

# Third year Survival Guide

*A collection of tips from past students –  
the tribe has spoken*

"Starting Third Year is like going to a foreign country. You don't speak the language, you don't understand the customs, and the natives are not necessarily friendly."

- From The New Physician, Number 8, 1982

## **Disclaimer:**

What follows is a collection of comments from past students, nothing more, nothing less. Please remember that it represents the thoughts of individual students and may not be applicable to your situation.

For the most up-to-date information regarding scheduling, clerkship directors, and contact info, go to: OASIS <http://med.uwisc.org/>.

Also, visit the rotations forum on the medical student website at <http://forums.uwmedstudents.com/index.php?board=31.0>

## **Life on the wards**

### **Staff/colleagues:**

- Introduce yourself to the HUC's and nurses, and stay on their good side! They'll answer most of your questions about the ward. You can learn a great deal from the nurses, especially in the ICUs
- The residents are likely to be your best source of learning...good residents are worth their weight in gold at UWHC or anywhere else. Virtually all the faculty spend time with you because they like to teach...styles can be vastly different ...and you always have a chance to evaluate every clerkship..use those evaluations to say what worked and what could be improved.
- Get along with your classmates, they are not the enemy. The residents notice how you treat your colleagues this will come back to haunt you if you're not nice.
- Paging a resident at any time for virtually any question is ok, as long as you know all of the information involved and can provide it in a stream-lined fashion. Along those lines, almost never page an attending doctor for a question unless the whole rank of residents has been exhausted.
- Don't be annoying. The residents have been through med school as have the faculty, try to find common ground with all of them. Don't pester them when they are busy or try to be a know it all. You stand only to be humbled.

- Don't lie to residents or faculty about what your interests are. They don't expect that everyone will go into their specialty and they will not be more likely to give you a good grade on that basis.
- Understand the hierarchy: ask your intern first! They usually don't have any say in your eval, so use them as your guide if you feel lost. However, never talk bad about other people, whine or complain in front of anyone above you, including the intern. Use your classmates for that.

### **Patients:**

- Value the personal interactions you will have with your patients and their families...they also will be a great source of learning and at times will be a wonderful confirmation of why you wanted to be a Doctor in the first place.

### **What you should be doing:**

- Keep a running log of your patients' labs. You may not need it, but you'll be glad you have it. It often doesn't help to have today's labs unless you know the trend. Check out <http://www.medfools.com/downloads.html> for sample sheets.
- Always be on time for rounds, conferences and whenever you are needed. Show up on time to whatever is going on--punctuality is one of the few things Med3's can control
- Read a few medical journal articles on every patient you work up and keep track of what you learn...by the end of your third year you will be amazed to see how much you have learned...and how relevant much of the first two years actually is to clinical work.
- Be neat and professional looking at all times you are seeing patients...and before you examine any patient, and just after, be sure to wash your hands or use the alcohol gel
- A big problem as a 3rd year is trying to figure out what you are supposed to be doing all day. The residents are always busy and you end up following them around, trying to help, but not ever knowing what to do. There are a lot of administrative types of things going on that we are never oriented to. These include writing orders, which forms different orders go on (diabetes has its own form, heparin, anti-infective orders), writing a discharge summary (standard form), and many other things like that. Its all different depending on which hospital you are at, but a lot of similarities. Getting some of that sort of information would help folks a lot.
- Reading is your best friend, you cannot read enough on the topics of each rotation
- Learn to enjoy pimping, it is really the only way that the attendings and residents can assess your knowledge level. You can either impress them or not. Enjoy pimp sessions. It is a great way to learn. It is good because you know your attending doctor is paying attention to you. Getting some (or lots!) of answers wrong is ok and actually part of the game. They usually ask you because they are 50/50 whether they think you will know it. I think it works such that any question you get right is a bonus, but any question you get wrong does not count negatively - they forget that you answer questions wrong but they remember that you get some right.
- Don't ask questions you don't know the answer to, or make sure to try to look it up first and then just ask for clarification. This will always be turned around on you and will invariably make you look bad
- Don't ever ask when you can leave. They expect you to be committed to what is at hand no matter how dull and uninforming it may seem to you. When you're in the fourth year, this

rule goes out the window. When they tell you that you can leave if you want, LEAVE! Don't assume it is a trick or that they actually mean for you to stay. (this will come up, trust me) Don't leave until someone tells you to leave (if you want a good evaluation). And the corollary, if someone tells you to leave, do it-- odds are there won't be anything else for you to do anyway.

- If you are unsure of what to be doing on a rotation, especially the first week or so, stick with your resident at all times until you know what is expected or they tell you to chill and go do something else. If at any point you are unsure of what to be doing, page your resident.
- A great phrase to always remember when you don't have anything to do: "Is there anything I can help with?" Residents love to hear medical students say that.
- In the OR, unless you are absolutely certain that it needs to be done, don't do anything unless you are told to do it. And when you are told to do something, do it until someone tells you to do something else.

#### **Other:**

- Some cell phones work well in most parts of the UWHC and some don't...beepers are helpful
- Live close to the hospital, don't believe that you will want to bike in or take the bus, this won't work.
- First of all in bringing up the x - this is shorthand for everything, i.e.
  - diagnosis=Dx
  - symptoms=Sx
- Keep a pocket sized notebook in your coat at all times. Use it to jot down any pearls, mnemonics and high yield facts that come up throughout the day...at rounds, conferences, etc.
- Always carry at least two pens--you're a likely target for residents who don't have one handy.
- Don't act as though the team's primary goal is to teach you, because it isn't. Be a team player.

#### **Books:**

- Similar to the pre-clinical years, the "required" textbooks are not required--only buy them if you plan on going into that field and would like the text for future use. Don't buy too many books. Swap with classmates who've already had the rotation.
- Blueprints are great for all rotations except Surgery. Use Surgical Recall for surgery. Blueprints Q&A, however, are great for all rotations including surgery for testing your knowledge.
- I really wish I knew about Maxwell's, blue book internal medicine pocketbook my 3rd year, Dubin EKG, Fluid Electrolytes Acid Base Companion. Those books and pocket books R really helpful.

## **Rounds**

### **Morning rounds** (or work rounds or resident rounds)

These generally begin at 7:30 or 8:00 a.m. on medical or pediatric services, and at 6:30 a.m. on most surgical services. All the residents and students on the team (plus the head nurse or pharmacist on occasion) meet to find out what's transpired since last doing rounds. The usual routine is for the

student who is following a particular patient to give a 10 second to 3 minute rundown on any patient complaints, abnormal vital signs or lab values, significant physical findings and anything else of concern for that day. Then, usually the whole team goes into the room and the residents chat with the patient and do whatever physical exam is necessary. [Most of the time this means they repeat the same questions and exam you already did.] Then the team leaves the room, briefly discusses the patient's progress, and formulates a plan for the day. Most teams bring the order book along and write any needed orders right then and there. Sometimes the residents may give a quick mini-lecture on a patient's problem.

How can you do a good job on morning rounds? Thoroughly PRE-ROUND to gather all the information your residents will want to know. Early in the year, you may need to allot 15 minutes per patient, or half an hour for a patient in the ICU, but by spring it'll be a breeze. The steps in pre-rounding (in order of importance) are:

- a) Ask patient how she/he feels, new complaints, etc.
- b) Check heart and lung sounds (yes, every day on everyone) plus any other pertinent physical parameters.
- c) Record vital signs.
- d) Track down results of labwork, x-rays or studies your patient had since yesterday.
- e) Look in the order book for any orders written for your patient during the night.
- f) Read the narrative section in the chart and the nurse's notes.

Also, read about your patient's condition so you'll be able to answer questions.

### **Attending rounds**

The staff physician conducts lecture/ discussion sessions two to five times a week, depending on the service. These may include the residents, too, and often involve patient presentations by the students. They're usually quite educational. Why these are called "rounds" when you rarely actually walk "around" to see patients is anyone's guess.

### **Grand Rounds**

This is a didactic lecture scheduled every week or so for members of the entire department. Well-known speakers from across the country are often invited to present at Grand Rounds. Students are strongly urged to attend.

### **Afternoon rounds**

The team gets together for a brief update on the patients since morning rounds. Pre-rounding for these is pretty much the same, except that you usually don't need to repeat your physical exam if it was unremarkable. These sessions may be more formally structured on the surgery services.

### **X-ray rounds**

A time for the whole team to head to third floor to review all the patients' x-rays, CT's, MRI's, and nuclear scans. These are usually held on the spur of the moment. It's really helpful to find radiologists to officially read the films. You can try your hand at it, too.

### **"Nutrition rounds"**

A tradition in general surgery. Most days the team goes to the cafeteria between morning rounds and starting in the OR (7:00-7:15 or so). Format includes food and fun. Other services have "soft-serve rounds", "Herb's rounds", etc.

## Presenting Patients

You will frequently be asked to "present a patient." This is an opportunity for you to tell everything you know about a patient to a group of physicians and students that may know nothing about the patient. Needless to say this can be an anxiety-producing experience. A few tips that may help:

1. Ask yourself--how much time do I have? Knowing this will also help in determining what's significant. At times you will be asked to give a very brief presentation. (5-10 min)
2. Try to be organized, bearing in mind your complete H & P: ID, CC, HPI, PMH, FH, SH, ROS, PE, labs, assessment and plan. One need not include everything, rather only the significant points. Again, try to present the information in the order of your original H&P.
3. Ask yourself--what do these people want to know about this patient? Knowing this will help determine "the significant points." If you are presenting to a neurology attending, you will want to emphasize the positive neurological symptoms and findings. If you are presenting to a group of attendings from a variety of specialties (God help you), you may need to be more complete.
4. Carrying a little note card with pertinent information on it (especially lab values) as well as occasionally practicing presentations can help when the real time comes.
5. Some general guidelines to keep presentations BRIEF:
  - CC and HPI are of primary importance, with all pertinent positives and negatives
  - PMH can be presented simply as a list of conditions and surgeries
    - To be REALLY concise, only include those that involve the organ system relating to this particular hospitalization.
  - Always mention meds--with dosages for short presentations.
  - FH and SH are often dismissed as being "non-contributory" unless there's a major impact upon the current problem.
  - ROS also usually "non-contributory". If something in ROS really relates to current issues, it should have been mentioned in the HPI anyway.
  - Physical exam results are shortened by phrases like "HEENT unremarkable", "abdomen benign", or "neuro exam grossly normal." Do expand on any abnormal findings, of course.
  - Tell about abnormal lab values and only pertinent normals. "SMA-12 normal" says a lot.
  - Summarize at the end in one or two sentence

## Work-ups

- A "work-up" is essentially an admission history and physical. ("Work-up" also sometimes refers to batteries of diagnostic studies for specific signs and symptoms (i.e., fever W/U, syncope W/U, D.I.C. W/U, etc.) They are the source of most of your learning as well as most of your frustrations. Your goal is to be efficient yet "thorough enough." There is no one single way to do an efficient H & P, and the word "thorough" is defined relative to specialty and biases of house staff, attendings, and yourself.
- This is a legal document. Write legibly, clearly, each entry has a date and time of entry. If you make an error cross it off with a simple line through with your initials.
- To best "survive and serve" you need a flexible yet organized routine.
  - Organized because...it prevents errors of omission, unnecessary position changes, and promotes confidence. It also promotes efficiency. You won't need to spend time thinking about what order to do things if your routine becomes automatic.
  - Flexible because...patients vary in how they present. In brief, you can't always obtain

the information you want and your basic routine may not be adequate.

- Old charts--Almost every patient has them. Records of previous admissions are sent to the ward with the patient. Ask the Unit Clerk where to find them--they're very valuable for your admission H&P. They give you accurate, specific information, in medical terms, without extraneous rambling. The key to sorting through these? Discharge summaries. Going through the 3 or 4 most recent discharge summaries will tell you the basics of each admission. In addition, you may want to check abnormal lab values/EKG's, pathology reports, radiology reports, old H&P's by Med III's, especially! If time is really tight, however, it is most important to know what's going on right NOW. Skip the old charts and emphasize CC, HPI, ROS, PE and current labs.
- Other ways to improve efficiency if you can start with the patient but fear you'll get interrupted.
  - try to get the CC and HPI first
  - do the ROS during the physical exam as you examine each system
  - start your physical with the "trunk" areas (heart, lungs, abdomen, genitalia, breasts, back). It's easy to come back later to do HEENT, extremities, and neurologic exam without asking the patient to "gown up".
- If you are interrupted, use that time to look at old charts, begin writing up what you have so far, or do some reading related to the patient's condition. Also, don't be afraid to follow your patient down to X-ray to continue getting information (they often wait a while in the X-ray waiting room).

## Rotations

### Surgery

- Choose your team wisely. If you are interested in surgery pick the blue team (you will have attending rounds each week, very high stress and totally determines your grade, prepare well for these), if you don't care at all pick the green team (a lot of down time), and if you want to get the most experience with surgeries pick the orange team
- White coat: do not wear in OR area - do wear everywhere else (esp grand rounds)-it is handy to have tape, gauze (4x4), suture scissors, pick ups (these can all be claimed from patients rooms or supply room), plus a power bar or similar for when you get hungry
- On your first day of a new rotation in surgery, wear professional clothes because you never know if you are going to have to go to clinic that day or not.
- Don't show up late to rounds!! Not only do you look bad, but you make your teammates look bad too because patients are not seen. The residents hate that!
- Work as a team. If one of the other students sleeps in (and someone will), page or call him/her, start rounding on his/her patients, and print out his/her labs. Then give these notes to him/her when she gets there. Sure, it sucks to do extra work and see someone else take credit for it (especially when you're getting there before 5 am); however, doing this is in the best interest of the team and the patient, and it will not go unnoticed. It may seem that knowing all of the answers and looking better than the other students is what wins residents over, but teamwork is key. Residents reward students with whom they would want to work every day by going to bat for you when it comes time for evaluations. It does not pay to show other students up. Residency directors would rather see comments like, "This student

is a great team player who will make a valuable intern,” in your dean’s letter than something about how you could always identify the falciform ligament. That being said, know your anatomy and be prepared for your assigned cases in the O.R.

- During prerounds, arrive early and always look to the orders section of the chart first to see what happened over night, then check with the nurse taking care of your patient to find out if there were any events or changes, and finally check the vitals and see the patient.
- Prepare for the OR by refreshing yourself on the anatomy, complications, indications, and alternatives to the surgery you are attending. Don't waste time with trying to memorize the procedural aspects except for a basic understanding of what will be cut and connected to what.
- Right before you walk into an OR room, do a mental check to make sure you have your cap, goggles if you wear them, and mask on - it'll save you from getting yelled at. Also, don't forget your dignity 😊
- Pay attention during procedures, ask questions only when it is quiet otherwise, never pass instruments to the scrub nurse, never grab instruments from the tray, always go early and meet the floaters and scrub nurse and put your full name on the board, grab your gloves in your size, and make sure to meet the patient prior to the procedure.
- Remember that a patient who has had abdominal surgery will probably have an NG and start out as NPO. The natural progression is from ileus to passing flatus before you can remove the NG and challenge them with a diet, typically starting with clears.
- The foley cath must stay in place until the epidural is dc'd.
- To get honors in surgery you must really be on your game and know your anatomy, know as much as possible about each topic as it comes up. This means read as much as you can during your free time. Don't ask questions you don't know the answer to or don't know anything about, they always turn them around on you. Remember, the residents are the bulk of your grade. The attendings will ask for their opinion when it comes time. Be their friend, help your classmates, don't outshine other students, always be eager and never complain....
- Have a system for remembering your patients. I wrote up the patient's CC, HPI, PMH, PSH, Meds, Allergies, etc on one side of a piece of notebook paper and kept track of the patient's daily vitals, labs, and plan on the other side. Then, I was always prepared if someone asked me something about my patient's history or meds or something.
- Get really involved with your patients. That is how you really learn on this rotation.
- Read "First Aid for the Wards" surgery section, it will tell you everything that is expected of you during the surgery rotation.
- Read Surgery Recall as you go. A few chapter a night will save you from panicing before the exam.
- Work as a team, you get a lot more done! Get to know your classmates, many of them are really cool!
- Enjoy!! I know a lot of us aren't going to be surgeons, so this may be one of the only times we get to see stuff this cool. The hours are long and you're tired a lot, but you don't notice so much if you keep walking. 😊
- Those of you on Blue Team...Tuesday morning presentations are a little scary. KNOW YOUR PATIENTS. And, always remember, they are going to ask you questions that you just don't know--trust me!
- You don't really have to read very much to seem like you know what you are talking about as long as you spend about 5-10 minutes reviewing your patient's history and reason for

undergoing surgery before you go to the OR. If you don't know the details of the operation or minutia about the anatomy, it's not big deal(unless you're on blue, so I hear) If you can say something about the patient's blood work or family history, that makes you look great.

- **Books:** Don't buy the required books. Just like the rest of med school. Haven't taken the test yet, but I think surgical recall and a practice test book is plenty.
- **Call:** I am still not sure, but I highly doubt that anything gets passed on from your nights of call to your actual team unless you really do something horrible, and even then I don't know. Therefore, unless you are truly interested in surgery to the point of not sleeping, don't volunteer for long operations in the middle of the night since you will never get to go to sleep. If you're not in the OR, it is highly likely that you will get some windows during which to sleep. Also, on ortho call, they truly want you to go when they tell you to, no matter how early it is, so unless you are really interested in ortho, take off!
  - When you are on overnight call, remember to bring a toothbrush, deodorant, a comb, etc. You have to round in the morning and even if, by chance, you do get some sleep, you are still going to smell. Be nice to those around you.
- **Write-ups:** The EBM write-up definitely has no bearing on your grade--just pass it. The other write ups only affect you indirectly in that the attendings see them, but the grade you get on them does not get factored into your final grade. I don't think most attendings care at all about them. Your time is much better spent doing a good job preparing presentations to verbally impress attendings in person.
- **Rotations:** Honors=A, Pass=B. There is no AB. Try to find out what attending is in charge of writing the grade reports with your chief resident. This is the person with whom you should try to interact the most. Don't suck up, just make your presence known. Know what is graded and what isn't. I wish I had scrutinized this earlier.
- **Quizzes:** Don't ever read that huge freaking book they give you for the quizzes. As a matter of fact, there will only be quizzes on quizzable lecture notes from the binder. You'll see what I mean. Also, the cut off for an A for quizzes is something like 3.6. Check with Sherry and if you're well over that mark with a few quizzes to go, then you can slack on them because a high A is no better than a low A. Yes, ridiculous, but true. An A counts as a 4.0 when factored into the total grade and it doesn't matter if you have a perfect quiz record or you just squeaked by.
- **Strategy:** Read the formula they give you to determine what you need to get the grade you want. For example, you may discover that you have an AB locked: you'd need a miracle to get an A and you'd need to punch an attending in the face to get a B. If you're only looking for an AB, then you can not study too hard for the test, and just stay away from fist fights with attendings.
- It doesn't last forever!

#### For specialties...

- **Cardiothoracic** - This is a good rotation in that you learn a lot but you have to be on the ball at all times. Make sure you get to the hospital early enough to see your ICU patients (which are tricky) and ask questions when you are in surgery with Dr. Edwards - he expects that. Be very respectful with the attendings and you will do fine. Oh yeah, always wear a coat (there are scrub coats with the rest of the scrubs) into the OR because you won't necessarily scrub in as you can't see much that way and it gets really cold when the patients are on cardiopulmonary bypass.

- If you know you don't want to go into surgery and are doing the Ortho rotation, ER consult and Trauma services are good choices. You have half clinic half OR time for trauma. On ER consult you learn lots of primary care stuff.
- If you do have ortho and you want to see a lot of surgery, I would recommend not selecting the ER consult service. It's interesting because you see traumas and put on casts and stuff, but you are NEVER scheduled in the OR.
- If you are a girl and you take ortho, be prepared to be AND feel like the minority. Most of the residents are great and I really enjoyed the rotation, but it is a bit of a "boys club".
- Transplant...ah, transplant. I actually really liked this rotation and would definitely take it again, but it is tons of time. Thus, this might not be the best rotation to choose for those of you with children, significant others, a life...

## Medicine

- White coat: handy to have your PDA, Sanford, and paper with vitals and labs of all your patients, plus a power bar or similar for when you get hungry
- Beg to get the VA for this rotation. it is the most autonomous, the most disease, and the happiest residents. The team is a senior resident, an intern, and maybe two students. The senior and the intern will grade you and their opinions count. The system is computerized.
- When working up a patient remember the basics. When you get stumped just go back to the basics of physiology and pathology. You don't have to know the answer, you just have to generate a list of potentials and then order labs to narrow it down.
- You will impress your residents and faculty if you follow up on imaging studies and labs. Always go in person to see the imaging, never just read the radiologist's impression.

## Psychiatry:

- General Advice: Study. Your work on the floor, although interesting and stimulating and fun, will not prepare you for the test. This applies to the adult services as well as Meriter Child. It's easy to go home and loaf – because you have the time – but remember, it's a shelf exam! Go to the lectures, but don't expect them to prepare you for the exam. You should at least do Pre-Test.
- B6/5: Hang out with your patients in the afternoon. Of course you should help with phone calls and consults and face sheets for your team, but then go talk with your patients. The attendings notice and appreciate this. When they say that you are the primary care provider for your patient, it is really true on this service. The day your patient is discharged and he goes around the room thanking everyone in rounds, he will mention your name first. You will find out things that no one else will. Don't expect others to repeat the information-gathering that you are doing like they do on other rotations. They won't be, so speak up in rounds! At the same time, this is a very multi-disciplinary service, and there will be others who know more than you about different aspects of patient care. Talk with the nurses who've been there all night, and work together with the social worker. This will make your life much easier.
- Learn how to write a psych note before starting this rotation.

- It is a lot of social work and if you are willing to make phone calls to counselors, prior doctors and community health agencies you will be allowed to act basically in the capacity of a psych intern.
- The test is a boards style exam so do practice questions to prepare.

### **Primary Care:**

- The transition from hospital care to clinic is not always smooth. The biggest challenge is learning how to do an outpatient work-up and what tests are most appropriate.
- EBM is a huge component of this course, make sure you freshen up and be ready for an exam laden with it.
- Each location is very different as are all of the preceptors so ask around about which to choose.

### **Radiology:**

- Attend the seminars with Dr. Yandow, and don't be afraid to speak up. This counts for 20% of your grade, and it is one of the most valuable learning experiences of 3<sup>rd</sup>/4<sup>th</sup> year.

### **OB-GYN**

- Study blueprints and read about the patients you see in a more extensive text.
- The test is boards style, so practice questions are the way to go.
- This rotation is either at meriter or milwaukee. Meriter is very slow and many students don't even learn to do a pelvic exam, while milwaukee is much faster paced and students deliver up to ten babies in their time there. Be ready to stay up all night in milwaukee and do deliveries and crash c-sections. (This comment is outdated now with the addition of Marshfield and Green Bay sites.)

### **Peds**

- This one depends on when in the year you take it. They don't give hardly any A's in the beginning of the year as they have been warned against giving too many A's in the past. So if you take it in the summer or fall you will have to really work and make a very strong impression to get an A.
- Choose either La Crosse or Meriter. UW doesn't provide a very extensive experience and most patients on big peds at the U are just post-op spine patients.

#### **in La Crosse:**

- The inpatient service can be very busy in the winter, and there are no peds residents, so you can get tons of intern-like experience on this rotation. It is great both for those who are considering pediatrics and for determining if the hospital environment is for you.
- One negative issue is that you work a ton with and really start getting to know an attending, and then they switch a week later. This makes it difficult to get letters of recommendation. If you are going into peds, you will probably need to do a sub-I or elective early in your 4<sup>th</sup> year to get a strong letter.
- Having patients in the PICU is a very valuable learning experience. Be sure that each student has at least one patient in the PICU during your 3 weeks on inpatient peds. The docs up there are amazing teachers. Your a.m. notes should cover every system, even if you

think a system is completely noncontributory to the patient's illness. If a system is stable, mention that, and state why you think it is stable. The attendings will truly take your thoughts into account, so make sure you are doing some critical thinking about these patients. It sounds intimidating, but it is actually a very fun and encouraging environment.

## 4<sup>th</sup> year:

- Take an easy rotation in September of 4th year so you have time to work on your applications, which are due in mid-October.
- Take Dec or Jan off in 4th year will make traveling to residency interviews much easier to schedule.

## Residency:

- Start thinking of letters of rec now! If you start a rotation and there's one particular attending you click with, make a point to spend time with them whenever you have the opportunity. At the end of the rotation, ask them if they'd be willing to write you a letter. Contrary to what many people tell you, it's hard to get all the letters you need 4th year in time for application deadlines.
- Residents (especially interns) are the best resource you have for advice on choosing a specialty and residency programs. Make use of them! Ask questions while you're on rotation, even if you're not sure what you want to do. Have a certain place (notebook, folder) where you keep all the tidbits you've collected over the year. When it comes to scheduling away rotations and looking at programs it'll save you a lot of time.

## Locations

### **CSC**

phone numbers:

- 2-2122 - The folks at 2-2122 (Information and operator) have a shocking amount of information at their disposal. Find out someone's pager number. These people can get you any phone number or pager or just about any other conceivable info you need. If you call them, they can page someone while you are on the line and connect you when that person calls in. Do **not** use this method for paging your residents unless you want to freak them out (page from 2-2122 usually means a new admission to your service) and have them get pissed off at you. It's fine to page classmates this way.
- 5-7000 (then pager #) page someone

### **Cafeteria**

- Best food - free, good luck
- next best - thursday morning is cheesy potato day, italian sub, caspian cafe
- worst food - anything chinese like

## APPENDIX A

### ABBREVIATIONS

Abbreviations save time and shorten notes; there are lots of them and they are widely used. Printed lists of commonly accepted abbreviations are useful as well as asking others "Hey what does \_\_\_ stand for." Seeing abbreviations foreign to you can be frustrating, but it's also a challenge to guess whether it stands for a procedure, disorder, organization, medication, direction, location, grammatical connection, body part, clothes designer, brand of beer, athletic league, etc. A few select examples follow because they are common, confusing, or similar.

While it is tempting to start using lots of abbreviations in your own notes, do keep in mind the following admonition from the CSC's House Officer Handbook:

**"Abbreviations should be avoided if possible. They may either be unintelligible, medico-legally unacceptable, or dangerous to life where medications are concerned."**

#### A. General

1. Dx diagnosis
- DDx differential diagnosis
- Rx therapy, medication
- Tx therapy or transplant
- Pt patient
- Fx fracture
- Bx biopsy
2.  $\bar{c}$  with
- $\bar{s}$  without
- $\bar{p}$  after
- $\bar{a}$  before
- $\bar{x}$  except
3. W/U work-up
- F/U follow-up
- S/P status-post
- D/C discontinue or discharge
- RTC return to clinic
- c/o complaining of
- h/o history of
- c/w consistent with
- r/o rule out
- o/w otherwise

#### B. Shortcuts on H&P's

1. History
- NKDA no known drug allergies
- PTA prior to admission
- LMD local M.D.
- AMA against medical advice
- HA headache
- DOE dyspnea on exertion
- SOB shortness of breath
- CP chest pain or cerebral palsy
- N/V nausea/vomiting
- D/C diarrhea/constipation (or discharge or discontinue)

- BRBPR bright red blood per rectum
- PND paradoxical nocturnal dyspnea
- LOC loss of consciousness
2. Physical Exam
  - y/o year old
  - WNWD well nourished, well developed
  - WM/F or BM/F white male or female; black male or female
  - NAD no apparent distress
  - AVSS afebrile, vital signs stable
  - WNL within normal limits
  - HEENT head, eyes, ears, nose, throat
  - NC/AT normocephalic/attraumatic
  - EOMI extraocular muscles intact
  - OS/OD left eye/right eye
  - PERRLA pupils equal, round, reactive to light and accommodation
  - TM tympanic membranes
  - cor heart
  - RRR regular rate and rhythm
  - SEM systolic ejection murmur
  - LLSB lower left sternal border
  - PMI point of maximal impulse
  - (m) murmur
  - BS breath sounds/bowel sounds
  - CTA clear to ascultation
  - CVA costo-vertebral angle
  - RUL/RLQ/RML right upper/lower/middle lobe
  - RUQ/RLQ right upper/lower quadrant
  - LUL/LLL left upper/lower lobe
  - LUQ/LLQ left upper/lower quadrant
  - NT non tender
  - HSM hepatosplenomegaly
  - HJR hepatojugular reflux
  - JVD jugular venous distention
  - CCE clubbing/cyanosis/edema of extremities
  - A+0x3 alert and oriented to person, place

	and time
CN	cranial nerves
DTR	deep tendon reflexes
MAE	moves all extremities
FROM	full range of motion
FTN/HTS	finger-to-nose, heel-to-shin tests
RAM	rapid alternating movements
3. Procedures and Studies	
ABG	arterial blood gas
BE	barium enema
CBG	capillary blood gas
CXR	chest x-ray
PA-lat	posterior to anterior-and lateral
EMG	electromyogram
EEG	electroencephalogram
KUB	kidney, ureters, bladder x-ray
IVP	intravenous pyelogram
LP	lumbar puncture
PFT	pulmonary function tests
NG	nasogastric (tube)
UGI	upper GI
US	ultrasound
V/Q	ventilation/perfusion scan
VCUG	voiding cystourethrogram

### C. Medications

1. Mode
  - PO by mouth
  - IV intravenous
  - IM intramuscular
  - PR per rectum
  - SL sublingual
  - SQ subcutaneous
2. Frequency
  - qD daily
  - qOD every other day
  - BID twice daily
  - TID three x daily
  - QID four x daily
  - qHS at bedtime
  - ac before meals
  - pc after meals
  - q6<sup>0</sup> every 6 hours
  - prn as needed
  - gtt drops
3. Common medications
  - ASA aspirin
  - PCN pencillin
  - HCTZ hydrochlorothiazide
  - DSS docusate sodium
  - Pb or □ barb phenobarbitol
  - MOM milk of magnesia
  - NTG nitroglycerine

### D. Nursing Orders

amb ambulate

I&O intake/output  
 TCDB turn, cough, + deep breathe  
 TKO to keep open (minimal IV rate)

### E. Diets

NPO nothing by mouth  
 NAS no added salt  
 Cl liq clear liquids  
 ADA American Diabetic Association  
 lo chol low cholesterol

### F. Labs

1. Blood
  - CBC complete blood count
  - diff differential
  - WBC white blood count
  - T&S type & screen
  - T&C type & cross
  - Hct hematocrit
  - HgB hemoglobin
  - ESR erythrocyte sedimentation rate
  - PT/PTT prothrombin time/partial thromboplastin time
2. Micro
  - GS Gram stain
  - UC&S urine culture/sensitivity
  - C&S culture & sensitivity
  - AFB acid fast bacilli (TB)
  - FTA ABS fluorescent treponemal antibody-absorbed
  - VDRL another syphilis test
  - HIV AIDS virus
  - HSV herpes simplex virus
  - HAV hepatitis A virus
  - HBV hepatitis B virus
  - HB e, c, s Ag hepatitis antigens
3. Other
  - UA urinalysis
  - PPD purified protein derivative (TB skin test)

### G. IV and Blood Products

NS normal saline (.9%)  
 D<sub>5</sub>W 5% dextrose in water  
 LR lactated Ringer's  
 FFP fresh frozen plasma  
 PPF purified protein fraction  
 PRBC's packed red blood cells  
 TPN total parenteral nutrition  
 plt platelets

### H. ICU terms

1. Swan Ganz readings
  - RAP right atrial pressure
  - PAP plumonary artery pressure
  - PCWP plumonary capillary wedge pressure
  - CVP central venous pressure

MABP	mean arterial blood pressure	CF	cystic fibrosis
CO	cardiac output	DPT	diphtheria/pertussis/tetanus
CI	cardiac index	FLK	funny looking kid
SVR	systemic vascular resistance	FTT	failure to thrive
2. Ventilator		OPV	oral polio vaccine
IMV	intermittent mandatory ventilation	PDA	patent ductus arteriosus
CMV	continuous mandatory ventilation	OM	otitis media
TV	tidal volume	MMC	myelomeningocele
PEEP	positive end-expiratory pressure	MMR	measles/mumps/rubella
IPPB	intermittent positive pressure breathing		
CPAP	continuous positive airway pressure	K. Psychiatry	
3. Telemetry		CMI	chronic mentally ill
NSR	normal sinus rhythm	ECT	electroconvulsive therapy
RBBB	right bundle branch block	MAOI	monoamine oxidase inhibitors
LBBB	left bundle branch block		
PAC	premature atrial contraction	L. Medicine	
PVC	premature ventricular contraction	AI	aortic insufficiency
SVT	supraventricular tachycardia	ARDS	adult respiratory distress syndrome
		ARF	acute renal failure
		AS	aortic stenosis
I. Ob-Gyn		ASCVD	atherosclerotic coronary vessel disease
AB	abortion	BMT	bone marrow transplant
AFP	alpha fetoprotein	BPH	benign prostatic hypertrophy
AROM	artificial rupture of membranes	CA	cancer
BCP	birth control pills	CAD	coronary artery disease
BOW	bag of waters	CEA	carcinoembryonic antigen
BSO	bilateral salping-oophorectomy	CHF	congestive heart failure
CPD	cephalo-pelvic disproportion	COPD	chronic obstructive pulmonary disease
C/S	Caesarean section	CRF	chronic renal failure
D&C	dilation & curettage	CVA	cerebravascular accident
DUB	dysfunctional uterine bleeding	DJD	degenerative joint disease
EDC	estimated date of confinement	DKA	diabetic ketoacidosis
FHT	fetal heart tones	DNR	do not resuscitate
GPAL	gravidia-para-aborta-living children	DVT	deep venous thrombosis
HCG	human chorionic gonadotropin	FUO	fever of unknown origin
LGA	large for gestational age	GB	gallbladder
LOA	left occiput anterior	GC	gonococcus
LMP	last menstrual period	HTN	hypertension
NSVD	normal spontaneous vaginal delivery	LVH	left ventricular hypertrophy
OC	oral contraceptives	MI	myocardial infarction
PID	pelvic inflammatory disease	MS	multiple sclerosis/morphine sulfate
PROM	premature rupture of membranes	NSAID	non-steroidal anti-inflammatory drugs
ROA	right occiput anterior	PE	pulmonary embolus
SGA	small for gestational age	RA	rheumatoid arthritis
SROM	spontaneous rupture of membranes	SBE	subacute bacterial endocarditis
TAH	total abdominal hysterectomy	TIA	transient ischemic attack
TVH	total vaginal hysterectomy	URI	upper respiratory infection
VBAC	vaginal birth after C-section	XRT	X-ray therapy
J. Pediatrics		M. Surgery	
A&B	apnea & bradycardia	AAA	abdominal aortic aneurysm
AML	acute myelogenous leukemia	ABD	army battle dressing
ALL	acute lymphocytic leukemia	A-C	acromio-clavicular
ASD	atrial septal defect	AKA/BKA	above (below) the knee
BPD	broncho-pulmonary dysplasia		
BOM	bilateral otitis media		
CDH	congenital dislocated hip		

amputation  
CABG coronary artery bypass graft  
CMS circulation, movement, sensation  
DIP distal interphalangeal joint  
EBL estimated blood loss  
ERCP endoscopic retrograde  
          cholangiopancreatography  
ESWL extracorporeal shock wave  
          lithotripsy  
ETT endotracheal tube  
EUA exam under anesthesia  
ICCE intracapsular cataract extraction  
I&D incision & drainage

JP Jackson-Pratt drain  
MAST military anti-shock trousers  
MVA motor vehicle accident  
ORIF open reduction internal fixation  
PIP proximal interphalangeal joint  
POD post-op day  
PTCA percutaneous transluminal coronary  
          angioplasty  
PVD peripheral vascular disease  
TURP transurethral resection of prostate  
T&A tonsillectomy/adenoidectomy  
VGB vertical banding gastroplasty  
ZE Zollinger-Ellison