Senior Residents – "Hints, Tips and Tricks" IM Medical Students

Not an official Gundersen Document-Not a standard for all senior residents

- Show initiative
  - Follow up on labs/imaging/studies
  - Check in on patients in the afternoon and report back to resident (if there is a pending lab/imaging to report, please talk to resident about plan first)
  - Don't just sit and study for shelf exam, read about disease processes related to your patients
  - Read about topics you don't understand at home and if you have more questions, return with those questions
  - I may ask you to give brief 5 minute oral presentation on interesting topics
- Be prepared and on time
  - Sign out starts at 7am; Morning report between 7:30-8a. Table rounds at ~8:30a
  - Expect to see all your patients before table rounds
  - Plan extra time in case there is an interesting roll over that you may pick up and need to see before table rounds (please actually perform your own brief history in the morning on roll over patients, otherwise we all could just read the H&P just as easily).
- Always present in H&P/SOAP format (even when you get comfortable and/or residents are not presenting in this format)
  - Try to keep presentations short if possible
  - Don't get distracted in details
  - Don't insert comments/questions when presenting labs/imaging (if you don't understand a study, then you can insert it as a problem in A&P and we can talk about this)
- Both 3rd and 4th years are expected to write notes--H&P and progress notes (attendings review you based on this and it's good practice to work on efficiency)
- Go to morning lecture (7:30a-8a, except on Thursday is core lecture which is longer 7:30-8:15a)
- Work one weekend day each week with senior resident
- Let us know of lectures beforehand if possible
- Remember that we're not perfect and if you forget to do a certain exam or missed asking the patient a question, I would rather have you say, "That's a good question. I did not ask the patient or do that exam, but can make a note of it to ask the patient or go back and examine," rather than making up what you think the patient would've said or what the physical exam was.

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H&P Presentation:

History of present illness:

- One liner—age, sex, mention only 2 relevant past medical history, chief complaint
  - Example: 89 yo male with hx of CHF and COPD here with shortness of breath)
- Subjectively why the patient presented (OPQRST)
- Note any previous admission/clinic visits pertinent to history
- In the ED, vitals if pertinent, remarkable studies leading to diagnosis, any treatment given in ED

Past medical history:

- Know details about medical history, but only list medical problem. Report details in presentation only if pertinent to admission, otherwise just be prepared to know details
  - Example: Last A1c for diabetes, last echo for heart failure, last PFT for COPD, last colonoscopy/EGD for GI bleeder

Past Surgeries:

Allergies:

- Review with patient their reaction to the medication

Medications:

- Ideally you should have a list of names and doses available, but for time sake, only name the medication.
- Don't need to mention why a patient is on a med unless it's an uncommon medicine (but be prepared to answer question for why they're taking that medication)
- No need to list supplements/vitamins unless pertinent
- Make sure you ask patients about OTC medications

Family history:

- Don't ever say unremarkable (some attendings don't like this)
- Positive or negative family history (ie. No history of early heart disease or clotting disorder)

Social:

- Who does the patient live with? How do they get around their house? Who manages their meds? (This will be important to know for disposition at discharge)
- What does the patient do for a living?
- Smoking hx, Alcohol use, illicit drug use

Code Status: Full, O-DNI/DNR, etc.

ROS: Do your exam when you ask your patients these questions to be efficient (ask question first and then proceed with exam, otherwise patients might become concerned)

Vitals: Temp, HR, BP, RR, intake/output (if available)

Physical Exam: Have a general head to toe exam memorized so you can just say this really fast and then focus on pertinent part of exam (General, cardiac, respiratory, abdomen, skin). It does sound better to say "heart is regular rate and rhythm and lungs clear throughout" rather than "heart and lungs normal."

Investigations:

- Personally review labs, imaging, ECG and compare to previous
- In presentation, may include previous tests that are pertinent (ie. Last TTE from this date showed X or last colonoscopy from this date showed X)

Assessment and plan:

- Most likely Diagnosis
  - Cause for diagnosis
  - Evidence supporting leading diagnosis (history, physical exam, labs, imaging)
- Differential
  - Evidence for why these alternative diagnoses are supported/unsupported
- Plan for exploring other differential/ causes (further labs, imaging, etc)
- Treatment for diagnosis

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- How are you going to assess if your treatment is working?

SOAP Presentation:

Subjective:
- Big events during day prior
- Events overnight.
- How patient is feeling today and pertinent ROS.

Objective:
- Vitals including intake and output
- Quick pertinent physical Exam (general, cardiac, resp, abdomen, and pertinent exam)

Assessment and Plan:
- Problem List
- Progress/severity of problem (improved, worsening)
- Further investigations and plan for follow up
- Treatment (make sure you have planned stop date—ie treatment for pneumonia, cellulitis, UTI, abdominal infection, COPD meds)
- Anything that can be stopped?
    - IVF, telemetry

FEN (fluids, electrolytes, nutrition):
- Be aware of IVF, any electrolytes needed to be replaced

Dispo:
- PT/OT recommendations
- Social worker consulted if needed
- If discharging:
    - New medications
    - Held medications at d/c
    - Follow up labs that will be ordered
    - Follow up appointments and time frame for follow up (ie. PCP in 1-2 weeks with labs prior)

**For overflow from overnight team, just give brief history of present illness, overnight pertinent investigations and treatments and then move on to SOAP presentation with subjective on how patient is doing today.