-50% O₂ by face mask)

It is important for the new clinical clerk to be aware of some of the important issues regarding chart work. The first is WRITE CLEARLY! The second is anything you enter into a patient’s chart has the potential to be used as a reference which may help to guide the patient’s future health management. It is also a legal document which may become public record if used in court. It is absolutely imperative that clinical clerks do not write anything in the chart which is not true or not actually observed by you personally. If you are going to include information which was observed by others (i.e. a physical finding noted in the residents notes, but not by you) you must include this as part of your note. If you simply do not have time to fully examine a patient before 5:00 a.m. OB/GYN rounds, you should probably not include this in your note. It is also unacceptable to photocopy any portion of a patient’s record (including your History and Physicals once they are in the chart), as this is a breach in patient confidentiality. It is always a good idea to "ask before you do." This will come in handy throughout your career in medicine.

History and Physical

A topic not discussed elsewhere in the manual is the responsibility of presenting patients to residents and attendings. The verbal presentation of a patient proceeds in the same order as the admission H&P, from chief complaint through clinical impression and plan. The object of presenting a patient is to communicate enough pertinent information about the patient that someone who does not know the patient will be adequately informed and satisfied. The key words here are, of course, "pertinent" and "enough". We know you're tired of hearing this already, but what is "pertinent" and what is "enough" varies so much that it is meaningless to attempt to define it. Some attendings are satisfied with the patient’s name, age, sex, and chief complaint, interrupt you shortly thereafter, and scurry off to the patient’s room because you were taking too long. Other attendings expect you to recite the patient’s entire history and physical from beginning to end in elaborate detail, and they will wait very patiently as you do so.

One way of beginning a presentation of an H&P is the following: "Mr. Doe is a 45 year old white male with a history of COPD, angina and an inferior MI in the past, who now presents with angina of increasing severity and duration". The first statement of the presentation is the most important and by including the pertinent past history gives the attending and others present a brief synopsis of the patient’s status. In general, it is wise to present only the pertinent findings in the H&P - laboratory work, x-rays, EKG, etc. Nevertheless, the most important piece of your presentation is the clinical impression and plan for the patient. This is where the attending will be able to assess your clinical expertise.

Further complicating any attempt to describe the art of presenting patients is the fact that some attendings will allow you to read your presentation directly from your admission write-up, others will allow you to carry 3x5 note cards for presentations, and still others, thankfully a minority, expect you to present your patients entirely from memory. Unfortunately, the latter category of attendings also
usually happen to be the ones who insist that your patients are presented in elaborate detail. In the final analysis, you just have to get a feeling for what is pertinent and what is not, what is excessive and what is enough, and what your particular attending expects. The best thing to do is to ask your resident what to expect before you come under the gun, although occasionally attending physicians may actually tell you what they want. The importance of figuring out what is expected of you with regard to patient presentation resides in the fact that a good portion of your clinical evaluation by the attending physicians may be determined by your skill at presenting patients to them, since they are likely to observe you doing that more than they will see you doing anything else. To repeat the basic rule of thumb, therefore, "it never hurts to ask."

**S.O.A.P. Notes**

**Subjective:** This part of the S.O.A.P. note should briefly describe how the patient feels and any complaints he/she might have. Analogous to the chief complaint portion of a History and Physical, it should be stated in the patient’s own words whenever possible.

**Objective:** This part of the S.O.A.P. note lists objective data including current vital signs, pertinent physical exam findings (which always includes general appearance, cardiovascular, pulmonary and abdominal exam and only the other physical findings which are pertinent to that patient), and laboratory results. Some attendings like to have pertinent laboratory values circled, others do not. Check with your individual residents.

**Assessment:** In this part of the S.O.A.P. note, each of the patient’s medical problems is listed, generally in descending order of importance, and basically conforming to the list which you generated in your admission H&P, with the addition, of course, of those problems which have developed or have been discovered since the patient was admitted. Each listed problem is updated according to evaluation of the current objective data which you listed under "Objective." In this problem-oriented format, the number of each problem is retained throughout the patient’s hospitalization, with new problems added to the list as they arise and problems deleted from the list as they are resolved. If a problem is not yet diagnosed, the assessment should include the “working differential diagnosis” or the top few most likely diagnoses. If the problem is diagnosed, the assessment should include your evaluation of the patient’s status or progress, as in "hypertension, well controlled.”

**Plan:** In this part of the S.O.A.P. note, diagnostic and therapeutic plans are listed as they apply to the patient’s current problems and in the same order. Included are any new medications or diagnostic procedures which are added, changes or additions to nursing orders, and plans for discharge or transfer. Your responsibilities as a clinical student will include knowing your patient’s current problem list, gathering and knowing the results of all diagnostic procedures, knowing the current status of all therapeutic interventions, and compiling all of this information into a problem oriented progress note in the S.O.A.P. format which you will record on the chart daily for all of your patients.

The following is an example of such a progress note:

**S.** “I feel just great today”. The patient is without complaints this morning.

**O.** P.E.VITALS: BP 136/82s orthostatic change, P80, RR18, T 37.0,

GENERAL: Much less dyspneic than yesterday. HEENT: unchanged; NECK: s JVD

CHEST: Fine insp. rales in post. bases, scattered insp. rhonchi., exp. phase prolonged, but decreased use of accessory muscles.

ABD: Obese, BS present, nontender to palpation, s HSM or masses

NEURO: CN II-XII intact, sensory, cerebellar, and motor exams WNL, DTR’s 2+ and bilat. =. No tremors, seizure activity, or asterixis, patient is alert and oriented ´c intact short-term memory.
EXTR: s clubbing, cyanosis or edema.

LABS:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>141</td>
<td>108</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&lt;89</td>
</tr>
<tr>
<td>4.0</td>
<td>26</td>
<td>1.0</td>
</tr>
</tbody>
</table>

sputum culture - neg. @ 24 hrs.
stools occult blood positive
7.37/42/84 on 21/NC
4 units PRBC's typed and cross matched
Upper GI endoscopy revealed diffuse, erosive gastritis

A. 1. GI bleed. Stable further blood loss, although stools remain heme. +. EGD revealed erosive gastritis as probable source of blood loss.
   2. COPD. The patient's pulmonary status continues to improve, c̄ improved air exchange by P.E. and improved ABGs. Sputum cult. neg. so far.

P. 1. Continue Tagamet and antacids, monitor the patient's Hb, and continue to Guiac stools. 4 units PRBCs typed and crossed.
   2. Continue Alupent aerosols, 02 at 21/NC, and IV Aminophylline. Taper Solumedrol and continue to monitor ABGs.
   3. Thiamine IM, monitor for sx of ETOH withdrawal ´c Librium use as indicated. Transfer to ADTU when #1 and #2 are stable.

Some services will ask you to write On-Service notes on your first day. This note includes a brief history of illness and review of hospital course to date, as well as pertinent labs and results of studies.

**Order Writing**

Your responsibilities as a clinical student will include writing orders on your patients for admission, discharge, transfers, and daily changes in medications, therapies, and diagnostic procedures. The extent to which you are responsible for order writing will vary from service to service, attending to attending, and resident to resident. On some services, you will be encouraged and expected to write every order for your patients, while on other services you may not be allowed to write orders at all. The usual case is somewhere between these two extremes, and you will be sharing the responsibility of writing orders with your resident. It is a good idea to find out at the beginning of a clinical rotation what your resident's expectations are in this regard, since your aggressiveness in writing orders on your patients is frequently a factor in your clinical evaluation by the residents. Furthermore, it is much easier to keep track of what is going on with your patients if you yourself wrote the order for their care.

It is always a good idea to write orders clearly, number each order individually, include the date and time in which the order was written, and always sign your name legibly.

The nursing staff will not follow through with student orders until they have been co-signed by a resident or attending. It is also your responsibility, therefore, to see that the orders which you have written are co-signed in a timely fashion so that they can be carried out in a timely manner.
Admission Orders

(ADC VAN DISSEL): Maxwell has a great (short) example.
The following format is useful for writing admission orders and is easy to remember using the mnemonic ADC VAN DISSEL. With some minor alterations, it is also useful for writing transfer and postoperative orders. The mnemonic stands for Admit, Diagnosis, Condition, Vital signs, Activity, Nursing procedures, Diet, Intake and output, Specific drugs, Symptomatic drugs, Extras, and Labs. Many physicians and residents have their own system for order writing. Find one that works best for you, is easy to remember and includes all of the important information/orders.

1. **Admit:** Floor, team, house officer, attending, etc. For instance, admit to 44C ICU, Med I Service, Dr. Smith H.O., Beeper #2222

2. **Diagnosis:** The diagnosis may be specific, for example acute appendicitis, or may be a symptomatic diagnosis if a specific diagnosis is not yet known, for instance, abdominal pain. For postoperative orders, include the surgical procedure which was performed, for instance, appendectomy. Always include under diagnosis the patient’s allergies or lack of known allergies, for instance NKDA or allergic to penicillin.

3. **Condition:** The patient’s condition on admission, transfer, or post-operatively is noted here as stable, critical, etc. Vital signs: This is technically part of nursing procedures, but is written separately by convention.

4. **Vitals:** Refers to the frequency with which the nursing staff will monitor and record the temperature, blood pressure, pulse, and respirations of the patient. Other specific monitoring, such as weight, CVP, PCWP, CO, neurologic signs, etc. should also be listed here. For instance, Vitals: Q1hr., daily weights, Swan-Ganz measurements Q shift.

5. **Activity:** This describes the activities allowed for the patient, for instance, up ad lib, bed rest, bathroom privileges, bedside commode, ambulate TID, up in chair QID, limited visitation, etc.

6. **Allergies:** List any drug allergies, and what reaction accompanies each (i.e. rash).

7. **Nursing procedures:** This consists of a variety of items including, but not limited to the following:

   **Bed position:** For instance, elevate HOB 30 degrees, Trendelenburg position, etc.

   **Preps:** This generally refers to preoperative patients and includes, for instance, bowel preps, surgical preps, showers, etc.

   **Dressing changes and wound care.**

   **Respiratory care:** Although respiratory care is generally provided by Respiratory Therapy rather than nursing, Respiratory Therapy orders that do not include medications are often included here, for instance, PD&C (percussion and postural drainage), TC&DB (turn cough and deep breathe), incentive spirometry, nasotracheal suctioning, etc.

   **Notify house officer if:** This establishes parameters in vital signs beyond which nursing will notify the patient’s resident for further orders, for instance, notify HO for temp 38, systolic BP 90, PCWP 20, etc.

8. **Diet:** NPO, regular, mechanical soft, clear liquid, 1600 cal ADA, 2 gm sodium restriction, tube feedings, protein restricted, etc.
9. **Intake and output**: This includes the frequency with which nursing will monitor and record I&O as well as any tubes, drains, or lines the patient might have, for instance:

   - Record hourly I&O
   - NG tube to low intermittent suction
   - Foley catheter to dependent drainage
   - Hemovac, surgical drains, chest tubes
   - Endotracheal tubes, arterial lines, central venous lines

10. **Specific drugs**: This includes all medications to be given on a specific schedule, for instance, antibiotics, diuretics, cardiovascular drugs, etc. Also include allergies to medications. IV orders include simply the type of IV solution and the rate at which it is to be infused, for instance, D5 1/2NS TRA 50 cc/hr. When the patient has both central and peripheral lines, these are specified separately, for example, D5 1/2NS TRA TKO via peripheral line and D5 1/2NS TRA 100 cc/hr via central line. Inpatient medication orders are written with the name of the drug, dosage, route of administration, and frequency of administration specified, for instance, Digoxin 0.125 mg PO Qday.

11. **Symptomatic drugs**: This includes all drugs to be given on a pm basis, for instance, pain meds, laxatives, sedatives, etc.

12. **Extras**: This includes any diagnostic procedures to be performed, for instance, EKG, chest x-ray, CT scan, sonogram, etc.

13. **Labs**: Blood tests, urinalysis, etc. These can be one-time orders for admission lab work or can be standing orders for continuous monitoring, for example, daily CBC.

**Discharge Orders**

Discharge orders should include the following basic information.

1. **Discharge**: Give location patient will be going after leaving hospital (i.e. home, nursing home). Specify what date and time.

2. **Follow-up Care**: Include with whom, when and what time. (i.e., Patient to follow-up with Dr. Meyer in Family Practice outpatient clinic, on Tuesday 7/23/08 at 1:00 p.m.). You will usually need to call to set these up.

3. **Discharge Medications**: When you are writing discharge orders, medication orders are written like outpatient prescriptions, and therefore include the name of the drug, form in which it is to be dispensed, amount to be dispensed, patient instructions, and number of refills, for instance, Ampicillin, 250 mg capsules, Disp:#40, Sig: 1 cap PO QID until gone, Refills: 0

**Striving and Thriving on Clerkships**

You will, with luck, find in this section a number of helpful suggestions that may ease the transition into the clinical years. This collection of information has proven helpful to most of us during this last year, and we hope it will do the same for you. None of this information is set in stone, but a lot of it serves as a good place to start.

**In General**

Work closely with your attendings (when allowed). Wichita teaching physicians are uniquely enthusiastic about medical education and about mentoring. They may be willing to mentor you through amazing experiences, especially when you demonstrate enthusiasm. Ask them, too, about the systems-based aspects of medicine: malpractice issues, nurse practitioners partnerships, call schedules, etc. Also, seek out learning experiences. When you’re not obligated to a rotation task, explore. A su-
perb attending in Wesley Pediatrics once argued that it is the RIGHT of medical students to explore the hospital, to sift through records, and to seek out learning experiences wherever they can. Do so.

**On the Wards**

Part of your clinical education is about learning how to be a good resident, a good worker in medicine. As soon as possible, challenge yourself to start thinking like a resident—with, of course, a healthy dose of realism in remembering that you are still a medical student. Thinking like a resident means knowing your patient through-and-through. What if you were called in the night about that patient? Would you know what his face looked like; what his labs were that day; what to order on him?

Challenge yourself, too, to fulfill your medical student roles to the best of your ability. Similar expectations will exist for you on each rotation in the hospital. You will learn these (write more comprehensive notes than the resident, run ahead to get charts for rounding attendings, check out with your resident before leaving each night). Some residents are very good at setting rotation-specific expectations for you on day one. Some are not. Ask your residents and your attendings, directly, on the first day to define your role and their expectations of you.

You must remember not to take the resident’s comments, moods or opinions personally. Do not get discouraged early on; instead, find value in the good work that you know you’re doing and continue to work hard. Success on the wards is getting back up more times than you are knocked off your feet.

Also, in the quest for success on the wards, you may want to fulfill the following tasks:

- **Always, always know your patient.** This includes history, labs, insurance provider, medications, radiology, etc. Take time to get to know them.

- **First impressions make all the difference.** Busy residents and attendings usually take the hardest look at your work ethic in the very beginning. Work very hard for the first two or three days to master the syllabus (it’s full of gems about how to excel) and the introductory chapters of a rotation-specific text book. You’ll write better notes and have better questions in the very beginning this way. Continue to work hard throughout the rotation.

- **Be nice to the nurses and the rest of the support staff.** They become powerful allies. Introduce yourself when you start on any new service. You’ll find that most of the ICU nurses know more than you, so listen to them. Do all you can for all staff without getting in the way.

- **Stock your pockets** (but not too heavily) with references and tools. It’s different for every student but necessary things to carry include your smart phone, a memo note pad, Maxwell Quick Medical Reference, a stethoscope, and as many pens as you can. Other items that may help include: a “facts and formulas” book (little blue book available at bookstore), the Washington Manual, the Clinician’s Pocket Reference (“Scut Monkey”), any extra equipment you may need on specific rotations (a Snellen eye chart, reflex hammer, tuning fork, safety pins, pen light on Neuro, a gestational wheel on O.B., a small pillow and food rations on Surgery, etc.). This will all vary based on what rotation you are on.

**Charting in a Nut Shell**

Learning how to document effectively is an important part of third-year. When in doubt, over-communicate. Don’t be afraid to use descriptive language and to trust your instincts. Later, you may ask your residents and attendings to edit and make suggestions to your notes. If you’re not familiar with the hospital setting and have never worked with medical records or patient charts, be sure to
find some time, and a helpful nurse, fellow student, or resident to introduce you to the system and some of the shorthand. You can never go too far to get all the necessary information: including showing up a little early, perusing other people’s notes whenever possible, and exploring charts over-and-over in an effort to begin to understand where to find information.

Outside the Patient’s Room
Approaching the hospitalized patient and then writing a note about that approach can be daunting at first. It goes much more smoothly if you develop a systematic way to look through the chart. Make sure to look at the following sections before you enter the patient’s room:

- Physician’s orders – (white) usually near the beginning of the chart. This is truly an important resource! It lets you know what tests have been ordered, what medications have been changed, what the physician’s plan is for the patient.
- Progress notes
- MAR (medication administration record)
- Vitals and I&O’s
- Labs and Imaging
- Nursing – (yellow at St. Francis) (listed at the very bottom of the electronic chart list at Wesley) aka – Multidisciplinary note

The Progress Note
The progress note will be a big part of all of your inpatient services—surgery, medicine, psychiatry, OB/GYN, and pediatrics. With the exception of the critical care notes that follow, they are fundamentally the same, although they may vary in required exhaustiveness.

Below is an example:
**Remember to DATE and TIME every note in the left hand margin

Med I—MS3 Note
S: Pt slept well overnight, awaking twice with a productive cough. Pt states pain control is OK with PCA. No further n/v/d. No SOA, cp. Pt requests “regular food” today.
O: Vital: Tmax 100.5 Tcurrent 98.4 BP 110/65 P 72 RR 18 02 Sat 94% on 1L n/c
I&O = 2350/2000 = -350cc
Gen: Elderly male in NAD, alert
HEENT: PERRL, EOMI, no palpable nodes or thyromegaly
CV: RRR with a 2/6 soft systolic murmur heard best at the RSB. Cap refill < 3 sec
Pulm: Some soft rhonchi bilaterally, improved. No wheezes.
Abd: S/NT/ND/+BS
Ext: 2+ pitting edema in ankles bilaterally extending to mid-calf. No clubbing, cyanosis.
Lab: CBC, BMP pending this AM
Imaging: CXR pending this AM
A/P: 1. 75 yo male with COPD exacerbation, HD #4, doing well.
   Continue to titrate O2, continue Levaquin and Solu-Medrol,
   continue albuterol breathing treatments PRN.
2. EtOH dependence: No signs of withdrawal at this time. Will use Ativan PRN for tremor or seizure.
3. Chronic leg pn: Will attempt to D/C PCA today and start on Neurontin.
4. D/C planning: Social work to see pt this AM. Will f/u at KU resident clinic.
   (Signed) Medical Student Name, MS3
Margin: list medications in the left margin. Note which ones are scheduled and which are prn. You must state how many days the patient has been on each antibiotic (i.e. vancomycin day #4).

Abbreviation key of above note
pt – patient
n/v/d – nausea, vomiting, diarrhea
PCA – patient controlled analgesia
SOA – shortness of air
Tmax – maximum temp over last 24 hours
Tcurrent – temp recorded with last set of vitals
BP – blood pressure
P – pulse rate
RR – respiratory rate
O2 Sat – oxygen saturation
n/c – nasal cannula
D/C – discharge
I&O – intake/output
NAD - no acute distress
PERRL – pupils equally round, reactive to light & accommodation
EOMI – extra ocular eye movements intact
RRR – regular rate and rhythm
S/NT/ND/+BS—soft/nontender /nondistended/+ bowel sounds
CBC – complete blood count
CMP – complete metabolic panel
CXR – chest x-ray
PRN – as needed
f/u – follow up

Surgery variation on this note
Surgery notes are the briefest notes you will write in your clinical years. In the subjective section, you will comment on concerns the patient had overnight, how well the patient's pain was controlled, whether the patient experienced fevers, chills, nausea, vomiting, chest pain or shortness of air. You will then comment on whether the patient had a bowel movement or moved gas rectally, whether the patient tolerated his or her diet, and whether the patient ambulated. For the objective section of the note, ask your resident on which day you should remove the bandage to check the sutures and do so each morning from that day forward. Note whether they are intact, dry, erythematous, etc. You will also include the results of your physical exam here.

General Suggestions
A reliable car is a requirement to survive Wichita clinics as you will often visit multiple sites in one day. Get used to driving around town frequently, especially to attend classes, conferences or lectures. You will be given driving time for most activities. Family Medicine/Ambulatory has Wichita maps available for you. The staff of Academic and Student Affairs can also be very helpful. Spend a little time driving around during Introphase getting to know where the hospitals are.

Call schedules are made available monthly. Don’t be terrified about exchanging with fellow students; most services permit it. When on call notify the operator and ask them to page one of the residents on call for your service so they are aware you are there. In general, you get out of call what you put into it, and often you have to be bold about requesting that a resident call you. On the other hand, there will be those nights when you really need to study or sleep and sixteen emergencies will appear in the E.R. and your resident will want you for clerical support. Wear scrubs and comfortable shoes.
Your resident can show you how to procure scrubs from each of the hospitals. Generally, taller people prefer the blue scrubs from Wesley over the green scrubs from St. Francis. At the VA, scrubs from either Wesley or St. Francis are acceptable. Inevitably, you will end up taking a few sets home so you have them for your call nights. There have been problems, however, over the past few years with people taking a ridiculous amount of scrubs home and returning them (or not) at the end of fourth year. Please do not take scrubs for every day of the month. It is inconsiderate toward the other medical students and the employees of the hospital.

In the past, some have suggested that you not let residents or faculty know what field you’re planning to go into if it is different from the clerkship you are in at the time. In all reality, most residents and attendings do not really expect everyone to want to go into their field. It is up to you to decide whether or not you feel comfortable sharing that information. By and large, though, it will almost never hurt you in any way. On the other hand, if you know you want to go into a particular rotation, it is probably to your advantage to let your attendings know that during that specific rotation.

On any rotation, get to know the support staff. They can help you get free access to copy machines, keys to on-call rooms, books, etc.

Adopt a good attitude going in to each rotation, no matter how much you might dislike the idea of the subject. There are learning opportunities on every rotation. Each rotation is a fresh start as well as an opportunity to acquire new skills. It is helpful to make a list of personal goals for each rotation. Let your residents and attendings know about your goals. It shows them you are interested. Also, don’t be afraid to ask questions at appropriate times. It may be helpful to keep a list of things you had questions about during the day in your pocket, then look them up that night and discuss them with the resident or attending the following day if you still have questions. This is your chance to tailor your education. By spring, you will recognize your own strengths and weaknesses and be happy for the opportunity to work on skills you need to perfect.

**Information about the Hospitals**

**Wesley**
The computer system at WMC is relatively user friendly. The hospital offers a “dial-in” service from your home PC that can come in very handy for keeping up on your patient’s lab values and procedures. Be careful not to rely on this too heavily since the information in the computer has to be entered in a timely fashion by the nursing staff in order to be accurate. It is imperative for you to learn to use the computer system at WMC in order to thrive in the clinics there. You will be given a password and a brief lesson on how to use the system during orientation week. You will need to call the IT department if you want to set up remote access.

There are conferences in Koch every day, and lunch is usually provided. If you have the time while you are rotating at Wesley, it is a great learning opportunity.

**Veteran’s Administration Medical Center**
Bring scrubs from Wesley or St. Francis for call. At the time this manual was printed, there was a refrigerator in the student call room and a microwave in the Internal Medicine room. Be sure on the first day to ask your resident in case that has changed since the cafeteria is not open in the evening. One key: things move very slowly at the VA, so be patient! The VA is a great place to learn. You see some pathology there that you won’t see other places, and you will be given a lot of leeway.

**St. Joseph**
Free coffee is available on all floors. You are rarely at St. Joe aside from some exceptions during the Neurology and Psychiatry clerkships. You will have on-call nights at St. Joe during the Family Medicine and Psychiatry rotations.
**St. Francis**
You will receive computer passwords to look up lab values, etc. and limited instruction about the system. It may seem overwhelming, but it will get easier. There is free coffee on all floors. Don’t eat from the Surgeon’s Lounge in the OR area (unless accompanied by your resident). The exact same food is available to you on the second floor in the satellite chart office/physicians' lounge. Seems silly, we know, but the surgeons often have less free time than you do to run downstairs for lunch, so it's considerate to leave the food in the OR lounge for them. Breakfast is also available there free of charge. Get there early for both meals (6:45am for breakfast and 10:30am for lunch) or the food will likely be gone!

**Students** may park in Employee parking lots. If you have completed your Vehicle Identification Form, and it has been processed, you may park on the North end, top level of the parking garage. St. Francis and St. Joseph both provide maps during orientation indicating where students may park. They will ticket you if you park where you shouldn't!

The call rooms have been revamped and are very nice. Enjoy them. They far outshine the other hospitals’ call rooms. You will actually feel safe and comfortable at the St. Francis call rooms. They even have a couple of study rooms with computers and internet access. There is also a small branch of the library in the Physician's Lounge that is always open and has computers, a copy machine and several textbooks.

**General Tidbits**

**Reference Cell Phone**
Reference cell phones will go into use June 2, 2014, in place of pagers, for all 3rd year students. Students are reimbursed for their purchase of a device upon presentation of a receipt. You may pick your own with a cost of up to $300. Be sure to keep your reference cell phone charged.

**Dress**
There will be some rotations where you will wear scrubs the majority of the time and some where you won’t wear them at all. If it is not a scrub rotation, you should dress professionally and modestly. If you aren’t sure about the dress code for a particular rotation on the first day, always dress up. You can’t go wrong if you are dressed professionally. If it is a scrub rotation, they always give you time to change (and you get your scrubs from the hospital anyway).

**Classes – scheduling and organization**
Due to the hectic nature of a doctor’s life, classes unfortunately are often cancelled or rescheduled. If it is last minute, you will receive a page (a good reason to have your reference cell with you always—even on an outpatient rotation). Most of the time you will get the calendar change by email. So, the rule is to check your email frequently—at least once every day. Also, make sure you have some way of organization that works for you – a paper planner, the printed calendar the rotation gives you, your calendar on your phone – something where you can keep track of where you are supposed to be and when. On some rotations, this can be quite complicated. If you can’t find it one day and are confused, just call your clerkship coordinator. They are all really nice and will be happy to help you.

**Medical Appointments**
You are excused from rotations for medical appointments. Please tell your chief resident or attending of any medical appointment you need to attend.
Health Care
Students should refer to their health insurance policy for instruction on access to health care facilities in and outside of Wichita.

Remember that things change rapidly and there is much more for you to know, so please ask a fourth year student or students in the rotations ahead of you for advice. Good luck!

Accidents And Needle Sticks

ACCIDENTS
Should you sustain injuries or have an accident, other than needle sticks, when on hospital rotations, follow procedures as mandated by your health insurance policy.

NEEDLE STICKS
You will receive a laminated card outlining procedures for each hospital. Please carry it with you when on a hospital service so you know the appropriate procedures. (It is a good idea just to keep the laminated card in your wallet for reference). The procedures are listed below.

Protocol for Blood-borne Pathogen Exposure for KU Medical School - Wichita Students

VA Medical Center
• Clean and decontaminate the exposed area. Notify service/unit supervisor.
• From 8am – 4pm M-F, notify Employee Health (53389). You will be asked to fill out a “Duty to Report” incident report using the employee safety hazard category. If it is after hours, have the operator page the Nursing Coordinator, who will assist you.
• Please print a copy of the “Duty to Report” for your reference.
• Go to the Emergency Department, open 24 hours. The physician on duty will order the appropriate labs on you (trainee) and the patient. Please notify Dr. Mona Brake or Dr. Syed Raffi during business hours and provide a copy of the “Duty to Report” incident report so that an official VA incident report (ASIST) may be filed.
• VAMC will cover the cost of emergency care related to the incident.

Via Christi Regional Medical Center
• Clean and decontaminate exposed skin and/or mucous membranes.
• Page the House Supervisor (24/7). They will bring you a packet and order the appropriate testing, guide you through the process, and contact you with test results.
• You will need to complete the Exposure Investigation Report.
• Identify the source patient information and account number.
• Employee Health will also follow-up with your results and recommendations.
• Your school will be notified.

Wesley Medical Center
• Wash and rinse wound area thoroughly with germicidal soap.
• Obtain source patient information and account number.
• Report to the Employee Health Office immediately (Level G, Medical Arts Tower, from 9am – 3:30pm). If Employee Health is closed, report to the Emergency Department for treatment.
• Residents and medical students should complete HNS form located on the Wesley Intranet or call 962-2210 for assistance.
• Treatment for individuals who have HIV-positive exposure must occur within two hours.

STUDENT INJURY FLOWCHART
Via Christi Health

• Injured student presents to Unit Director/Shift Leader or House Leader and Faculty.
• Complete the Employee Report of Injury Form with Faculty co-signing and initiates first step of treatment process.

Treatment Process

1. Acute Injuries that are emergent -
   • Fill out Employee Report of Injury Form.
   • Go to the Emergency Room.
     The student’s insurance company will be billed.

2. Acute Injuries that are non-emergent -
   • During respective school's Student Health Clinic operating hours the student should report to the Student Health Clinic for evaluation and treatment.
   • After hours of the respective school's Student Health Clinic operating hours the student will report to the Emergency Department for evaluation and treatment (with the Employee Report of Injury Form) at no cost to the Medical Center.
     The student's insurance company will be billed.

Call the Care Coordinator Hotline if you have any questions at 650-5570/261-3282; fax 291-4291. This number is answered 24/7.