Surgery is a participatory, team, and contact sport. Present yourself to patients, residents, and attendings with enthusiasm (which covers a multitude of sins), punctuality (type A people do not like to wait), and cleanliness (you must look, act, and smell like a doctor).

1. **Why should you introduce yourself to each patient and ask about his or her chief complaint?**

   Symptoms are perception, and perception is more important than reality. To a patient, the chief complaint is not simply a matter of life and death; it is much more important. Patients routinely are placed in compromising, uncomfortable, embarrassing, and undignified predicaments. Patients are people, however, and they have interests, concerns, anxieties, and a story. As a student, you have an opportunity to place your patient's chief complaint into the context of the rest of his or her life. This skill is important, and the patient will always be grateful. You can serve a real purpose as a listener and translator for the patient and his or her family.

   Patients want to trust and love you. This trust in surgical therapy is a formidable tool. The more a patient understands about his or her disease, the more the patient can participate in getting better. Recovery is faster if the patient helps.

   Similarly, the more the patient understands about his or her therapy (including its side effects and potential complications), the more effective the therapy is (this principle is not in the textbooks). You can be your patient's interpreter. This is the fun of surgery (and medicine).

2. **What is the correct answer to almost all questions?**

   *Thank you.* Gratitude is an invaluable tool on the wards.

3. **Are there any simple rules from the trenches?**

   a. **Getting along with the nurses.** The nurses do know more than the rest of us about the codes, routines, and rituals of making the wards run smoothly. They may not know as much about pheochromocytomas and intermediate filaments, but about the stuff that matters, they know a lot. Acknowledge that, and they will take you under their wings and teach you a ton!

   b. **Helping out.** If your residents look busy, they probably are. So, if you ask how you can help and they are too busy even to answer, asking again probably would not yield much. Always leap at the opportunity to grab x-rays, track down lab results, and retrieve a bag of blood from the bank. The team will recognize your enthusiasm and reward your contributions.

   c. **Getting scutted.** We all would like a secretary, but one is not going to be provided on this rotation. Your residents do a lot of their own scut work without you even knowing about it. So if you feel like scut work is beneath you, perhaps you should think about another profession.

   d. **Working hard.** This rotation is an apprenticeship. If you work hard, you will get a realistic idea of what it means to be a resident (and even a practicing doctor) in this specialty. (This has big advantages when you are selecting a type of internship.)

   e. **Staying in the loop.** In the beginning, you may feel like you are not a real part of the team. If you are persistent and reliable, however, soon your residents will trust you with more important jobs.

   f. **Educating yourself, and then educating your patients.** Here is one of the rewarding places (as indicated in question 1) where you can soar to the top of the team. Talk to your patients about everything (including their disease and therapy), and they will love you for it.
4. **Maintaining a positive attitude.** As a medical student, you may feel that you are not a crucial part of the team. Even if you are incredibly smart, you are unlikely to be making the crucial management decisions. So what does that leave? Attitude. If you are enthusiastic and interested, your residents will enjoy having you around, and they will work to keep you involved and satisfied. A dazzlingly intelligent but morose complainer is better suited for a rotation in the morgue. Remember, your resident is likely following 15 sick patients, gets paid less than $2 an hour, and hasn’t slept more than 5 hours in the last 3 days. Simple things such as smiling and saying thank you (when someone teaches you) go an incredibly long way and are rewarded on all clinical rotations with experience and good grades.

h. **Having fun!** This is the most exciting, gratifying, rewarding, and fun profession and is light years better than whatever is second best (this is not just our opinion).

4. **What is the best approach to surgical notes?**
   Surgical notes should be succinct. Most surgeons still move their lips when they read. See Table 1.1.

**HOSPITAL DISCHARGE**

5. **What is a care transition?**
   It is a fancy word for any change in a clinical care setting. Examples include from hospital to home, from home to emergency department (ED), and from nursing home to home.

6. **What is one of the most dangerous things that you can do to your patient?**
   Discharge them from the hospital.

7. **Why is a hospital discharge a dangerous procedure?**
   Hospitals are designed for maximal support. Procedures are managed; diet is controlled; and even the increasingly obligate polypharmacy is orchestrated such that each pill is swallowed with metronomic precision. Then, much like a baby eaglet, the patient is unceremoniously “pushed out” of this federally regulated inpatient nest. And again, like the baby eaglet, we expect that patient to take flight at home.

8. **What would improve safety at discharge?**
   Follow through on the “last sign out.” Sign out to your patient, their family members, and the next doctor who is going to take care of them in the nursing home or clinic.

9. **What are the most important elements of the final sign out (discharge summary)?**
   Discharge summaries should include:
   - Primary and other diagnoses
   - Pertinent medical history and physical findings
   - Dates that they were hospitalized and brief hospital course (assume that the doctor on the outside knows how to treat hyperkalemia)
   - Results of procedures
   - Abnormal lab tests
   - Recommendations of the specialists that you consulted
   - Information that you gave to the patient and family
   - Discharge medications
   - Details of follow-up arrangements
   - To-do list of appointments, pending tests, or procedures to be scheduled or checked
   - Name and contact information of the inpatient doctor
   The idea that a hospital discharge is a risky business, but the risk can be reduced by a conscientious physician or medical student, comes from Kripalani et al.

**Table 1.1 Best Approach to Surgical Notes**

<table>
<thead>
<tr>
<th>Admission Orders</th>
</tr>
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<tbody>
<tr>
<td><strong>Admit to 5 West (attending’s name)</strong></td>
</tr>
<tr>
<td><strong>Condition:</strong></td>
</tr>
<tr>
<td><strong>Diagnosis:</strong></td>
</tr>
<tr>
<td><strong>Vital signs:</strong></td>
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<tr>
<td><strong>Parameters:</strong></td>
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<td></td>
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</tbody>
</table>
Diet: NPO
Fluids: 1000 LR w 20 mEq KCl @ 100 mL/h
Medication(s): ASA 650 mg PR PRN for T >38.5°C

Thank you.

Sign your name/leave space for resident’s signature (your beeper number)

History and Physical Examination (H&P)

Mrs. O’Flaherty is a 55 y/o w[white woman] admitted with a cc [chief complaint]: “My stomach hurts.” Pt [patient] was in usual state of excellent health until 2 days PTA [prior to admission] when she noted gradual onset of crampy midepi gastric pain. Pain is now severe (7/10; 7 on a scale of 10) and recurring q 5 minutes. Pt described + vomiting (+ bile, – blood) [with bile, without blood].

PMH [past medical history]

Hosp[italizations]:
- Pneumonia (2001)
- Childbirth (1982, 1984)

Surg[ery]:
- Splenectomy for trauma (1987)

Allergies:
- Codeine, shellfish

Social:
- ETOH [alcohol]
- 1 ppd [pack per day] x 25 years

ROS [review of systems]

Resp[iratory]:
- Productive cough
- ò chest pain
- ò MI [myocardial infarction]
  [ò = not observed, noncontributory, or not here]
- ò dysuria, ò frequency

Cardiac:
- RSR [regular sinus rhythm]

Renal:
- ò dysuria, ò frequency

Neuro[logic]:
- WNL [within normal limits]

Physical Examination (PE)

BP: 140/90
HR: 100 (regular)
RR [respiratory rate]: 16 breaths/min
Temp: 38.2°C

WD [well developed], WN [well nourished], mildly obese, 55 y/o female; in moderate abdominal distress

HEENT [head, eyes, ears, nose, and throat]: WNL

Resp: Clear lungs bilaterally
- ò wheeze, rales

Heart: RSR [regular sinus rhythm]
- ò m [murmur]

Abdomen: Mildly distended
- High-pitched rushes that coincide with crampy pain
- Tender to palpation (you do not need to hurt the patient to find this out)
- ò rebound

Rectal: (Always do; never defer the rectal exam on your surgical rotation)
- Hematest stool—negative for blood
- No masses, no tenderness

Pelvic:
- No masses
- No adnexal tenderness
- No cervical motion tenderness or chandelier sign; if quick motion of cervix makes your patient hit the chandelier — nonspecific peritoneal sign, possibly pelvic inflammatory disease (PID; gonorrhea)

Extremities:
- Full ROM [range of motion]
- ò edema
- Bounding (3+) pulses

Table 1.1 Best Approach to Surgical Notes (Continued)

Continued on following page
Table 1.1 Best Approach to Surgical Notes (Continued)

Imp[ression]:
Abdominal pain
r/o SB [small bowel] obstruction 2° [secondary] to adhesions

Rx:
NG [nasogastric] tube
IV fluids
Op[erative] consent
Type and hold (Blood Bank)

[Signature]

Notes on the surgical H&P
- A surgical H&P should be succinct and focused on the patient’s problem.
- Begin with the chief complaint (in the patient’s words).
- Is the problem new or chronic?
- PMH: always include prior hospitalizations and medications.
- ROS: restrict review to organ systems (lung, heart, kidneys, and nervous system) that may affect this admission.
- PE: always begin with vital signs (including respiration and temperature); that is why these signs are vital.
- Rebound means inflammatory peritoneal irritation or peritonitis.

Preop[erative] note
The preoperative note is a checklist confirming that you and the patient are ready for the planned surgical procedure. Place this note in the Progress Notes:

Preop dx [diagnosis]: SB obstruction 2° to adhesions
CXR [chest x-ray]: Clear
ECG [electrocardiogram]: NSR ø ST-T wave changes
Blood: Type and cross-match x 2 u
Consent: In chart

Operative note
The operative note should provide anyone who encounters the patient after surgery with all the needed information:

Preop dx: SB obstruction
Postop dx: Same, all bowel viable
Procedure: Exp[loratory] Lap[arotomy] with lysis of adhesions
Surgeon: Name him or her
Assistants: List them
Anesthesia: GEA [general endotracheal anesthesia]
I&O [intake and output]: In: 1200 mL Ringer’s lactate (R/L)
Out: 400 mL urine
EBL [estimated blood loss]: 50 mL
Specimen: None
Drains: None
[Sign your name]

ASA, Aspirin; BP, systolic blood pressure; BRP, bathroom privileges; h, hour; HO, house officer; HR, heart rate; NPO, nothing by mouth (this includes water and pills); OOB, out of bed; PR, per rectum; PRN, as needed; q, every; r/o, rule out; T, temperature.

Note: You cannot be too polite or too grateful to patients or nurses.

BIBLIOGRAPHY