BROWN
Alpert Medical School

The Guide to Taking Electives

for

Visiting International Medical Students

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TABLE OF CONTENTS

I. INTRODUCTION

- A. Hierarchy of American Medicine—“the team members”
- B. Appropriate dress
- C. Appropriate salutations
- D. Relationships—getting what you want and what you need

II. MEDICAL RECORDS

- A. Formal written admissions note
- B. SOAP notes
- C. Oral presentations
- D. Ordering/cosigning

III. MEDICATIONS MOST COMMONLY USED

IV. PRACTICAL INFORMATION

I. INTRODUCTION

Welcome to the Alpert Medical School at Brown University. We hope that your clinical experience here will be excellent and one of learning and growth. Here is some information that may assist you to acclimate to the American Medical System.

A. Hierarchy of American Medicine—"the team members"

American medicine is practiced in teams. The Health Care TEAM—nurses, attendings, residents, interns, ancillary services, and clerks (you), are all important members of the healthcare team. Treat all of them with respect, and hopefully they will do the same to you.

You will learn within the context of these teams usually in one of these formats:

Work Rounds: Includes the members of the team as well as a nurse, usually the "charge" nurse who is a registered nurse (RN). This usually takes place by the patient's bedside. They are brief and focus on the plans for the day based on the tests and progress of the patient from the previous days. Be very careful of CONFIDENTIALITY when speaking about patients.

Attending Rounds: The team's patients are presented and more in depth discussions take place around the assessment, management and treatment of the patient. This does not usually in the patient's room but rather in a conference area (sometimes the hallway, so again, *confidentiality* is important).

Grand Rounds: Large educational lectures. May involve a case presentation but sometimes a professor will just lecture on a topic.

Attending
This person is the doctor who is in charge of the patient(s) on his/her team or service. He/she has completed all the necessary training to be in charge, which would be residency, residency plus fellowship, or residency plus fellowship plus research. To you, the attending is the last word on patient management…unless your resident or the nurse questions the decisions being made, in which case you are just caught in the middle until management parameters are worked out. The attending is a great source of medical information, advice on future career decisions, and the person who will oversee your evaluation.

Consultant
This is an attending on a specialty service who is called in to provide specialty expertise on the patient. There may be others on the consult service. In fact most of the time, a visiting international medical student will be on a consulting service.

Fellow
This person is the doctor who has already completed residency, but is pursuing additional training in a subspecialty fellowship. You will often see him/her on a consult service or running a surgical case with the attending supervising. He/she knows as much as your resident or more, and can be a great source for medical information and career advice.

Resident (PGY-2+, R2+, a.k.a. house officer/house staff)
This person is the doctor-in-training who has more responsibility than you want to think about right now. He/she is in charge of your team and is the person with all the answers. He/she is also the person who may inadvertently ask you really hard questions simply from thinking aloud. Forgive him/her. He/she is sleep-deprived. He/she is also the person often considered responsible for your education. They are more experienced so you should spend time with the resident and learn from him/her.

Intern (PGY-1, R1, a.k.a. house officer/house staff)
This doctor-in-training is the first-year resident who is asked to do everything, learn everything, and on top of all that—teach you. They are often even more sleep-deprived than the resident, but they will teach you how to be a good intern, and if you stick with them you will learn many procedures.
Cardinal Rule: *Always ask your intern if he/she needs help, because he/she probably does and will appreciate it.*

Physician Assistant (PA)
These are medical personnel trained to assist physicians. They may do histories and physicals (H&Ps), prescribe medications, perform bedside procedures (placing central lines, performing lumbar punctures), and treat or assist in a diverse range of medical applications. You will mostly see PAs working with doctors in outpatient settings. In the hospital, they often work in intensive care units (ICU) (managing patients in the neurosurgical ICU, while the residents perform surgeries), the emergency department, or see consults for physicians.

Nurse Practitioner (NP)
You will often see NPs in the outpatient setting working with doctors. You may also see them in the hospitals as well. He/she is similar to a doctor in that he/she sees patients, does histories and physicals (H&Ps), and prescribes medications. However, he/she will also consult physicians for medical guidance, or even transfer patient care to the doctor if the patient's medical problems become too complex to manage.

Registered Nurses (RN)
This includes operating room nurses, emergency nurses, intensive care nurses, and floor nurses. They are listed first because without them, none of us could be a doctor. Remember, they have been doing their job for a long time and have a

great deal of practical experience. Listen to them, ask them for help, and learn from them. They can teach you a lot.

Similarly there are: Licensed Practical Nurses and Certified Nursing Assistants. These folks take care of the patients on a daily basis but usually report to the RNs who collate the information for the rest of the team.

Ancillary services/Support staff
This includes, among others, physical and occupational therapists, case managers, respiratory therapists, central transport, and phlebotomists. You will spend little to no time with them, but they are invaluable to patient care in terms of rehabilitation, arranging for discharge, and dealing with acute care issues (you will become familiar with some alarm bells ringing, and then a voice over the hospital address system: “Respiratory therapy, stat, <room number>”.

Certified Registered Nurse Anesthetist (CRNA)
This person is basically an anesthesiologist without a medical degree. She received her nursing degree just like other nurses, but completed an additional two years of training in anesthesia. You will often find her running most of the straightforward surgical cases from induction to recovery with the attending anesthesiologist dropping in at times to make sure everything is all right or when it is not.

Sub-Intern (a.k.a. Sub-I, Extern, Acting Intern, A-I)
This person is a fourth-year (sometimes a third-year) medical student. He/she is knowledgeable and is gearing up to be <gulp> a real doctor. In fact, the residents on your team will expect your Sub-I (pronounced “sub-eye”) to perform at the level of an intern.

Medical Student–Clerk
This is YOU and maybe other medical students from Brown. You will learn a great deal from each other so make friends early!!!

B. Appropriate Dress

ID—you MUST wear your Brown ID at all times.
I suggest that you buy one of the clip on badge holders with a lariat to go around your neck if you don’t have one. This makes it easy to remember to wear your badge.

Clothes
Knowing what to wear is a combination of common sense, courtesy, and comfort. Basically, unless you are wearing scrubs, you should dress professionally. What constitutes professional attire varies from practice to practice and site to site.

For **men**: button-down dress shirt, slacks, tie and white coat. Closed toe shoes. No sneakers except for operating room. No jeans or t-shirts.

For **women**: shirt or blouse, slacks or dress. No short skirts (use common sense on length and look at others on the team), no lace, no bare arms or deep cut necklines. Closed toe shoes not sandals or sneakers. White coat. Pants are fine

Footwear
You will be walking miles upon miles throughout the hospital. A friend of mine wore a pedometer and found out that she walked a few miles already before lunch. Thus, it is a good idea to have comfortable shoes, but also those that look appropriate with both scrubs and your professional clothes.

White Coats
So, you should ***BRING A WHITE COAT*** with you. It should be a short white coat. There are many purposes to the short white coat:

1. It is part of the medical student uniform.
2. It identifies you to patients as part of the medical team.
3. Its short length identifies you to medical staff as a medical student.
4. It has extra pockets!
5. It protects your professional wear from stains and assorted body fluids.

C. Appropriate Salutations—What do I call everyone?

You should always introduce yourself when meeting a patient or new "team." Give your full name and state that you are a medical student from ___________ Medical School (fill in with the name of your medical school working at the Alpert Medical School.

Attending: generally refer to attending by title: Dr. "Whoever".

Residents/Fellows/Interns: Start with Dr., but most will tell you to call them by their first names.

Patients: Always refer to patients by proper name: Mr. or Mrs. or Miss or Ms. unless the patient says it is okay to call them by their first name.

D. Relationships–Getting What You Want and What You Need

You have to be "professional" at all times. It is expected that you will be attentive and respond to questions. However YOU are expected to advocate for yourself

also. This means if you are not getting what you want or you do not understand, the expectation is that you will ask. It is best to ask the resident or intern first. They may refer you to the attending. You are responsible to all the people on the team and in general they will ALL be evaluating you. Most of the time you will spend time in direct patient contact. The reading you do will be after you leave the hospital though there may be time during the day also.

If you feel you are not getting appropriate guidance, please contact Dean Julianne Ip (Julianne_Ip@Brown.edu) or Ms. Hilary Sweigart (Hilary_Sweigart@Brown.edu) and we will assist you.

II. MEDICAL RECORDS

As a medical student, you will most likely need to complete full history and physicals (H &Ps). Perhaps the most important thing about your H&P is that you collect *all* the information, and have it available in case you are asked about it, however you may not necessarily include it in your formal presentation (unless it was relevant). As time goes on, you will get a better sense of what is relevant, but it is safer at the beginning to err on the side of more information rather than less. Some attendings do not mind if you refer to your notes to check on some details while presenting, while others want you to have all details memorized (except for nit-picky lab data).

A. Formal Written Admissions Note (serves as basis for formal oral presentation also)

The complete history and physical The format is as follows:

Chief Complaint CC (in patients own words); include if the patient is "reliable"

History of Present Illness (HPI) gives a synopsis of the patient's current problem(s) using **OPQRST**—**O**nset or origin; **P**ain, including pain scale of 1-10; **Q**uality; **R**adiation; **S**everity; **T**iming, Associated symptoms, What aggravates or alleviates the symptoms, Previous episodes. Concerns or what the patient may think about what they have.

Past Medical History:
Other active medical problems
Hospitalizations
Surgeries
Birth History if relevant (pediatrics)
Obstetric History if relevant (obviously just in women)
Medications (prescribed, over the counter and herbal)
Allergies and reaction description

Family History:
Pertinent illnesses and ages of parents, siblings

Social History
Living arrangements/finances
Support systems
Job
Stresses/Hardships
Cultural and Religious beliefs that may impact treatment
Sexual History (particularly pertinent to Ob/Gyn but should be included in all H & Ps)
Tobacco Use

Alcohol Use
Recreational non-prescription drug use

Review of Systems:
General
Skin
HEENT
Cardiac
Pulmonary
GI
GU
Musculoskeletal
Immuno/hematology
Neurologic
Psychological

Physical Examination
General appearance
Vital Signs
HEENT
Cardiac
Pulmonary
Abdominal
GU
Neurological
Mental

Assessment
Differential diagnosis and rationale on how to proceed to make the diagnosis. May be one run-on sentence summary of who the patient is, why he is here, what has been done since admission into the Emergency Department or the doctors office, including lab results or tests down prior to admission.

Plan
What are you going to order, what studies are being done, who is being consulted) either by **system** or by **problem**. A brief discussion on the management and possible therapies for the patient particularly as they related to your assessment.

Some attendings/residents like it if you outline the plan by **system**, i.e. running through neurologic, cardiovascular, pulmonary, renal, GI, heme, musculoskeletal, infectious disease, etc. and describing any problems if it exists or does not exist. This method of running through systems ensures that you do not forget any problems—it is a very thorough technique.

However, other residents/attendings do not want to hear every system if it is not involved in the current plan of care—they prefer a **problem**-based presentation, where you talk about the current issues (i.e., a patient with HIV might have issues such as pneumonia, rash, joint pain, headache, etc.).

B. SOAP Notes

Basically a daily progress note on the patient. On a consult service, you will often be called upon to write the SOAP note from the service based on the rounds that you make on the patient.

The details of the SOAP format are as follows:

S = **Subjective** (overnight events, what the patient tells you about how they are feeling)—Usually includes a brief chief complaint, brief history of present illness, medications. May include pertinent past medical, surgical, family, and social history.
O = **Objective** (what you find on the vital signs, physical exam, labs, tests)—Objective information.
A = **Assessment** (briefly recap the clinical situation in a few lines)—Usually a one-line, run-on sentence.
P = **Plan** (what we are going to do about each and every issue)—Organized either by **system** (usually used in the ICUs) or by **problem** (usually used on the floors).

Some attendings / residents like it if you outline the plan by **system**, i.e. running through neurologic, cardiovascular, pulmonary, renal, heme, GI, GU, musculoskeletal, infectious disease, etc. and describing any problems if it exists or do not exist, then formulating a plan for any problems. This method of running through systems ensures that you do not forget any problems, and it is a very thorough technique.

However, other attendings / residents do not want to hear every system if it is not involved in the current plan of care. Hence, they prefer a **problem**-based presentation, where you talk about the current medical issues (i.e. a patient with congestive heart failure might also have issues such as coronary artery disease, hypertension, COPD, diabetes, etc.). For each problem, there needs to be a formulated plan for how to address that problem.

The Assessment and Plan are often written together as **A/P**.

The length and style of a SOAP note varies with each clerkship (shorter notes in Surgery, longer ones in Medicine), but the idea is the same. Look in the patient charts to see the type of notes expected of you. Get used to writing one and feel

confident telling your resident/fellow/attending you can write the SOAP note on a patient.

C. Oral Presentations

Order of presentation on subsequent mornings:

1. Brief reminder of the patient and his problems (similar to the Assessment above)
2. Pertinent events from the day before
3. Events overnight
4. This morning: vital signs, pertinent physical exam findings, labs
5. The plan for today

D. Common Abbreviations

GLOSSARY OF COMMON ABBREVIATIONS	Description
WDWN	Well developed, well nourished
NAD	No Acute Distress
CAD	Coronary artery disease
DM	Diabetes mellitus
HBP	hypertension
SOB	Short of breath
CP	Chest pain
N/V/D	Nausea, vomiting, diarrhea
DOE	Dyspnea on exertion
PID	Pelvic inflammatory disease
STI	Sexually transmitted infection
G#P#	Gravida # Para #
PUD	Peptic ulcer disease
GERD	Gastro-esophageal Reflux Disease
HEENT	Head, eyes, ears, nose and throat
UTI	Urinary tract infection
GC	gonorrhea
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome

PND	Paroxysmal nocturnal dyspnea
PVD	Peripheral vascular disease

E. Ordering/Cosigning

You should always date your notes. Also, make it a habit to write the time on your notes, as it can be helpful to folks who visit your note later.

What Color Pen to Use   Black. *Always* use a black pen, not blue. And of course, *never* use pencil.

How to "Erase" a Mistake in a Note?
You don't.
A patient's record is a medical and legal document, and you should never "erase" any mistakes or scratch them out so that they are illegible. Instead, draw one line through the words you do not want to use anymore, followed by the word "omit" or "error." Sign you initials next to it.

Example:

58 yo M with ~~CAD, AF,~~ <error GC> DM presents to RIH ED with 3 day h/o abdominal pain.

How to Sign Your Name

Like this:

First name/initial Last name, AMS-VIMS <pager number>

And yes, **always** write your pager number!

You will discover that many doctors' signatures are so illegible that no one knows who wrote a set of orders. *Don't you become one of those doctors!*

Be responsible for your actions and take responsibility for your patients by legibly writing your name and pager number so that nurses and other housestaff can contact you with questions. Once you do, you will soon discover **how important the medical student note is.**

Co-Signatures
Every time you sign your name to a piece of paper that is part of a patient's medical record, you are attesting to the fact that you did order or do whatever it is you wrote. Your signature carries a lot of power and *RESPONSIBILITY*. Use it wisely—sign only what you have written, and after you write something, always sign it!

Until you become an MD in your own right, however, there is one signature more important that yours: that of the MD or DO supervising you. That person could be

your attending, a resident, your intern, or your preceptor. Whoever it is, it is **imperative** that that person co-sign everything that you sign!

Now while medicolegal experts will tell you that it is your supervisor's responsibility to read what you have written and to co-sign your notes, you in good conscience, as not only a medical student but as a member of a healthcare team, need to take responsibility to have your notes co-signed. **You should also take responsibility and make sure as much as you can that your supervisor *reads* what you've written**.

Be a team player. Reread your notes, make sure your notes are co-signed, and ask whether your co-signatory actually read what you wrote.

Codes

These are hospital emergencies for various situations. Some you will hear during your rotations, while others you hope you will never hear. Below are three you might hear on the ward:

CODE BLUE: This is cardiopulmonary arrest. Usually, a team is specifically assigned to codes. You may be asked to move or leave the patient's room if you are not "helpful." Other times, you may be asked to participate in providing basic cardiopulmonary resuscitation. Please tell the team leader if you are NOT comfortable or knowledgeable and then get out of the way!!!

Code red: Fire

Code pink: kidnapping of a baby (WIHRI only)

III. MEDICATIONS MOST COMMONLY USED

By Prescriptions Dispensed by brand name then (pharmaceutical compound name)
1. **Lipitor** (atorvastatin calcium) is a synthetic lipid-lowering agent)
2. **Singulair** Montelukast sodium, the active ingredient in SINGULAIR[1], is a selective and orally active leukotriene receptor antagonist for asthma
3. **Lexapro** (escitalopram oxalate) is an orally administered selective serotonin reuptake inhibitor (SSRI) for depression
4. **Nexium** esomeprazole magnesium for decreasing gastric acid-GERD and PUD
5. **Synthroid** levothyroxine sodium tablets, USP) is identical to that produced in the human thyroid gland
6. **Plavix** clopidogrel bisulfate) is an inhibitor of ADP-induced platelet aggregation used for CAD and PVD (stroke)
7. **Toprol XL** metoprolol succinate Extended-Release Tablets for hypertension
8. **Prevacid** lansoprazole for PUD
9. **Vytorin** ezetimibe/simvastatin for mixed hyperlipidemia
10. **Advair Diskus** fluticasone propionate 100 mcg and salmeterol 50 mcg inhalation powder for treatment of asthma
11. **Zyrtec** cetirizine hydrochloride for seasonal or chronic rhinitis and urticaria
12. **Effexor XR** venlafaxine hydrochloride for depression
13. **Protonix** pantoprazole sodium for esophagitis and GERD
14. **Diovan** valsartan for hypertension
15. **Fosamax** alendronate sodium for osteoporosis
16. **Zetia** ezetimibe for hypercholesterolemia
17. **Crestor** rosuvastatin calcium for hyperlipidemia
18. **Levaquin** levofloxacin broad based anti bacterial
20. **Klor-Con** potassium chloride for potassium replacement
21. **Cymbalta** duloxetine hydrochloride as anti-depressant
22. **Actos** pioglitazone hydrochloride anti-diabetic decreases insulin resistance
23 **Premarin Tabs** conjugated estrogens post menopausal
25. **Celebrex** celecoxib-NSAID for pain or arthritis
26. **Flomax** tamsulosin hydrochloride for benign prostatic hypertrophic symptoms
29. **Nasonex** mometasone furoate monohydrate nasal spray for allergic rhinitis
31. **Lantus** insulin glargine [rDNA origin] injection
32. **Viagra** sildenafil citrate for erectile dysfunction
34. **Yasmin 28** drospirenone and ethinyl estradiol oral contraceptives
36. **Adderall XR** amphetamine for ADHD (attention deficit hyperactivity disorder
39. **Ambien CR** zolpidem tartrate for insomnia

Most Commonly prescribed GENERIC drugs with their brand names

Brand Name	**Generic Name**
ALLEGRA	Fexofenadine
AMOXIL	Amoxicillin
ATIVAN	Lorazepam
AUGMENTIN	Amoxicillin-Clavulanate

BACTRIM	Sulfamethoxazole/Trimethoprim
CIPRO	Ciprofloxacin
CLEOCIN	Clindamycin
COUMADIN	Warfarin
DIFLUCAN	Fluconzaole
DYAZIDE	Triamterene w/Hydrochlorothiazide
FLEXERIL	Cyclobenzaprine
FLONASE	Fluticasone (nasal spray)
GLUCOPHAGE	Metformin
KEFLEX	Cephalexin
KLONOPIN	Clonazepam
LASIX	Furosemide
LOPRESSOR	Metoprolol
MOTRIN	Ibuprofen
NAPROSYN, ANAPROX	Naproxen
NEURONTIN	Gabapentin
PAXIL	Paroxetine
PRAVACHOL	Pravastatin
PRINIVIL, ZESTRIL	Lisinopril
PROZAC	Fluoxetine
SYNTHROID	Levothyroxine
VALIUM	Diazepam
VASOTEC	Enalapril
XANAX	Alprazolam
ZITHROMAX	Azithromycin
ZOCOR	Simvastatin
ZOLOFT	Sertraline

IV. PRACTICAL INFORMATION

FOOD

Eat when you can. Simple enough. Given the responsibilities, obligations, and commitments you have in the hospital though, you soon realize how much you take for granted normal mealtimes. That being said, there is no reason for you to starve and there are ways to help keep yourself fed…most of the time.

Rhode Island Hospital / Hasbro Children's Hospital Lunch is also provided at noon conferences during your Medicine rotation. Otherwise you are on your own.

Women and Infants' Hospital You are on your own. The food at W&I is pretty good and relatively inexpensive considering its quality.

The Miriam Hospital You are on your own here also. The sandwiches are good, but pricey.

Memorial Hospital Arguably some of the best food among the hospitals. Lunch is also provided at noon conferences during your Medicine rotation. The rest of the time, you are on your own.

VA Medical Center Lunch is provided at noon conferences three times a week during your Medicine rotation. Breakfast is provided and sometimes lunch during your on-call rotation.

Butler Hospital The controversy continues on the quality of food here. It has definitely improved and is worth trying.

Bradley Hospital Arguably some of the best food in the hospital system, you are unfortunately on your own here.

TRANSPORTATION

You should use your Brown Card ID for the BrownMed Shuttle and for public transportation on RIPTA (Rhode Island Public Transit Authority) buses as the ID makes it FREE.