a LANGE clinical manual

Clinician's Pocket Reference

6th Edition

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Based on a program originally developed at the University of Kentucky College of Medicine, Lexington, Kentucky

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Preface to the Fourth Edition

The *Clinician's Pocket Reference* is based on three previous editions of a University of Kentucky house manual entitled *So You Want to Be a Scut Monkey, Medical Student's and House Officer's Clinical Handbook*. The "Scut Monkey" Program at the University of Kentucky College of Medicine began in the summer of 1978. It was developed by members of the Class of 1980 to help ease the often frustrating transition from the preclinical to the clinical years of medical school. Working with the College of Medicine's Division of Educational Development, members conducted interviews with third and fourth year students, house officers, and faculty to develop a list of essential information and skills that third year students should be familiar with at the start of their clinical years. The "Scut Monkey" Program was developed around this core of material. A random sampling of 44 other medical schools around the country indicated that a similar need existed elsewhere.

The "Scut Monkey" Program consists of reference manuals (similar to this edition) and a series of workshops conducted at the start of the third year. Held originally as a pilot program for the University of Kentucky College of Medicine Class of 1981, the orientation is now an official part of the third year curriculum. It is the responsibility of each new fourth year class to conduct the orientation for the new third year students. We feel that much of the success of the program is due to the fact that it is a program developed and taught by students for other students. This method has allowed us to maintain perspective on those areas that are critical not only for learning while on the wards but also for delivering effective patient care. This program could not have been conducted without the full support of the Office of the Dean. Detailed information on the "Scut Monkey" Orientation Program is available on request.

The program was presented at the 1980 National Convention of the American Medical Students Association, and since that time over four dozen medical schools have requested not only information on the workshops but also copies of the manuals. These requests and feedback from members of the Class of 1980 who found that the book was useful to interns and residents as well as to students have led to the extensive revision and publication of this manual. The original text of the fourth edition was prepared using a computer-assisted editing program.

We would like to express special appreciation to D.K. Clawson, M.D., Dean of the University of Kentucky College of Medicine, for his extensive support of the "Scut Monkey" Program and his encouragement to make this manual available outside the University of Kentucky Medical Center.

Many persons have made the first three editions of this book possible. The majority (more than 40) were members of the Classes of 1980 and 1981 who made their contributions while still medical students. Although we cannot list each one by name, we wish to note our appreciation and gratitude for their efforts. Continuing contributions to the program by Len Heller, EdD, and his staff at the Division of Educational Development have been outstanding, and the cooperation of Roy Jarecky, EdD, Terrence Leigh, EdD, and the entire Office of Academic Affairs is gratefully acknowledged. We are also thankful for the assistance of Darreldean Winkler, a clinical nutritionist at the College of Medicine. Many faculty members at the College of Medicine have been kind enough to review the majority of chapters in this book. We wish to thank our friends at the Ohio State University College of Medicine for allowing us to

modify their selection entitled "So You Want To Be A Toad" that is used in the first chapter. We would also like to acknowledge Sheila Sullivan and Jane Keeble for their efforts in preparing this manuscript for publication and Capistrano Press, Ltd. for their enthusiastic support of our manual.

The "Scut Monkey" Project is meant to be a continuing endeavor. Comments and feedback are always welcome. We trust the benefits of this manual will adequately reflect the effort and enthusiasm with which it was compiled.

Leonard G. Gomella

Introduction

It is difficult to believe that the original "Scut Monkey" book made its appearance 10 years ago. Comparing the original "book," which was really only a series of handouts, with the Sixth Edition is, on the surface, like comparing apples and oranges. However, over the years, although the format of the book has changed, the concept has remained the same: to identify and provide a ready reference for the common questions and issues that arise caring for patients on a day-to-day basis. The task has become increasingly difficult from those early efforts because of the literal explosion of new techniques, new laboratory tests, and new medications that are continually introduced. I hope we have succeeded in identifying the key areas.

In response to the popularity of the drug reference section (Chapter 22), we have expanded the number and scope of the medications. This provides the most complete and useful listing currently provided in a pocket reference manual not specifically dedicated to pharmacology. The critical care section (Chapter 20) has undergone extensive revisions to again provide a more complete approach to the critically ill patient.

In breaking with the tradition of the book, we have dedicated an entire chapter to AIDS in response to the dramatic impact this disease has had on all areas of medicine. We hope we will be able to exclude this chapter from the next edition.

The commitment of Appleton & Lange to produce high quality educational materials is obvious in all of their productions. Lin Paterson, President and Bill Schmitt, Editorial Director are to be commended for their excellent leadership and the assistance they provide to their authors.

I am indebted to my entire family for the support and encouragement they provided during the preparation of this manual. I would like to thank all the contributors to the Sixth Edition. My special thanks go to Howard Greenberg for providing the office space needed to finish the book.

As always, comments from our readers are welcome, since revisions in the book would not be possible if it were not for the ongoing interest on their part. I hope this book will not only help you learn some of the basics of the art and science of medicine but also allow you to care for your patients in the best way possible.

Leonard G. Gomella

Table of Contents

1 "So You Want to Be a Scut Monkey": An Introduction to Clinical Medicine*

The transition from the preclinical years to the clinical years of medical school is often a difficult one. Understanding the new responsibilities and set of "ground rules" can ease this transition. Below is a brief introduction to clinical medicine for the new "clinical clerk."

THE HIERARCHY

Most services can be expected to have at least one of each of the following physicians on the team.

The Intern

In some programs, the intern is known euphemistically as the first year resident. This is the person charged with the day-to-day responsibilities of patient care. This duty combined with a total lack of seniority, usually serves to keep the intern in the hospital more than the other members of the team and may limit teaching of medical students. Any question concerning details in the evaluation of the patient, eg, whether Mrs. Farkle gets a complete blood count (CBC) this morning or this evening, is usually referred first to the intern.

The Resident

The resident is a member of the house staff who has completed at least 1 year of postgraduate medical education. The resident is usually on call less often than the intern, is in charge of the overall conduct of the service, and is the person you might ask a question, such as "What are the kinds of things that might give Mrs. Farkle a white blood cell count (WBC) of 142,000?" You might also ask your resident for an appropriate reference on the subject or perhaps to arrange a brief conference on the topic for everyone on the service.

The Attending Physician

The attending physician is also called simply "The Attending," and on nonsurgical services, "the attending" (only kidding!). This is a physician who has completed postgraduate education and is now a member of the faculty. The attending is morally and legally responsible for the care of all patients whose charts are marked with the attending's name. All major therapeutic decisions made on the care of these patients are ultimately passed by the attending. In addition, this is the person responsible for teaching and evaluating house staff and medical students. This is the member of the team you might ask "Why are we treating Mrs. Farkle with busulfan?"—if the attending does not ask you first.

*Adapted with permission from "So You Want to Be a Toad," Epstein A, Frye T (eds), Ohio State University, College of Medicine.

The Fellow

Fellows are physicians who have completed their postgraduate education and elected to do extra study in one special field, eg, nephrology, high-risk obstetrics, or surgical oncology. They may or may not be active members of the team and may not be obligated to teach medical students but usually will be happy to do so if asked any questions. This is the person you might ask to help you read Mrs. Farkle's bone marrow smear.

TEAMWORK

The medical student, in addition to being a member of the medical team, must interact with members of the professional team of nurses, dietitians, pharmacists, and all others who provide direct care for the patient. Good working relations with this group of professionals can make your work go smoother; bad relations with them can make your rotation miserable.

Nurses are generally good tempered, but overburdened. They respond very favorably to polite treatment. Leaving a mess in a patient's room after the performance of a floor procedure, standing by idly while a 98-lb licensed practical nurse (LPN) struggles to move a 350-lb patient onto the chair scale, or obviously listening to three ringing telephones while room call lights flash are acts guaranteed not to please. Do not let anyone talk you into being an acting nurse's aide or ward secretary, but try to help when you can.

You will occasionally meet a staff member who is having a bad day, and you will be able to do little about it. Returning hostility is unwarranted at these times, and it is best to avoid confrontations except when necessary for the care of the patient.

When faced with ordering a diet for your first sick patient, you will no doubt be confronted with the inadequacy of your education in nutrition. Fortunately for your patient, there are dietitians available. Never hesitate to call one.

In matters concerning drug interactions, side effects, individualization of dosages, alteration of drug dosages in disease, and equivalence of different brands of the same drug, it never hurts to call the pharmacist. Most medical centers have a pharmacy resident who follows every patient on a floor or service and who will gladly answer any questions you have on medications. The pharmacist or pharmacy resident can very often provide pertinent articles on a requested subject.

YOUR HEALTH AND A WORD ON "AGGRESSIVENESS"

In your months of curing disease both day and night, it becomes easy to ignore your own right to keep yourself healthy. Numerous bad examples are available among the medical and surgical interns who sleep 3 hours a night and get most of their meals from vending machines. Do not let anyone talk you into believing that you are not entitled to decent meals and sleep. If you offer yourself as a sacrifice, it will be a rare rotation on which you will not become one.

You may have the misfortune some day of reading an evaluation that says a student was not "aggressive enough." This is an enigmatic notion to everyone. Does it mean that the student refused to attempt to start an intravenous line after eight previous failures? Does it mean that the student was not consistently the first one to shout out the answer over the mumblings of fellow students on rounds? Whatever constitutes "aggressiveness" must be a dubious virtue at best.

A more appropriate virtue might be assertiveness in obtaining your education. Ask good questions, have the house staff show you floor procedures and review your chartwork, read about your patient's illness, participate actively in your patient's care, and take an interest in other patients on the service. This approach avoids the need for victimizing your patients and comrades that the definition of "aggression" requires.

ROUNDS

Rounds are meetings of all members of the service for discussing the care of the patient. These occur daily and are of three different kinds.

Morning Rounds

Also known as "work rounds," these take place anywhere from 6:30 to 9:00 AM on most services and are attended by residents, interns, and students. This is the time for discussing what happened to the patient during the night, the progress of the patient's evaluation or therapy or both, the laboratory and radiological tests to be ordered for that patient, and, last but not least, talking with the patient. Know about your patient's most recent laboratory reports and progress–this is a chance for you to look good.

Ideally, differences of opinion and any glaring omissions in patient care are politely discussed and resolved here. Writing new orders, filling out consultations, and making any necessary telephone calls are best done right after morning rounds.

Attending Rounds

These vary greatly depending on the service and on the nature of the attending. The same people who gathered for morning rounds will be here, with the addition of the attending. At this meeting the patients are often seen again (especially on the surgical services); significant new laboratory, radiographic, and physical findings are described (most often by the student caring for the patient); and new patients are formally presented to the attending (again, most often by the medical student).

The most important thing for the student on attending rounds is to know the patient. Be prepared to concisely tell the attending what has happened to the patient. Also be ready to give a brief presentation on the patient's illness, especially if it is unusual. The attending will probably not be interested in those details that do not affect therapeutic decisions, eg, the fact that Mrs. Farkle tripped and fell the previous evening but did herself no harm. Additionally, the attending will probably not wish to hear a litany of normal laboratory values, only the pertinent ones, eg, Mrs. Farkle's platelets are still 350,000/mm^3 in spite of her bone marrow disease. You do not have to tell everything you know on rounds, but you must be prepared to do so.

Open disputes among house staff and students are bad form on attending rounds. For this reason, there is an unwritten rule of the road that any differences of opinion that have not been previously discussed shall not be initially discussed in the presence of the attending.

Check-out or Evening Rounds

Usually, formal evening rounds where the patients are seen by the entire team a second time are done only on surgery and pediatrics. Other services, such as medicine, often will have check out with the resident on call for the service that evening. Expect to convene sometime between 3 and 7 PM on most days. All new data are presented by the person who collected them (usually the student). Orders are again written, laboratory work desired for early the next day is requested, and those unfortunates on call compile a "scut list" of work to be done that night and a list of patients who need close supervision.

BEDSIDE ROUNDS

Basically these are the same as any other rounds except that tact is at a premium. The first consideration at the bedside must be for the patients. If no one else on the team says good morning and asks how they are feeling, do it yourself; this is not a presumptuous act on your part. Keep this encounter brief and then explain that you will be talking about the patient for a while. If handled in this fashion, the patient will often feel flattered by the attention and will listen to you with interest.

Certain things in a hallway presentation are omitted in the patient's room. The patient's race and sex are usually apparent to all and do not warrant inclusion in your first sentence. The patient must never be called by the name of the disease, eg, Mrs. Farkle is not "a 45-year-old CML (chronic myelogenous leukemia)" but "a 45-year-old with CML." The patient's general appearance need not be reiterated. Descriptions of

evidence of disease must not be prefaced by words such as "outstanding" or "beautiful." Mrs. Farkle's massive spleen is not beautiful to her, and it should not be to the physician or student either.

At the bedside, keep both feet on the floor. A foot up on a bed or chair conveys impatience and disinterest to the patient and other members of the team.

Although you will probably never be called upon to examine a patient during bedside rounds, it is still worthwhile knowing how to do so considerately. Bedside examinations are often done by the attending at the time of the initial presentation or by one member of a surgical service on postoperative rounds. First, warn the patient that you are about to examine the patient's wound or affected part. Ask the patient to uncover whatever needs to be exposed rather than boldly removing the patient's clothes yourself. If the patient is unable to do so alone, you may do it, but remember to explain what you are doing. Remove only as much clothing as is necessary, and then promptly cover the patient again. In a ward room, remember to pull the curtain.

Bedside rounds in the intensive care unit call for as much consideration as they do in any other room. That still, naked soul on the bed might not be as "gorked out" as the resident (or anyone else) might believe and may be hearing every word you say. Again, exercise discretion in discussing the patient's illness, plan, prognosis, and personal character as it relates to the disease.

READING

Time for reading is at a premium on many services, and for that reason it is important to use it effectively. Unless you can remember everything you learned in the first 15 months of medical school, you will probably want to review the basic facts about the disease that brought your patient into the hospital. These facts are most often found in the same core texts that got you through the preclinical years. Unless specifically directed to do so, avoid the temptation to sit down with the *Index Medicus* and try to find all the latest articles on a disease you have not read about for the last 7 months; you do not have the time.

The appropriate time to head for the *Index Medicus* is when a therapeutic dilemma arises and only the most recent literature will adequately advise the team. You may wish to obtain some direction from the attending, the fellow, or the resident before plunging into the library on your only Friday night off call this month.

THE WRITTEN HISTORY AND PHYSICAL

Much has been written on how to obtain a useful medical history and perform a competent physical examination, and there is not much to add to it. Three things worth emphasizing are your own physical findings, your impression, and your own differential diagnosis.

Trust and record your own physical findings, even if other examiners have written things different from those you found. You just may be right, and, if not, you have learned something from it. Avoid the temptation to copy another examiner's findings as your own when you are unable to do the examination yourself. It would be an unusually cruel resident who would make you give Mrs. Farkle her fourth rectal examination of the day, you may write "rectal per resident." **DO NOT do this routinely just to avoid doing a complete physical examination. Check with the resident first.**

Although not always emphasized in physical diagnosis, your clinical impression is probably the most important part of your write-up. Reasoned interpretation of the medical history and physical examination is what separates physicians from the computers touted by the tabloids as their successors. Judgment is learned only by boldly stating your case, even if you are wrong more often than not.

The differential diagnosis, i.e., your impression, should include only those entities that you consider when evaluating your patient. Even under duress, try to avoid including every possible cause of your patient's ailments. List only those things that you are seriously considering, and include in your plan those things that you intend to do to exclude each one. Save the exhaustive list for the time your attending asks for all the causes of a symptom, syndrome, or abnormal laboratory value.

THE PRESENTATION

The object of the presentation is to briefly and concisely (usually in a few minutes) describe your patient's reason for being in the hospital to all those members of the team who do not know the patient and the story. Unlike the write-up, which contains all the data you obtained, the presentation may include only the pertinent positive and negative evidence of a disease and its course in the patient. It is hard to get a feel for what is pertinent until you have seen and done a few presentations yourself.

Practice is important. Try never to read from your write-up, as this often produces dull and lengthy presentations. Most attendings will allow you to carry note cards, but this method can also lead to trouble unless content is carefully edited.

Presentations are given in the same order as a write-up: identification, chief complaint, history of the present illness, past medical history, family history, social history, review of systems, physical examination, laboratory and x-ray data, clinical impression, and plan. Only pertinent positives and negatives from the review of systems should be given. These and truly pertinent items from other parts of the interview often can be added to the history of the present illness.

Finally, length and content of the presentation vary greatly according to the wishes of the attending and resident, but you will learn quickly what they do and do not want.

RESPONSIBILITY

Your responsibilities as a student should be clearly defined on the first day of a rotation by either the attending or the resident. Ideally, this enumeration of your duties should also include a list of what you might expect concerning teaching, floor skills, presentations, and all the other things for which you are paying several thousand dollars a year.

On some services, you may feel like a glorified unit secretary (clinical rotations are called "clerkships" for good reason!), and you will not be far wrong. This is NOT what you are going into hock for. The scut should be divided among the house staff.

You will frequently be expected to call for a certain piece of laboratory data or to go review an x-ray with the radiologist. You may then mutter under your breath "Why waste my time? The report will be on the chart in a day or two!" You will feel less annoyed in this situation if you consider that every piece of data ordered is vital to the care of your patient.

The student's responsibility may be summarized in three words: know your patient. The whole service relies to a great extent on a well-informed presentation by the student. The better informed you are the more time there is for education, and the better your evaluation will be. A major part of becoming a physician is learning responsibility.

ORDERS

Orders are the physician's instructions to the nursing staff on the care of the patient. These may include the frequency of vital signs, medications, respiratory care, laboratory and x-ray studies, and nearly anything that you can imagine.

There are many formats for writing concise admission, transfer, and postoperative orders. Some rotations may have a precisely fixed set of routine orders, but others will leave you and the intern to your own devices. It is important in each case to avoid omitting instructions critical to the care of the patient. Although you will be confronted with a variety of lists and mnemonics, ultimately it is helpful to devise your own system and commit it to memory. Why memorize? Because when you are an intern and it is 3:30 AM, you may overlook something if you try to think it out.

One system for writing admission or transfer orders uses the mnemonic "A.D.C. Van Dissel." This is discussed in Chapter 3.

The word *stat* is the abbreviation for the Latin word *statim*, which means "immediately." When added to any order, it puts the requested study in front of all the routine work waiting to be done by the laboratory. Ideally, this order is reserved for the truly urgent situation, but in practice it is often inappropriately used. Most of the blame for this situation rests with physicians who either fail to plan ahead or who order stat results when routine studies would do.