

**MEDICAL STUDENT  
SURVIVAL GUIDE  
& CLINICAL  
ORIENTATION  
MANUAL**



**KU** SCHOOL OF MEDICINE  
**WICHITA**  
The University of Kansas

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Welcome from the Wichita Class of 2013 President!

Dear Class of 2015,

On behalf of the class of 2013, welcome to Wichita and the official start of your clinical years as a third-year medical student! We are so glad that you are joining us in Wichita, and hope that you will all enjoy your experience here as much as we have.

Oh how I remember those 10- and 12-hour days during 2<sup>nd</sup> year filled with lectures, podcasting, afternoon small groups, anatomy, etc...and how I could not wait to be a 3<sup>rd</sup> year in the hospitals and clinics seeing patients and applying what I was (supposedly) learning! You will quickly find out that the transition from 2<sup>nd</sup> to 3<sup>rd</sup> year is HUGE. However, there are many people who are here to help. Never hesitate to ask any of us in the fourth year class for advice about rotations, directions in the hospitals, or basic questions about the philosophy of life. We were just in your shoes one short year ago, and therefore will be readily prepared and eager to provide solicited and unsolicited assistance.

Here in Wichita, we are truly blessed to have wonderful people in the Academic and Student Affairs (ASA) office whose priority is to help us with ANYTHING, med-school-related or not. Every single one of them is extremely friendly and extremely knowledgeable. We recommend that you get to know all of them early on an individual basis, as we will work with them a lot during our two years here. They are life-savers!

On a practical note, I highly recommend that each of you buy a small notebook to keep in your white coat pocket. Personally, I use a 6x9 inch one, but some classmates prefer a little smaller size. Use it to keep track of patients, write notes to yourself, copy templates of Progress Notes for particular specialties like OB/GYN and surgery, or even just to write down patient information during an H&P. You will not regret having this pocket-sized resource close by. And always carry an extra pen or two for when your attending or a resident needs one...

In order to ease the transition (and anxiety), previous medical students have compiled a survival guide and orientation manual. We recently revised it in May 2012 to reflect the changes that have occurred over the past year, and to include the specific suggestions from our class to yours. We are all more than happy to answer any questions that you guys have during the next year, but also feel free to email me personally. Congratulations again on making it through two tough years of academics, and best of luck with the next two years of clinics!

Sincerely,  
John Hunninghake MS4  
President of Class of 2013, KU - Wichita  
[jhunninghake@kumc.edu](mailto:jhunninghake@kumc.edu)

## Phone Numbers and General Information

### Academic & Student Affairs

**Phone: 293-2603**

Garold O. Minns, MD, Associate Dean; Heather Morrison, Director; Karen Drake, Assistant Director; Lynnette Amey, Administrative Specialist; Wendy Holt, Maggie McNamara, Melanie Runge, Trang Trinh, Coordinators; Sue Kennedy, Accounting Specialist.

### Clerkship Directors

<b><u>Department</u></b>	<b><u>Director (Coordinator)</u></b>	<b><u>Phone #</u></b>
Family & Community Medicine	Scott Moser, M.D., (Mary Hursey) <a href="mailto:mhursey@kumc.edu">mhursey@kumc.edu</a>	293-2607
Geriatric Medicine	Jerry Old, M.D., (Deb Dixon) <a href="mailto:ddixon@kumc.edu">ddixon@kumc.edu</a>	293-2607
Internal Medicine	Justin Moore, M.D. / Chris Faulk, M.D. (Jean Olsen) <a href="mailto:jolsen@kumc.edu">jolsen@kumc.edu</a>	293-2650
Neurology	Andrew Massey, M.D., (Jean Olsen) <a href="mailto:jolsen@kumc.edu">jolsen@kumc.edu</a>	293-2650
OB/GYN	Michael Brown, M.D., (Margaret Santos) <a href="mailto:Margaret.Santos@wesleymc.com">Margaret.Santos@wesleymc.com</a>	962-7396
Pediatrics	Mark Harrison, M.D., (Donnita Pelser) <a href="mailto:Donnita.Pelser@wesleymc.com">Donnita.Pelser@wesleymc.com</a>	962-2250
Psychiatry	Michael Burke, M.D., PhD (Ronda Magness) <a href="mailto:rmagness@kumc.edu">rmagness@kumc.edu</a>	293-3508
Surgery	Teresa Cusick, M.D., (Ashley Martin) <a href="mailto:ashley.martin@via-christi.org">ashley.martin@via-christi.org</a>	268-5990

**KU Bookstore Wichita Campus**

**Phone: 293-2618**

Hours: 9 a.m. to 5:30 p.m. Monday through Friday

Closed for lunch 1 p.m. to 1:30 p.m. daily

Email: [ccarter@kumc.edu](mailto:ccarter@kumc.edu)

**Hospital Information**

Hospital:

Wesley Medical Center

550 N. Hillside

Via Christi-St. Joseph

3600 E. Harry

Via Christi-St. Francis

929 N. St. Francis

Robert J. Dole VA Medical Center

5500 E. Kellogg

Physicians' Exchange

**Page Number**

962-3030

685-1111

268-5000

Wesley to page

262-6262

**Farha Medical Library**

**Phone: 293-2629 (24-hour access with security card)**

<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 lower level features three private study rooms with computers as well as housing additional books and journals.

**KU School of Medicine-Wichita - After Hours Access**

You will receive a security card that will gain 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). A replacement card is \$3.00.

## Graduation Competencies

Curriculum Objective:	Graduation Competency:
<p><b>Patient Care:</b><sup>1</sup>  <i>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.</i></p>	<p><i>Before graduation from the School of Medicine, students will be able to:</i></p> <p><b>PC1:</b> Assess patients presenting with undifferentiated urgent, acute, or chronic health problems.</p> <p><b>PC2:</b> Develop a prioritized differential diagnosis and/or problem list based on patient assessment.</p> <p><b>PC3:</b> Select and interpret diagnostic tests based on scientific evidence and patient considerations.</p> <p><b>PC4:</b> Use sound problem solving strategies to propose initial patient management plans (see also PBL 1, SBP1-4).</p> <p><b>PC5:</b> Assess and address disease prevention/health promotion for individual patients.</p> <p><b>PC6:</b> Perform selected investigations and technical skills correctly and with attention to patient safety and comfort (Appendix C).</p>
<p><b>Medical Knowledge:</b>  <i>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.</i><sup>2</sup></p>	<p><b>MK1:</b> Access updated, reliable, high-quality scientific information in order to support clinical decisions.</p> <p><b>MK2:</b> Provide evidence for their diagnostic and management decisions based on application of medical knowledge and clinical reasoning.</p> <p><b>MK3:</b> Scientifically appraise innovative concepts and practices for potential value in patient care.</p>
<p><b>Practice-Based Learning/Improvement:</b>  <i>Students will demonstrate critical and analytic thinking, awareness of the limitations of their knowledge and skills, and commitment to continuous learning and improvement.</i></p>	<p><b>PBL1:</b> Refine diagnoses, management strategies, and prognosis as conditions evolve as active participants in the ongoing care of patients.</p> <p><b>PBL2:</b> Accept and provide constructive feedback.</p> <p><b>PBL3:</b> Critically reflect on patient care activities, using analysis of experiences to improve performance.</p> <p><b>PBL4:</b> Set personal learning objectives and describe strategies to achieve them.</p>

<sup>1</sup> See objectives of individual modules, courses and clerkships For specific types of patients (eg children, elderly), medical conditions, diagnostic investigations, and procedures.

<sup>2</sup> 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.

<p><b>Interpersonal and Communication Skills:</b>  <i>Students will communicate effectively and appropriately with patients, family members of patients, colleagues, other health professionals, and relevant other as a basis for trusting, collaborative relationships to promote optimal health outcomes.</i></p>	<p><b>ICS1:</b> Communicate effectively with patients and families, including situations involving sensitive, technically complex, or distressing information.</p> <p><b>ICS2:</b> Conduct a culturally-competent clinical encounter.</p> <p><b>ICS3:</b> 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.</p> <p><b>ICS4:</b> Create, maintain and use appropriate confidential records of clinical encounters using standard terminology and formats.</p>
<p><b>Professionalism:</b>  <i>Students will integrate the concepts of altruism, accountability, excellence, duty, service, honor, integrity, and respect for others into all aspects of their professional lives.</i></p>	<p><b>P1:</b> Demonstrate appropriate professional attitudes and behaviors (altruism, respect, accountability, duty, honor, integrity and commitment to excellence) in their clinical and educational activities.</p> <p><b>P2:</b> 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.</p> <p><b>P3:</b> Recognize and address personal limitations, attributes or behaviors that might affect their effectiveness as a physician.</p> <p><b>P4:</b> Recognize and address ethical concerns in the practice of medicine.</p>
<p><b>Systems-Based Practice:</b>  <i>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.</i></p>	<p><b>SBP1:</b> Demonstrate effective participation in a health care team.</p> <p><b>SBP2:</b> Appropriately adapt to participate in patient care in a variety of settings, each with different priorities, opportunities, and constraints.</p> <p><b>SBP3:</b> 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.</p> <p><b>SBP 4:</b> Discuss the causes of medical error: Act to anticipate, prevent, and respond appropriately to threats to patient safety.</p> <p><b>SBP 5:</b> Identify, analyze, and propose solutions for a health problem in the community.</p>

## Family Medicine

### *Quick and Dirty*

Length:	8 weeks
Setting:	Private Practitioner's Office
Schedule:	8 a.m. – 5 p.m.
Setting:	JayDoc 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) <a href="mailto:mhursey@kumc.edu">mhursey@kumc.edu</a>
Website:	<a href="http://wichita.kumc.edu/fcm/">http://wichita.kumc.edu/fcm/</a>

### **General Information**

This rotation went from 6 weeks to 8 weeks in 2009. It 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.
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, like asthma, hypertension, dysfunctional uterine bleeding, etc. 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.—Lectures and Workshops
Tuesday	8 a.m.-5 p.m.—Clinic or 7 a.m.—Call
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. Once per month
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 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 Medical Home Essays**

During the clerkship, students will attend lectures on the PCMH, and then will complete a series of interviews in order to write two essays that focus on concepts related to the PCMH. You will end up interviewing a member of the office staff, your preceptor, and multiple patients. The essays are a new addition to the curriculum. Although they sound difficult, it is really not that bad and gives you a chance to learn more about the PCMH.

### **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; the other is OB. You can expect to be very busy when you are on OB call because there are no OB/GYN residents at St. Joe. All patients are monitored and delivered by FM residents. It can be a really great experience -- just don't expect a lot of sleep.
3. Continuity Maternity Care Experience – You will be assigned an OB patient with a family medicine resident. 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, the National Board subject exam, a departmental written exam, an Objective Structured Clinical Exam (OSCE), a 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**

### ***Quick and Dirty***

Length of Course:	4 Weeks
Clinical Schedule:	Normally 8:00-5:00 p.m. M-F; Sat & Sun Off
Call:	None
Clerkship Director:	Jerry L Old, M.D. <a href="mailto:jold@kumc.edu">jold@kumc.edu</a>
Assistant Director:	Melissa Gaines, M.D. <a href="mailto:mgaines@kumc.edu">mgaines@kumc.edu</a>
Clerkship Coordinator:	Deb Dixon (293-2607); <a href="mailto:ddixon@kumc.edu">ddixon@kumc.edu</a>
Website:	<a href="http://wichita.kumc.edu/fcm/">http://wichita.kumc.edu/fcm/</a>

### **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 “Angel,” 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 before the rotation begins, if you have a preference.

### **Example of a Typical Week**

Monday	8 a.m.-5 p.m.—Didactics and Workshops
Tuesday	8 a.m.-5 p.m.—Clinic
Wednesday	8 a.m.-noon—Dementia Rounds 1 p.m.-5 p.m.—Clinic
Thursday	8 a.m.-noon—Hospice 1 p.m.-5 p.m.—Clinic
Friday	8 a.m.-noon—Clinic 1 p.m.-5 p.m.—Standardized patients
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

- Wound Clinic
- Seminars
- Workshops
- Standardized Patients
- Specific self-study reading assignments
- Patient presentations
- Case based discussions

**Textbooks**

The following textbooks are required and are available for loan from the Department of Community and Family Medicine at no cost. They must be returned in good condition at the end of the course.

1. Ham & Sloan, Primary Care Geriatrics: A Case Based Approach
2. Old & Swagerty, A Practical Guide to Palliative Care

**Grades**

Grades are 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, 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**

***Quick and Dirty***

Length:	8 weeks – divided into two 4-week blocks between two panels
Setting:	St. Francis, Wesley 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:	Ashley Martin (268-5990) <a href="mailto:ashley.martin@via-christi.org">ashley.martin@via-christi.org</a>
Website:	<a href="http://wichita.kumc.edu/surgery/">http://wichita.kumc.edu/surgery/</a>

**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 4<sup>th</sup> and 5<sup>th</sup> week.

### **The Panels**

All panels are general surgery 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.
- Unassigned: This service is now combined with Trauma. If you are on unassigned service you need to notify the resident on trauma and they will contact the unassigned resident to seek out cases for you to scrub in on.
- General: General surgery and colorectal surgery. This is a busy general surgery service. Reading before cases is imperative. This service is well received by students, just stay on the ball.
- Transplant: Students find this experience valuable. This is a busy service and a great opportunity to learn a lot.
- Wichita Clinic + Kansas Surgical Specialists: General surgery with good teachers. This is a slower service. If you are assigned to this service spend time preparing for the shelf. You will be assigned to a busier service next.

- Breast Service: This service is now combined with Vascular. Breast Service has a clinic each month at the Chang Specialty Clinic from 1-4:30 p.m. Students are required to attend class and dress professionally.

### Grades

Cognitive Skills (Final Exam 35%; Oral Exam + Case Presentation 15%) =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 **56 or greater** on the final exam – the NBME subject examination. A minimum score of 56 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.
- 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-quiz 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

### *Quick and Dirty*

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.)
Clerkship Director:	Justin Moore, M.D., and Chris Faulk, M.D.
Clerkship Coordinator:	Jean Olsen (293-2650) <a href="mailto:jolsen@kumc.edu">jolsen@kumc.edu</a>
Website:	<a href="http://wichita.kumc.edu/im/">http://wichita.kumc.edu/im/</a>

### General Information

The main emphasis of Internal Medicine is learning to take a history and administer a physical examination in the proper way. Also important is learning how to write and present the 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.	
Tues., Wed., Thurs.	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 month; you will round, write notes, then do attending rounds. Typically, you are free after that. The weekend between 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 another opportunity in other clerkships. On each service, your attending will assign you two critical case summaries taken from completed work-ups. This is where you are given the task of focusing on the differential diagnosis for that patient. Your task is to write out an explanation of how you arrived at this differential. Then you are to identify which is the most likely diagnosis and why. This will include brief pathophysiology, epidemiology, etc. You research in texts and articles for this project. The department will give you a guideline to follow. Your attending should give you a timeframe for completing this (usually 3-4 hours).

### **How to Excel**

The H&Ps become especially good teaching tools when the attending assigns you the **critical case summary**. (The format of the critical case summary may be changing in the future. Rumor has it that it will be replaced by oral cases, so take the rest of these suggestions with a grain of salt.) This is an excellent time to shine. Another key to this clerkship is the presentation of patients and writing a daily progress note. The SOAP note format is most often used, although 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. 1<sup>st</sup> year residents should know how to manage most common conditions by end of their 1<sup>st</sup> 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. Critical case summaries: You will do four of these formative exercises. These are written exercises in which you will develop a differential diagnosis based on history, presenting symptoms, labs, radiographic studies, and all other data collected on one of your patients. You are allowed to use any information source while you are

writing this summary but there is a time limit. The medicine office will distribute detailed instructions and an example of a well-written critical case summary. These are evaluated by your attending.

3. **Bedside practical 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 exam (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. 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

Clinical Performance Rating (30% for each 4-week block)	60 %
Critical Case Summaries (4) Formative Exercises	pass/fail
Bedside Practical Examination (1)	pass/fail
Written Examination (NBME)	40%
<b>TOTAL</b>	<b>100%</b>

### MINIMAL PASSING INTERNAL MEDICINE REQUIREMENTS

1. Satisfactory or better for **each** ward rotation.
2. Pass for the Bedside Practical Examination.
3. Satisfactory or better overall.
4. Completion of all assigned tasks.
5. Raw score of 59 or better on NBME subject exam.
6. 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 59 on NBME subject exam requires the student to repeat the exam. If the repeat score is less than 59 points the student will fail the clerkship and must repeat the clerkship. If the repeat score is 59 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 4<sup>th</sup> 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)
- Washington Manual on Medical Therapeutics - a good, quick reference book.
- 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**

### ***Quick and Dirty***

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 4 <sup>th</sup> to 5 <sup>th</sup> night; may take call from home
Clerkship Director:	Andrew Massey, M.D. (IM Office).
Clerkship Coordinator:	Jean Olsen (293-2650) <a href="mailto:jolsen@kumc.edu">jolsen@kumc.edu</a>
Website:	<a href="http://wichita.kumc.edu/im/">http://wichita.kumc.edu/im/</a>

### **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 neurological 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 (Wichita VA, KUSM-W , outpatient offices of KU Clinical Neurology Faculty) and Specialty Clinics (Huntington’s, KUSM-W; Muscular Dystrophy, Via Christi-St. Francis Hospital Campus; Epilepsy Clinic; Geriatric Neurology; Larksfield Nursing Home).

### **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, KUSM-W Neurology Clinic, Wichita VA Neurology Clinic, outpatient clinics of the Clinical Neurology Faculty, Larksfield Nursing Home.

### **Grading**

Inpatient Consultation Service	40%
Outpatient Clinics/Neurophysiology Lab	25%
Practical Exam	Pass/Do Again
Other (Case Discussion)	10%
NBME Subject Exam for Clinical Neurology	25%

### **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.

**Essentials of the Human Brain**, (Mosby, c. 2010), by John Nolte. Nearly 500 pages shorter than **The Human Brain** (6<sup>th</sup> ed, Mosby, c.2009), also a good reference by John Nolte.

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

American Academy of Neurology “Advice to Medical Students Studying Neurology”.

## **Psychiatry**

### ***Quick and Dirty***

Length:	4 weeks: 2 weeks adult inpatient and 2 weeks subspecialty
Setting:	Via Christi Behavioral Health and with community preceptors
Schedule:	Inpatient psychiatry morning report 7:30 a.m.; outpatient psychiatry in afternoons; schedules vary by preceptor
Call:	2 nights at least one of which will be a Friday or Saturday night
Clerkship Director:	Michael Burke, MD, PhD
Clerkship Coordinator:	Ronda Magness (293-3508) <a href="mailto:rmagness@kumc.edu">rmagness@kumc.edu</a>
Website:	<a href="http://wichita.kumc.edu/psych/">http://wichita.kumc.edu/psych/</a>

### **Introduction**

These four weeks of psychiatry can truly be enjoyable 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 you are likely to find affecting patients you’ll see on other rotations.

## **Grading**

Grading breakdown is as follows:

Psychiatry Clinical Performance (totals 60%)	
Adult Inpatient 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 (aka Good Shepherd). You'll be given keys for using the elevators and unlocking doors at Good Shepherd, because you'll be dealing with patients on locked wards.

Everyone completes a two-week elective in Consultation/Liaison, Geropsychiatry or Adolescent Psychiatry based on personal interests and availability. There are also two afternoons spent at various outpatient settings. Other required outings include AA or other community self-help meetings and visits to a substance abuse rehabilitation facility.

## **Requirements**

As previously mentioned, there are requirements to visit a rehab center (Positive Adjustments) and a community self-help meeting. 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.

## **Call**

Two nights of call are required during this four-week clerkship, at least one of which will be a Friday or Saturday night. You will be issued a key to the call room, which is on the second floor of Via Christi Behavioral Health. There are usually sandwiches and snacks available in the Doctor's Lounge. Weekday calls are located at Via Christi Health at Harry in the Assessment Center, located near the Emergency Room.

## **Extras**

Interactive Testing in Psychiatry from the NYU Department of Psychiatry. This is a collection of online quizzes, which may or may not be helpful in exam preparation. (One of the Website's authors is co-author of the *Comprehensive Textbook of Psychiatry* and the *Pocket Handbook of Clinical Psychiatry*.) Find it online at this URL: <http://www.med.nyu.edu/Psych/itp.html>. Most students use High-Yield to review for the shelf exam.

## **How to Excel**

Generally learn to be adaptable with your interviewing skills. An interviewing workshop is part of this clerkship, and it has real value for clinician-patient encounters regardless of whether you go into psychiatry or not. Try to learn how to 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; and know about the drugs used to treat your patient's disorder, especially with regard to their potential side effects.

### **Books**

The department will check out several required texts to you:

- Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)
- 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**

### ***Quick and Dirty***

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.
Call:	4 OB 24 hour calls, 1 GYN 14 hour call Weekends: Patients must be seen. Friday, Saturday and Sunday. Call persons round for the entire group. Everyone works approximately 2-3 weekends.
Clerkship Director:	Michael Brown, M.D.
Clerkship Coordinator:	Margaret Santos (962-3181) <a href="mailto:Margaret.Santos@wesleymc.com">Margaret.Santos@wesleymc.com</a>
Website:	<a href="http://wichita.kumc.edu/obgyn/">http://wichita.kumc.edu/obgyn/</a>

### **General Information**

Upon completion of the rotation, you will be able to actively participate in an uncomplicated delivery from start to finish. You will also be exposed to GYN procedures/admissions while on call. This experience varies depending on resident/night on call. Overall, this rotation greatly depends on luck (i.e. in the right place at the right time). If you show **true enthusiasm**, residents and attendings will try to get you involved. Always remember, every resident and attending has different approaches to procedures and patient care, but all are there for the same goal.

## Starting Out

The first day will primarily be orientation, lectures, and handing out schedules. The OB notes (in the OB student manual) are very straightforward. It is good to memorize the orders and style of SOAP notes expected early. Also, ask a few residents what he/she expects from you in your SOAP note. Get a password for the computer to allow you to get a list of your patients and check labs. You will be assigned to follow the surgery patients you scrubbed in on and the patients you delivered. Make sure to **ASK QUESTIONS** about what the residents expect and how you are doing. Always introduce yourself and your role to the resident, patient, attending, nurse, and scrub tech. If people know who you are, they are more likely to get you involved.

## Clinic

Clinic is a weekly requirement. You will see new OB, return OB, and GYN patients. Take initiative and be prepared to work quickly and make concise presentations. This can be an excellent learning opportunity if you work hard and show initiative. Average time out of clinic is about 5:00 p.m. Wear your white coat to clinic. Clinic is a good opportunity to see procedures such as colposcopy, endometrial biopsies, and LEEPS.

## Surgeries

Rules about assigning surgeries

- The person on labor and delivery call should **not** cover any scheduled surgeries during call hours.
- Students are encouraged to attend the surgeries of Dr. O'Hara and Dr. Farley (Maternal-Fetal Medicine), Dr. Grainger, Dr. Tjaden, and Dr. Tatpati, (Reproductive Endocrinology), Dr. Delmore and Dr. Jacqui Morgan (Gynecologic Oncology). Students are responsible for covering scheduled surgeries in the OR and LDR (Labor and Delivery). This includes c-sections, hysterectomies, tubal ligations, etc.
- The student should introduce themselves to the patient in pre-op and be familiar with the case/H&P.
- The surgery schedule for the next day is put up after 5:00 p.m. at the nurses' station. If the schedule is not there that evening, ask the 1<sup>st</sup> level resident for a copy from resident library.

The students are responsible for assigning surgeries. Each group will decide their own system but usually the OB on-call student is responsible for assigning the surgeries. There is a surgery sheet in the student lounge where each student is responsible to mark the surgeries and deliveries they do. At the end of the clerkship it is typed up to see how evenly spread out the cases are and to ensure that no one student gets all the surgeries. **EACH SURGERY MUST BE COVERED!!!**

## Call and Weekends

There are two calls: GYN and OB. **On OB call**, don't expect any sleep ever. The call is 24 hours long, 6 a.m. to 6 a.m. Meet at the board at 5:50 a.m. for check-out. You will be expected to do H&P's on patients as they come into Labor and Delivery and will generally deliver one or two babies a call. The most action you will likely see is with clinic patients, so be sure to know those patients! These patients are listed on the board as WC (Wesley Clinic) HHC (Hunter Health Clinic) or M&I. The more aggressive you are – **introducing yourself to attendings**, learning the turns and holds (babies are slippery!), the more you will

be allowed to do (very resident dependent). Also be sure to introduce yourself to the patients in labor. You will be more likely to get a delivery if you know the patient and patient knows you. If the attending hands you the towel, get in there and get ready to deliver. **On GYN call**, you see patients in the Emergency Department and at the Birthcare Center. Ask if you can participate in deliveries there. Contact the second level resident on call at 5 p.m. to see what is going on. Sometimes you don't sleep, but most nights are light. A student must see all patients on the weekend. You are allowed to cover for each other as long as all patients are seen.

### **Grading**

Clinical Evaluations: 50%    Departmental Exam 10%    Subject Exam: 40%

### **How to Excel**

To get a good evaluation, do your work and show up every day. The departmental test is at the beginning of the fourth week. Most of us found this to be the most straightforward of all the mini-boards. Many students read the required text selectively, many students read only Blueprints. The Appleton & Lange review book is an excellent source in question/answer format.

**The key to this rotation is TEAMWORK.** You will learn what it means to carry your own weight. This is not the rotation to exert laziness...it won't be tolerated by your fellow students, the residents or the staff. It may well affect your grade. Helping each other is a must. You may need the help yourself someday. For example, if you have one patient, you may pair up with another student so that only one student needs to come in at 5 a.m. But, remember to return the favor! Finally, realize that often times the residents and faculty treat the group as a whole – so helping each other out may help your cause too.

### **Other Hints**

- You can wear scrubs all the time! Take a pair home and wear them in the morning. You can go 6 weeks without laundry. (except underclothing). Return the scrubs to the hospital at the end of the rotation.
- Many classes will be canceled/rescheduled; continue to read.
- Check with a 4<sup>th</sup> year or the library for loan of books.
- OB call: sleep in the OB lounge. It is loud and light.
- GYN call: sleep in the OB lounge.
- DO NOT let surgeries go “uncovered” by a student unless there is no alternative.
- When in doubt which responsibilities take precedence, just follow this rule of thumb: #1 Class (lectures), #2 Clinic, #3 Call, and #4 Surgery. Although surgery is #4, class or shortage of students are the only reasons a surgery should go uncovered.
- This rotation allows students to make their own choices in scheduling, switching call and weekends! Make sure you do your part and things run very smoothly. This can be an extremely exciting rotation if you show interest.
- Learn to tie knots before going to a surgery. The attendings want you to know how to do this!
- If an unscheduled c-section, the student on OB call may ask the 1<sup>st</sup> level to scrub – but if the board is busy, the student should call the student room to notify a classmate of the case.
- **Ask questions if you have questions!!!**

## Pediatrics

### *Quick and Dirty*

Length:	6 weeks
Setting:	3 weeks of inpatient are at Wesley, 1 week of Wesley New born Rounds at Wesley 1 week residency clinic and faculty clinic at Wesley Pediatric Clinics at 620 N. Carriage Pkwy 1 week of outpatient preceptor
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 Coordinator:	Donnita Pelsler 962-2250 <a href="mailto:Donnita.Pelsler@wesleymc.com">Donnita.Pelsler@wesleymc.com</a>
Website:	<a href="http://wichita.kumc.edu/pediatrics/">http://wichita.kumc.edu/pediatrics/</a>

### **General Information**

The clerkship orientation is presented at 7:15 a.m. the first day of the rotation. Scheduled faculty lectures are given at Wesley Medical Arts Tower pediatric classroom 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, 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 "W" drive and ANGEL. 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 three weeks will be split between the PICU and the wards. On the wards there are two panels: one for teaching staff and one for private attendings. In the PICU you will work with Drs. Smith, Vellaichamy and/or Murphy. Take advantage of this time, as they are excellent teachers. Check the syllabus or the survival guide for an example of a good PICU progress note—they are all-inclusive and system-based. You need to see your patients and have progress notes written before morning report at 8:00 a.m. in the Peds conference room on the 6<sup>th</sup> floor. 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 writing daily progress notes. Students are also required to attend NICU rounds, usually once a week. You are also assigned two week night calls and one weekend call throughout the three weeks. You are usually very active on call. You are expected to round on Saturdays and

Sundays while on inpatient with two weekend days off. 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 Wesley pediatric resident/faculty 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 9am - 5pm. The other 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, student will 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.

### **Inpatient Newborn Rounds**

One week is spent at Wesley Hospital learning how to care for newborn babies. 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.

### **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. Two review texts are typically used, Blueprints and Pediatrics by Tom Lissauer and Graham Clayden. 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 Mid-term Exam covering pediatric CLIPP cases online will be given the 4<sup>th</sup> 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 15 percent of the clerkship grade. Students will be tracked on how many cases they complete online. An oral exam has also been added.

### **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 (10%) or (*Oral Exam*) (5%). To pass Pediatrics:

1. You must earn a score of 5<sup>th</sup> percentile or higher on NBME Pediatric Subject Exam. If you receive a score less than the 5<sup>th</sup> 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 5<sup>th</sup> 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**

AAA	abdominal aortic aneurysm
abd	abdomen
ABG's	arterial blood gases
a.c.	before meals
ACBE	air contrast barium enema
ACE	angiotension-converting enzyme
Accuo	finger glucose monitoring
ADA	American Diabetes Association (refers to diabetic diet)
ADL's	activities of daily living
ad lib	as desired
AF	atrial fibrillation, ≠ afebrile
AFB	acid fast bacilli
AKA	above the knee amputation
AMA	American Medical Association
AP	anterior-posterior
AS/AI	aortic stenosis/aortic insufficiency
ASHD/ASCVD	atherosclerotic heart disease/cardiovascular disease
ASA	acetylsalicylic acid; aspirin
ASAP	as soon as possible
BaE, BE	barium enema
BBB	bundle branch block
b.i.d.	twice daily
BKA	below the knee amputation
BM	bowel movement
BMP	basic metabolic panel
BP	blood pressure
BPH	benign prostatic hypertrophy
BR	bed rest
BRP	bathroom privileges

B.S.	bowel sounds (+ or -) can also mean breath sounds or blood sugar as well as in expletive.
BSO	bilateral salpingo-oophorectomy
BUN	blood urea nitrogen
BUS	Bartholin's gland, urethra, Skene's
Bx	biopsy
$\bar{c}$	with
c/o	complains of
CA	cancer
CABG	pronounced "cabbage" - coronary artery bypass graft
CABG x_	coronary artery bypass graft times <u>number of vessels bypassed</u>
CAD	coronary artery disease
CBC	complete blood count
CC	chief complaint
CHF	congestive heart failure
CMP	comprehensive metabolic panel
CN	cranial nerves
CPE	complete physical exam
CPK	creatinine phosphokinase
CRF	chronic renal failure
C & S	culture and sensitivity
CSF	cerebrospinal fluid
CT	computed tomography
CVP	central venous failure
C.X.R.	chest X-ray
CMP	comprehensive metabolic panel
D/C	discontinue or discharge
DD	dependent drainage
DDX	differential diagnosis
Dx	diagnosis
D5NS	5% dextrose in 0.9% saline (W = water, LR = lactated ringers)
DJD	degenerative joint disease
DKA	diabetic ketoacidosis
DNR	do not resuscitate
DM	diabetes mellitus
DOE	dyspnea on exertion
DTR	deep tendon reflexes
EBL	estimated blood loss
EDD	estimated due date
EGD	esophagogastroduodenoscopy
EMD	electro-mechanical dissociation
EOMI	extraocular muscles intact
ETOH	ethanol
ESR	erythrocyte sedimentation rate
FB	foreign body
FBS	fasting blood sugar

FFP	fresh frozen plasma
FiO <sub>2</sub>	inspired oxygen tension, expressed a %
FMHx	family history
FR	french (a catheter size)
FROM	full range of motion
f/s/c	fever/sweats/chills
Fx	fracture
G	gallop
GB	gallbladder
G_P_A_	G = gravida, # of time pregnant P = Paral # of viable infants A = Aborted (s = spontaneous, t=therapeutic)
GSW	gunshot wound
gtt	drops
GTT	glucose tolerance test
HA	headache
HCTZ	hydrochlorothiazide
H/H	or H and H – hemoglobin (hgb) and hematocrit (HCT)
HEENT	head, eyes, ears, nose, and throat
HJR	hepatojugular reflux
HOB	head of bed
H&P	history & physical
HPI	history of present illness
HR	heart rate
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 dequibus
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
<u>M</u>	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	nonsteroidal anti-inflammatory drug
NSR	normal sinus rhythm
NTG	nitroglycerin
N/V	nausea and vomiting
OBS	organic brain syndrome (dementia)
OC	oral contraceptives (OPC) or BCP = birth control pills
ORIF	open reduction, internal fixature
OS/OD	left eye/right eye
OTC	over the counter
p	after
P&A	percussion and auscultation
PAC/PVC	premature atrial contraction/ventricular contraction
PCN	penicillin
pc/pp	after meals/post prandial
PCW	pulmonary capillary wedge
PE	physical exam
PERRLA	pupils equally round to light and accommodation
PFT	pulmonary function tests
Plt	platelets
PO/PR/PV	by mouth/by rectum/by vagina
PMHx	past medical history
PND	paroxysmal nocturnal dyspnea

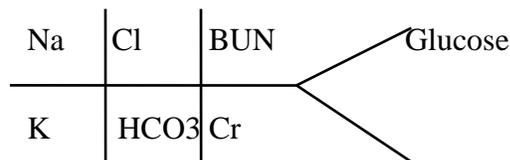
p.o.	orally
PRBC	packed red blood cells
p.r.n.	as needed
PT/pt	physical therapy/patient
PTCA	percutaneous transluminal coronary angioplasty (balloon)
PUD	peptic ulcer disease
PVD	peripheral vascular disease
Px	physical
q	every
qAM	every morning
qD	every day
qhs	at every bed time
qhc	at meals
q.i.d.	four times a day
q.o.d.	every other day
QNS	quantity not sufficient (for analysis)
R.A.	room air
RR	respiratory rate
RLE	right lower extremity
RML	right middle lobe
RRR	regular rate and rhythm
r/o	rule out
ROS	review of systems
RT	respiratory therapy
RTC	return to clinic
RUQ	right upper quadrant
Rx	prescription
s	without
SBE	self breast exam
SBFT	small bowel follow-through
SEM	systolic ejection murmur
sig	labeled directions; sigmoidoscopy
SLR	straight leg raises
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
$\bar{x}$	except
†	one
† †	two

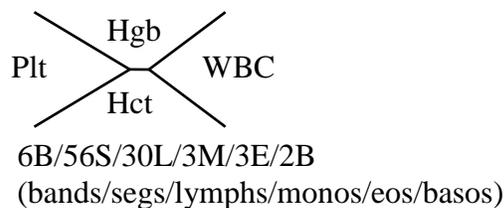
There are many more abbreviations used and some of the above may be frowned upon by some attendings.

### Shorthand Notation for Lab Values

Metabolic Panel, Basic:



Complete Blood Count (CBC):



ABG:      pH | pCO<sub>2</sub> | pO<sub>2</sub>

@specify oxygen (i.e 2l NC-2l nasal cannula; 50% FM-50% O<sub>2</sub> 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  $\bar{c}$  intact short-term memory.

EXTR: s clubbing, cyanosis or edema.

LABS:

141	108	14	$< 89$ See CBC with Diff
<hr/> 4.0	<hr/> 26	<hr/> 1.0	

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,  $\bar{c}$  improved air exchange by P.E. and improved ABGs. Sputum cult. neg. so far.
  3. Probable alcoholism. Patient continues s evidence of acute withdrawal.
- P.**
1. Continue Tagamet and antacids, monitor the patient's Hb, and continue to Guaiac stools. 4 units PRBCs typed and crossed.
  2. Continue Alupent aerosols, O2 at 21/NC, and IV Aminophylline. Taper Solumedrol and continue to monitor ABGs.
  3. Thiamine IM, monitor for sx of ETOH withdrawal  $\bar{c}$  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 easi-

er 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 superb 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:** Vitals: Tmax 100.5 Tcurrent 98.4 BP 110/65 P 72 RR 18 O2 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

### Pagers

SOM-Wichita will issue you a pager and the hospital paging systems will have those numbers. Should your pager break, just take it to Academic and Student Affairs (ASA). They will exchange it for you. Also, be sure to keep an AAA battery handy for when the battery gets low (about once every 6 weeks). Alternatively, you are allowed to use batteries from the hospitals as long as you don't mind asking someone for help as for where to find them (every department has a stash).

### 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 pager 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 & Residents Prepared by Academic & Student Affairs (3/12)**

#### ***VA Medical Center***

- Clean and decontaminate the exposed area. Notify service/unit supervisor.
- From 8 am to 4:30 pm 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 (resident physician) 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.

#### ***Wesley Medical Center***

- Wash & rinse wound area thoroughly with germicidal soap.
- Obtain source patient information & account number.
- Report to Employee Health immediately (7a – 4:30p Mon-Fri) Level G, Medical Arts Tower/HR Dept. After hours, report to Emergency Dept. for treatment.
- Complete HMS form located on GME Page/Wesley intranet or call ext. 23361 for assistance.
- Treatment for individuals with HIV positive exposure must occur within 2 hours.

**All follow-up care must be handled through your personal insurance provider.**



**POST-EXPOSURE PROTOCOL**  
FOR RESIDENTS, MEDICAL STUDENTS, NURSING STUDENTS,  
AND OTHER ALLIED HEALTHCARE STUDENTS

In the event of an occupational exposure during a clinical rotation at Via Christi Health, please follow these steps for appropriate post-exposure care:

**1. Exposure to blood or other potentially infectious material (OPIM):**

- Clean and decontaminate exposed skin and/or mucous membranes.
- Complete Blood Borne Pathogen Exposure Investigation Report.
- **PAGE the House Manager.**

The House Manager and/or Employee Health Services will arrange:

1. Baseline blood test
  2. Initial doses of antiviral drugs for HIV prophylaxis (Please note: prophylaxis is recommended to be started within 1-2 hours of a high risk exposure which includes deep injury with hollow bore needle, needle removed from patient's vein or artery, or a patient with end-stage HIV infection.)
  3. Emergency care if required, e.g., suturing
  4. Results of blood tests
  5. Coordination of follow-up care with WCGME (residents) or other teaching Institution (students)
- Contact Employee Health Services at 650-5570 for the results of blood tests (source patient and healthcare worker)
  - The Source patient will be tested, at no charge, for HIV, Hepatitis B and Hepatitis C.

**2. Other Occupational Exposures:**

- Employee Health Services will coordinate treatment and testing as appropriate for other exposure situations, e.g. tuberculosis, meningococcal meningitis, pertussis, etc.

**Definitions:**

- **Occupational exposure to blood or other potentially infectious material (OPIM)-** needlestick, cut, or other percutaneous injury with a contaminated instrument that pierces the skin; blood/OPIM that splashes or splatters the mucous membranes of the eyes, nose, or mouth; or blood/OPIM contact to open skin.

- **OPIM (other potentially infectious material)** - includes cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, and sexual fluids.

– Reviewed Feb 09 by Theresa Gassett-Haynes, Infection Control Coordinator



## 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.