Welcome to Third Year!
A STEP BY STEP GUIDE
The following is a presentation of the collected wisdom from Downstate’s class of 2016- wisdom which was *earned* through countless hours on four boroughs from hundreds of doctors and nurses. It is hard to simulate the learning impact of a life experience, but the information in this guide has been selected carefully to emphasize the **core knowledge and common-sense base** to get you off and running. If a point sounds trivial in this guide, we can assure you it is not; these are the basics. Above all: be honest, be thorough, and **WELCOME TO THE WARDS!**
Step 1
Step 1

….just kidding. Lighten up 😊
Step 1

Wake Up
Step 2

Get Dressed
Get Dressed

• Do not wear a dirty white coat

• Do not wear a dirty white coat

• Do not wear a dirty white coat

  • Get a second white coat and use it while you wash the dirty one. Trust us.
Step 3

Pre-Round
Pre-Round (service-dependent)

1. Gather Information
   • From the EMR
   • From the paper chart (sometimes, consulting service reports are only found in the physical paper chart)
   • From the overnight resident
   • From the overnight nurse
     • Nurses can be your best friend, or your worst nightmare. Make friends early
Gather Information

Vital Signs

- Give a range over the last 24 hours
- Note any abnormal values (tachycardia overnight, spiked a fever yesterday, etc)
- Know if your patient is breathing room air, on nasal cannula, on continuous (+) airway pressure, what % O2 they’re breathing, etc.
WHAT IS THIS!?
Labs, the Easy Way

Na⁺ | Cl⁻ | BUN | Gluc
K⁺ | HCO₃⁻ | Cr

Ca²⁺ | Mg
PO₄⁻

WBC | Hgb | Plt

Hct

INR | PT | PTT
Gather Information

FROM THE PATIENT
From The Patient

• It is good to gather as much objective information as possible before speaking with the patient so you can focus your questions and examination,

• As well as answer questions they may have about the period in which you were absent from the hospital.
• **THIS** is the thing attendings want to hear most about - the chief complaint, the medical history, the family history, the travel history, etc.

• Big attending pet peeve? Students jumping to ER course/objective lab data too soon in presentations
From The Patient

• Ask about overnight events, fevers, pain (0-10), bowel movements, vomiting, appetite, and questions related to their chief complaint.

• Focus your physical on the heart, lung, abdomen, extremities (LOOK AT THEIR LEGS), surgical wounds, and again, areas relating to the chief complaint.
Pre-Round

WHAT IS THIS?!

SOAP
Subjective

Don’t be afraid to:

◦ Use quotes “to write exactly what your patient tells you,” because that is exactly what this is: what the patient reports

◦ This is where overnight events go
**Objective**

Often, the medications the patient is taking will be listed here as well. Here’s one pearl that can make you look like a champion.....

If your patient was placed on antibiotics, always put the date antibiotics were started next to the name so you know what day of therapy they’re on. We cannot stress how impressive this looks when you have this information right at your fingertips.
Assessment & Plan

1. SUMMARY

2. Problem List

1. This is the name of the first problem (ex. Sickle Cell Crisis)
   - In bullet points underneath, you will list what you will do for the problem
   - You will, in SOAP notes, also comment on pertinent in-hospital events regarding the problem

2. This is the name of the second problem (ex. DMII)
   - You get the drift
Patterns!

This flow should sound familiar...

What the patient told me, what I found out, what we’re gonna do about it.....

Full Admission Write-Ups!
CC: 
HPI: 
PMH: 
PSH: 
SH: 
ROS: 
Etc........

Subjective

Objective

Why do we bring this up?

Because when you present to the attending, you’ll use the **exact same format**

Which brings us to our next point....
Step 3

Rounds
Rounds
This is Mr. H, our 37 year old male with nephrotic syndrome. No acute events overnight. This morning, the patient complains of increased swelling in his L arm after his IV was replaced. He denies any pain or redness at the area. He denies any fevers or chills overnight. He reports his cough has improved from yesterday with Tylenol with codeine. He says he’s urinating well and no longer feels he has to strain. Overall, he feels better and that his total body swelling has decreased. Patient was afebrile overnight, heart rate ranged from 80-96, blood pressure remains elevated, ranging from 145/88 to 174/91, and he is sitting well on room air. On physical exam, patient remains edematous; however, level of edema is now 3+ just above the knees; sacral edema is not appreciated, and periorbital edema has resolved. The left arm does appear to be more swollen than the right. Peripheral IV is in place in the left antecubital fossa, dated yesterday. The site is nonerythematous, non-tender, and there is no increased edema at the IV site compared to the rest of the arm. Lungs sound clearer than yesterday, still with some appreciable crackles in the lung bases bilaterally. In his labs for today, his K+ dropped slightly to 3.1, BUN and Cr remain elevated, but are stable. Hemoglobin and hematocrit are decreased, but stable. Last three glucose were 200, 150, and 130. 24 hour urine protein came back as 10g. SPEP and UPEP have been ordered but are pending. Patient also had an echo done yesterday which showed an estimated ejection fraction of 55-60%, no wall motion abnormalities, and mild mitral regurgitation. To summarize, this is Mr. H, our 37 year old with a past medical history of uncontrolled diabetes type 2 and hypertension who presents with nephrotic syndrome. His first problem is the new swelling in his L arm after the IV was replaced. Based on physical exam, it doesn’t appear infected so we’re not worried about cellulitis or thrombophlebitis. We should have the nurse check the IV today and replace it in his R arm. Next would be his nephrotic syndrome. The patient is improving symptomatically with diuresis and continues to have large net urine output. Renal is on board and recommends continuing diuresis with Lasix 80mg IV bid as he remains edematous. His next problem is hypertension. His blood pressure remains elevated since admission. Due to his Utox being positive for cocaine, we avoided Beta-blockers and started a calcium channel blocker. Renal recommended increasing nifedipine to 90mg daily. Next, his chronic kidney disease. BUN and Cr remain stable since admission, and he is still voiding well. Again, renal is on board and they recommend obtaining venous mapping and consulting vascular surgery for placement of an AV fistula as patient will most likely need dialysis for long term management. Next is his diabetes. He is currently only on insulin sliding scale, requiring only 5 units in the past 24 hours. His sugars have been well controlled since admission, so we can continue with that with plans for continuing his outpatient regimen on discharge as his hemoglobin A1c on admission was 6.8. He also has a microcytic anemic with an H&H of 8.2 and 24.6 and an MCV of 82. This has been stable since admission. Patient remains asymptomatic with no complaints of fatigue, dizziness, or lightheadedness. The anemia is most likely secondary to his chronic kidney disease, however, we will order iron studies. He is on heparin 5000 units twice daily for DVT prophylaxis due to his poor kidney function. He is full code and his disposition will be continued diuresis in house with discharge to home.
The Team

Attending

Fellow

Resident

Intern

Nurses, Social Workers, Case Managers...

Sub-Intern (MS4)

3rd Year!
Your Role

• You are the one with the **MOST FREE TIME** to talk to the patient and get the history right. Do it- the only way you get better at history taking, is by taking histories

• Making phone calls: volunteer to do this. It can be very rewarding to call a **family member** and update them on the status of their loved one, or act as a **liaison for an outside primary care doctor**, informing them about their patient’s stay in the hospital.
Adult Education

• Above all, MS3 is the true beginning of “adult education”

• Nobody will be holding your hand guiding you towards what to learn or how to study........

• ...And it’s truly a wonderful, liberating experience.
Adult Education

• Ask questions. Attendings like students who like to learn.

• Don’t be afraid to be wrong right now. You’re still a student - you don’t directly manage patient care so it’s better to be wrong now and learn it now than to be scared to speak up now and get it wrong as a resident physician.

• Nobody expects you to know everything. That’s why you’re here.