University of California, Irvine
School of Medicine

Inpatient Medicine Clerkship
Academic Year 2010-2011

Student Handbook

Alpesh Amin, M.D.
Director, Inpatient Medicine Clerkship
University of California, Irvine
101 The City Drive South
Route 1, Building 58, Room 110
Orange, CA 92868
(714) 456-3785
anamin@uci.edu

Desiree Avery
Clerkship Program Representative
(714) 456-5176

University of California, Irvine
Inpatient Medicine Clerkship
Department of Medicine

Contents of Inpatient Packet

Students – Please review the attached materials:

1. **Student Handbook**
   - Orientation Instructions & Requirements
   - CDIM-Internal Medicine Texts for Clerkship Students
   - Documentation Requirements
   - Preparing & Presenting a Case
   - Policies & Procedures
   - Readings:
     - "Medicine"
     - "Comprehensive History: Adult Patient"
   - Inpatient Medicine Logs
   - Junior Medicine Clerkship Curriculum
   - Addt'l Policies & Procedures
   - Patient Confidentiality
   - Physician Handwriting Legibility

2. **Grading Handbook & Oral Exam Protocol**
   - Policies & Procedures
   - Sample Evaluation Forms
   - Inpatient Medicine Grading
   - Oral Examination Protocol, Questions & Sample Evaluation Form
   - CEX

3. **Schedule Handbook**
   - Student Schedules
   - Student Pictures
   - Student Conference Schedule
   - Daily Schedule UCIMC
   - Daily Schedule LBVA
   - Map of UCIMC
   - Map of LBVA

4. **Clinical Vignettes Handbook**

5. **Sample Shelf Questions**

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Orientation:
(ALL STUDENTS)

7:00 am – With Dr. Amin at UCIMC, above Library
7:45 am – With Chief Residents at UCIMC, above Library
8:00 am – UCI students report to Wards

9:00 am – LBVA students report to LBVA
9:00 am – VA Chief Resident Orientation at LBVA, room G2
10:30 am – VA students report to Wards

Textbook Options

1. Medicine; Fishman
2. Cecil Essentials of Medicine -- by Thomas E. Andreoli (Editor), et al; Paperback
3. Cecils Textbook of Medicine
4. Harrison's Principles of Internal Medicine; Fauci et al
5. Kochar's Concise Textbook of Medicine; Kelly et al
6. Essentials of Internal Medicine; Kelly

Lectures: **UCIMC:** See attached daily schedule
LBVAMC: Provided at orientation

Ward assignments: See attached rotation schedule

Clinical Exam Exercises (mini CEX): **Two each** during wards at UCI and LBVA

Oral Exam: 7th - 8th week of clerkship

FINAL EXAM: FINAL FRIDAY 9:00 AM-11:30 AM, LOCATION TBA

- **First Rotation**:
  Students rotating first to the **LBVAMC** will receive an additional orientation to the service there at 9:00 am in Conference Room G2.

- **Second Rotation:**

  UCIMC: Students scheduled to report to **UCIMC** to meet with the Chief Resident(s) at 8:00 am.
  LBVAMC: Students scheduled to report to the **LBVA** are to report to the VA at 8:00am in Conference Room G-2. There is a map in your orientation packet.

Member Services Committee
Review of "Abbreviated" Internal Medicine Texts for Clerkship Students
Reviewers: Eric Alper, Anne Colbourne, Chip Legerton, Tayloe Loftus, Phil Masters, Doug Paauw, Julius Sagel
Citation: **Medicine-editors Fishman, Hoffman, Klausner, Thaler**

Reviewers: Two

Title/ Edition	Publisher	Estimated Cost	Pages/ Chapters	Format	Strengths	Weaknesses
Medicine 4th Edition 1996	Lippincott-Raven	$36.00 (used copies available through amazon.com for $22.00)	approx 70 chapters, 11 sections, 620 pages	Divided into subspecialty sections, most disease-based but a few symptom-based chapters	1. Text is very readable 2. Short enough to be read during a clerkship 3. Presents a good brief overview prior to further reading from other, more complete, sources	1. Published in 1996- some areas out of date 2. Disease oriented without consideration of broad topics such as fever, weight loss, chest pain or other symptoms 3. Far too brief a description of major illnesses for junior students – eg, the chapter on coronary artery disease only briefly describes the myriad symptoms that comprise angina pectoris, provides a very limited and general overview of the differential diagnosis, and fails to define contraindications for exercise stress tests 4. Very limited on patho-physiology 5. Very little evidence-based medicine presented 6. Limited number of references 7. Many chapters do not discuss adverse effects of the therapies presented.

Comments: A very general and readable text. However, the student would clearly need to read more in-depth resources on major diseases and presenting symptoms.

Member Services Committee
Review of "Abbreviated" Internal Medicine Texts for Clerkship Students
Reviewers: Eric Alper, Anne Colbourne, Chip Legerton, Tayloe Loftus, Phil Masters, Doug Paauw, Julius Sagel
Citation: **Cecil Essentials of Medicine-editors Carpenter, Griggs, Loscalzo**

Reviewers: Three

Title/ Edition	Publisher	Estimated Cost	Pages/ Chapters	Format	Strengths	Weaknesses
Cecil Essentials of Medicine-editors Carpenter, Griggs, Loscalzo	W.B. Saunders	$49.00	133 chapters, 1000 pages	Sixteen sections organized primarily by disease/organ system; chapters further divided by pathophysiology, specific disease states, and treatment principles.	1. The writing is clear and easy to understand with good explanations. 2. Contains appropriate, clinically-based reviews of physiology and pathophysiology useful at the third year clerkship level. These discussions seem to promote understanding and retention of the clinical principles which follow (and in this way this book is superior to some of the other more "list-like" abbreviated texts) 3. Well-referenced and includes a useful table of commonly-used laboratory values 4. Although a bit expensive ($35-45), a companion study guide is available that directly references the full-sized Cecil Textbook of Medicine 5. Contains interesting sections on genetics, aging/geriatrics and substance abuse, and one on evidence-based medicine	1. At approximately 1000 pages, tends to be a bit long and approaches a "full textbook" length book. It is dense reading, hard to get through "digestible" sections for nightly reading. It would be difficult for a student to read on an 8-12 week clerkship. 2. Contains very little information concerning ambulatory or primary care medicine, or discussion of general approach to undifferentiated symptoms like fever, weight loss, chest pain, fatigue, etc. 3. Does not include review/application questions

Comments: An extremely useful resource for students at the third year clerkship level. Although perhaps difficult to read 'cover-to-cover' during a traditional 8-12 week clerkship because of length, it provides a good interface between an abbreviated and full textbook of medicine with adequate depth to cover the expectations of national curricular standards.

Member Services Committee
Review of "Abbreviated" Internal Medicine Texts for Clerkship Students
Reviewers: Eric Alper, Anne Colbourne, Chip Legerton, Tayloe Loftus, Phil Masters, Doug Paauw, Julius Sagel
Citation: **Harrison's Principles of Internal Medicine Companion Handbook**

Reviewers: One

Title/ Edition	Publisher	Estimated Cost	Pages/ Chapters	Format	Strengths	Weaknesses
Harrison's Principles of Internal Medicine Companion Handbook, 14th Edition 1998	McGraw - Hill	$35.00	1237 pgs. 16 sections	Introductory sections on "important signs and symptoms" and "medical emergencies"; otherwise organized by discipline (i.e. GI, endocrinology, etc.)	1. Similar in breadth to the full length textbook – extremely comprehensive for an abbreviated text that provides more than adequate coverage of significant topics in medicine 2. Useful format that concisely reviews etiology, risk factors, pathology, pathophysiology, clinical features, diagnosis and treatment of most major disorders 8. Helpful sections on psychiatric disorders, adverse drug reactions and laboratory values 9. Includes references to other more detailed information sources for most topics 10. Good index and effective use of tables and 'flow charts'	1. Text is small and bulky in size, making it inconvenient to carry on rounds 2. Does not include review questions, although a separate review text is (around $45)

Comments: A "hybrid" between an abbreviated textbook and pocket book; unfortunately, size, length and depth make it less useful as a pocket referral resource, and small size makes it inconvenient for use as a text for programmed reading in a clerkship context. However, it provides the necessary information appropriate for use in a basic medicine clerkship.
NOTE: This book will apparently not be published again in the future (due to change in format).

Member Services Committee
Review of "Abbreviated" Internal Medicine Texts for Clerkship Students
Reviewers: Eric Alper, Anne Colbourne, Chip Legerton, Tayloe Loftus, Phil Masters, Doug Paauw, Julius Sagel
Citation: Kochar's Concise Textbook of Medicine

Reviewers: Two

Title/ Edition	Publisher	Estimated Cost	Pages/ Chapters	Format	Strengths	Weaknesses
Kochar's Concise Textbook of Medicine, 3rd Edition	Williams and Wilkins	$35.00	1039 pgs. 15 sections 261 chapters	1. Introductory section on the "Art and Science of Medicine" 2. Subsequent sections organized primarily by organ system 3. Nice method of emphasis on important points with outline and "bold" formats.	1. Text is very readable and chapter/section length good for a rapid review of major subject/problem areas 2. Includes a nice blend of underlying physiology/patho physiology with disease presentation and practical management 3. Includes topics appropriate to ambulatory medicine (i.e. prevention and screening) as well as inpatient medicine 4. Each section has 10-20 review questions and suggested readings 5. Appendix includes 33 color plates of skin disorders and blood smears 6. Reasonably up to date	1. Review question answers are not explained

Comments: Truly a 'concise' textbook that provides a broad-based exposure to the content and approach of internal medicine practice. Very useful/appropriate as a primary study text in the context of an 8-12 week medicine clerkship. Seems superior to Stobo given year of publication and enhanced readability.

Member Services Committee
Review of "Abbreviated" Internal Medicine Texts for Clerkship Students
Reviewers: Eric Alper, Anne Colbourne, Chip Legerton, Tayloe Loftus, Phil Masters, Doug Paauw, Julius Sagel
Citation: **The Principles and Practice of Medicine-editors Stobo, Hellman, Ladenson, Petty, Traill**

Reviewers: Two

Title/ Edition	Publisher	Estimated Cost	Pages/ Chapters	Format	Strengths	Weaknesses
The Principles and Practice of Medicine, 23rd Edition 1996	McGraw-Hill (published initially by Appleton & Lange)	$49.95	1064 pgs. 15 sections, each section with 2 to 15 subsections	Sections organized by organ system and disease (i.e. cardiovascular disease, rheumatology, etc.); includes sections on neurology and psychiatry, and a section on "special topics" that includes areas such as preventive medicine and perioperative medical management of surgical patients	1. Text is very readable and chapter/section length good for review of major subject/problem areas 2. Very strong in reviewing physiology and pathophysiology of major disorders; management tends to be discussed in more general terms 3. Good use of tables, flow diagrams and illustrations 4. Each subsection has a brief summary highlighting key points of that subsection 5. Includes 8 pages of color plates of skin disorders, physical exam findings and blood smears	1. Does not contain any review questions 2. References for further reading, while still appropriate, are becoming somewhat outdated 3. Text is also somewhat outdated on topics with newer developments (e.g., H pylori, low molecular weight heparins) 4. Text tends to focus on disease processes and does not tend to address specific aspects of inpatient vs. ambulatory medicine 5. Wordy

Comments: An updated version of William Osler's original text published in 1892 by the faculty of John Hopkins. An excellent basic text quite useful as a primary resource for a basic medicine clerkship. Despite being a relatively older work (1996) and in need of an update, it still is appropriate given its strong coverage of basic medical principles at a junior student level. Probably the strongest on pathophysiology of those we reviewed.

Member Services Committee
Review of "Abbreviated" Internal Medicine Texts for Clerkship Students
Reviewers: Eric Alper, Anne Colbourne, Chip Legerton, Tayloe Loftus, Phil Masters, Doug Paauw, Julius Sagel
Citation: NMS Medicine- Allen R. Myers

Reviewers: Two

Title/ Edition	Publisher	Estimated Cost	Pages/ Chapters	Format	Strengths	Weaknesses
NMS Medicine 4th edition © 2001	Lippincott Williams and Wilkins	$35.00	Approx 700 pgs. 11 Sections, 143 chapters	Organized by system Text in outline format Each chapter followed by 2-4 pages Q&A End of book has ~60 pages Case studies/ Comprehensive board style exam	1. Text is very readable, important points in bold 2. Outline format makes it easy to find information, skim rapidly 3. Nice diagrams/tables, although relatively few 4. Broad, generally good overviews 5. Question and Answer at end of each chapter, clinical problem solving cases and comprehensive exam at end of book may help prepare students for end of clerkship examination and may facilitate learning. Answers of great educational value. 6. Very up to date in some areas (i.e. newest treatments for Rheumatoid arthritis)	1. Outline format and dense text may make a little more difficult to read 2. Information substantially abridged in some areas; in other areas more detail than might be expected in overview textbook 3. Organization sometimes problematic 4. Not sure if always the "best" information (see below) 5. No dedicated section on Ambulatory Medicine 6. System-based. No chapters covering general approach to patients presenting with weight loss, edema, etc 7. More emphasis needed on differential diagnoses 8. No references at end of chapters 9. More graphics would be of value

Comments: Overall, a good overview textbook of medicine. Probably best used as a board review, as intended. As above, don't know if this text always has the "best" information. In a brief review, in the section on DVT, under causes of hypercoaguability, lists estrogen, malignancy and hyperviscosity, but does not mention the inherited/acquired causes of hypercoaguability, e.g. Factor V Leyden etc. Also lists CHF as a common cause of DVT. Questions nicely tied to reading but most are fact-based questions, fewer clinical scenarios. Clinical problem solving cases at end of book allow reader to understand thought process of approach to problems. Overall, recommend as a useful text for end of clerkship examination studying/self-evaluation. Would not recommend as the only text for the clerkship experience, although some may find it valuable for this.

Member Services Committee
Review of "Abbreviated" Internal Medicine Texts for Clerkship Students
Reviewers: Eric Alper, Anne Colbourne, Chip Legerton, Tayloe Loftus, Phil Masters, Doug Paauw, Julius Sagel
Citation: Guide to Internal Medicine-editors Paauw, Burkholder, Migeon

Reviewers: Three

Title/ Edition	Publisher	Estimated Cost	Pages/ Chapters	Format	Strengths	Weaknesses
Guide to Internal Medicine 1999	Mosby	$ 29.00	232 pgs. 3 sections 36 chapters	Introductory section on the "Introduction to the Medicine Clerkship" Second Section on pts presenting with a symptom, sign or abnormal lab value, then third section on pts presenting with known condition, illustrative case-based questions at end of each chapter, 54-item exam at end of book	1. Text is very readable, no word wasted. Question and answer format reflects common educational style on rounds. 2. Based on SGIM/CDIM curriculum guide. 3. Gives clerkship level review of common conditions in an etiology, evaluation, and treatment format. 4. Important points summarized at end of each chapter, and cases give practice opportunities. 5. The "Introduction to the Clerkship" section includes "practical skills for medical students." 6. Practice exam at end 7. Special sections on The Healthy Patient, Substance Abuse, Women's Health, Ethics 8. Very clinically oriented 9. The text is brief so as to be easily read during the clerkship	1. Patho-physiology is not covered. 2. Topics covered fairly briefly, not in a lot of depth. 3. At least one case at the end of sections does not "match up" to the case described in the answer (11-1). 4. No literature citations. 5. Would be nice if it were pocket-sized as it would be good to have immediately available in clinical settings.

Comments: This is a VERY useful reference for students. It is a unique resource that encompasses an orientation to the clerkship, a question and answer format and case studies that seek to build clinical judgement. It cannot however be used as sole reference text for clerkship—it is probably best used as a "student-level-Washington-manual" type text.

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Student Physicians:

Welcome to the Junior Medicine Clerkship.

The materials accompanying this memo outline our objectives, expectations, and grading criteria for the course. Please take a moment to review them. I would like to emphasize some important points. You are a member of your ward team. As such, you are expected to assume responsibility for the care of your patients and for the efficient functioning of your team. In large measure, your learning experience will be dependent upon your enthusiasm and availability.

You are expected to work up at least one patient per long and short call day and to submit written reports to your residents. The most important section of these reports will be the assessment and plan. These should demonstrate a knowledge of the pathophysiological and psychosocial as well as the clinical aspects of your patients' problems. You are not required to serve as the primary clinician for each of the patients you evaluate if you and your resident feel that your patient load is too heavy. However, you will be expected to carry a minimum of 2 patients at any given time.

Please review "Preparing and Presenting a Case". It provides crucial guidelines. Additionally, you have received a conference schedule along with this packet. Conference attendance is required. Please pay special attention to the Case-Study Vignettes. Review these topics in advance. ***The quality of this educational experience is entirely dependent upon your preparation.***

Ask for feedback early and often. Take advantage of teaching situations and make sure your residents understand what you want out of the rotation. In addition, speak early on to your attendings and residents to understand what they expect of you. It's important to clarify expectations and to review them as you go along if there are questions. Your residents and attendings are supposed to provide you with an evaluation every 2 weeks or so.

A summary of the grading policy is attached.

Enjoy the clerkship. Feel free to contact me at any time and please let me know as soon as problems arise so that we may deal with them early.

Alpesh Amin, M.D.
Director, Junior Medicine Clerkship

Preparing and Presenting a Case

The case presentation is the distilled essence of the clinical process. Throughout your careers, it will be the way you most commonly communicate with residents, faculty, and colleagues. In preparing the presentation, you are refining your own data base and thought processes. The more you do so, the more you must know and think about the patient, the more you will learn, and the better off your patient will be. The analogy between a "case" in medicine and a "case" in law is a clear one. In both, you are marshaling your resources and making your "case".

The opening statement (Chief Complaint) must clearly state the direction you are taking.

No presentation should be longer than 7 minutes. Most attendings know you can ask every question in the ROS. It is most crucial to show that you recognize which specific findings are important to your patient's case and care.

The H&P should be about 4 minutes and the assessment and plan should be about 3 minutes. If longer than this, you haven't thought enough about what is truly important to your case or you are being redundant. Keep cutting back until you can present even the most complicated case in 7 minutes.

The HPI should be a chronology of events, beginning at the beginning and ending at the end. Any "history" has a beginning and an end. Any relevant information obtained in other parts of the process such as the family history or the review of systems should be given in the HPI if appropriate and relevant.

The physical exam represents your findings. It should be logical, concise, and pertinent.

The assessment should show that you have carefully thought through the differential, prioritized the most likely diagnoses, and read about your patient. Create a list of possible diagnoses for each problem and explain why at each turn. Keep asking yourself what is going on. Try to explain everything. Do not just accept the ER's or the clinic's diagnosis. Think for yourself. Just as importantly, show your thought processes.

The plan should reflect the differential diagnosis developed in the assessment. What else do we need to do to diagnose the most likely or the most important diagnostic possibilities? What should we do to treat them? Why did we pick a specific test or antibiotic?

Practice your presentation just as you would any other formal presentation. Ask others for constructive feedback.

Not every attending or resident wants to hear the same kind of presentation. Ask them directly how they want the case presented. Ask for immediate feedback so that you can make corrections for the next presentation.

The best presentations reflect the best preparation and the highest commitment to intellectual process. Excess length is not a substitute for conciseness and coherence. You will learn the most from each patient if you commit yourself to the highest quality presentations.

UCI School of Medicine
Medical Student Medical History Format

Identifying Data

Age, gender, marital status, occupation
Source of the history
Source of the referral

Reliability

Identify factors that may affect the reliability or completeness of the data.

Chief Complaint

The type and duration of symptoms or concerns that have occasioned the patient to seek care or to interact with the health system

Present Illness

A chronological narrative of the course of events, obtained using the **5E's of Communication**, including

- Engage
  - Appropriate open-ended questions and listening.
  - What were you hoping to talk about or get out of our visit today?
  - What are your beliefs about the causes of your symptoms or conditions?
- Empathize
- Educate
- Extend
- Enlist

Start with	Open-ended Questions (General)	What were you concerned about today?
	Open-ended Questions (Topical)	Tell me more about your headaches?
	Use Facilitators	Body language, reflection, repetition, summarizing
Proceed to	"W-H" Questions	Where, What, When, Why, Who, How?
	Laundry lists or menus	ROS
	Closed-ended Questions or Yes-No Questions	Did it hurt in your left ankle as well?
Avoid	Complex or Leading Questions	Did if feel like a knife or a hammer? How many times did it occur and under what circumstances did it get better?

Coulehan & Block; The Medial Interview, 4th Edition

Past History

Childhood illnesses:
Adult illnesses: medical, surgical, psychiatric, (obstetric)
Prescription medications or over the counter therapies including vitamins
Alternative approaches to treatment, prevention or health maintenance

Health maintenance & prevention

Child: Development, Safety, Nutrition, Immunization
Adult: Male: Testicular exam, prostate, cholesterol, safety, skin check, colon cancer, immunization
Female: Breast, pelvic, Pap smear, cholesterol, colon cancer, skin check, immunization

Family History

Cardiovascular: Stroke or heart attack before age 55, Hypertension
Cancer: Breast, colon, ovarian, or other
Psychiatric: Depression, alcoholism, suicide, psychosis

Social & Personal History

Personal, Social, & Occupational History

- Do you work outside the home?
- What kind of work do you do or how do you support yourself?
- Tell me what that job is like for you?
- What jobs have you held in the past?
- Have you ever had any exposure to fumes, chemicals, dust, loud noise, or radiation?
- Do you think anything at work is affecting you, including stress?

- Do you work around animals?
- Military service? Where, when, exposures?

Nutrition & Exercise

- Are you happy with your weight?
- What has been happening with your weight?
- Tell me about the most common kinds of food that you eat.
- Are there any kinds of food that you do not get enough of?
- What do you eat during a typical day?
- Do you snack between meals or eat after dinner?
- Do you have any trouble taking medications because they must be taken with food?
- Do any foods make you feel bad?
- Tell me about your use of salt, fiber, dairy products, fatty foods, caffeine
- Do you exercise?
    - Tell me about the exercise you get and how much you do.
    - How do you feel when you exercise?

Support, Spirituality & Insurance

- How is your current state of health affecting your life?
- Do you have any personal beliefs that would affect the way I help you with your health care?
- If you are sick or become sick, how much do you want me to tell you? To tell your family?
- Do you have health insurance? If so, what kind?
- Do you have any concerns about your ability to pay for your health care? If so, would you like to meet with someone to discuss your options?
- FICA(S)
    - Faith: Do you consider yourself a spiritual or religious person?
    - Influence: Are these beliefs important in your daily life or with this illness?
    - Community: Are you part of a religious community?
    - Address: How would you like me address these issues in your health care?
    - Support: Who are the people from whom you get the most support?

Cultural Beliefs and Context (These questions are often best interwoven into the rest of the interview and not as stand alone questions.)

- People who are sick may frequently use other types of therapy to help manage their problem. Have you visited with any other doctors or alternative healers for this condition?
- Have you used any alternative, home, family or traditional approaches to this condition?
- For what other medical conditions do you use alternative therapies?
- How did you find these therapies?
- What do you feel will be the most important things that will help you get better?
- What do your family or friends think is going on? Do you agree with them?
- Have I used any words or suggested anything that makes you concerned or afraid?

Alcohol & Drugs

- How much alcohol do you typically drink? If you do drink,
    - Have you ever felt the need to cut down?
    - Have people annoyed you by criticizing your drinking?
    - Have you ever felt bad or guilty about your drinking?
    - Do you ever have a drink first thing in the morning
- Have you ever had the shakes, DTs or seizures or been in the hospital or rehab for alcohol or drugs?

- Do you every use any street drugs or illegal drugs?
  - If yes, please tell me more about that.
  - Do you ever use alcohol and drugs or medications at the same time?
- Do you take any medications that were not prescribed for you?

Tobacco

- Do you smoke cigarettes or use any kind of tobacco?
- If you smoke cigarettes?
  - How many cigarettes do you smoke in a day, and how long have you been smoking?
  - Have you every tried to quit? If so, how did you try to do it and what was the result?
  - Do you want information or help with quitting?
- If you use other tobacco products
  - Tell be about what you use and how much?
  - Are you aware of the health risks?
  - Would you like help to quit?

The Domestic Situation

- Whom do you live with?
- HITS
  - Has anyone ever hurt you?
  - Has anyone every intimidated your?
  - Has anyone every threatened you?
  - Has anyone ever screamed at you?
- Where would you turn if you were in danger?

Sexual History

- Are you currently sexually active?
- Do you have questions about your sexual health?
- Do you have health problems that interfere with your sexual activities?
- At what age did you first become sexually active?
- Do you have sex with men, women or both?
- Do you use condoms when you have vaginal, oral or anal sex?
- Tell me about what you use to prevent pregnancy?
- Has anyone ever forced you to engage in sex against your will or to do things that you were uncomfortable with?

Provisions for Surrogate Decision-making

- Who will make decisions for you if you cannot make them for yourself?
- Do you have a written note that tells who will make decisions for you?

Review of Systems (May be performed during the physical exam. Take care to avoid jargon with the patient.)

General:	Weight, weakness, fatigue, fever, loss of energy
Psychiatric:	How has your mood been? Have you had feelings of sadness, anxiety, irritability that affect your function?
Skin:	Rash, lumps, sores, itching, dryness, color change, change in hair or nails
HEENT:	Headache, dizziness, vision change, glasses, pain redness, tearing, dryness, double vision, flashing lights,ringing in ears, spinning feeling, ear pain or discharge, stuffiness, nose bleeds, mouth pain, mouth lesions, hair loss tooth pain or loss
Neck:	Lumps, glands, stiffness
Breasts:	Lumps, pain, discharge, self-exam practices
Respiratory:	Cough, sputum, shortness of breath, coughing blood, wheezing, chest pain
Cardiovascular:	Chest pain, palpitations, shortness of breath, shortness of breath lying down, swelling
Gastrointestinal:	Swallowing, heartburn, appetite, nausea, vomiting, change in bowel movements, blood in bowel

	movements, black or tarry stools, diarrhea, constipation
Urinary:	Urinating more often or larger volumes, getting up at night to urinate, decrease in force or caliber of the stream, blood or pus in urine, color or smell changes of urine
Genital:	Male: Lumps in the groin or testicles, sores in the groin or on the penis Female: Bleeding between periods, duration and amount of bleeding during periods, pain with intercourse, sores, lumps, swelling,
Extremities:	Pain with walking, swelling, tender veins, ulcers, hair loss in legs, changes in skin color, change in color or nails
Musculoskeletal:	Pain or stiffness in muscle or joints, joint swelling, back pain, limitation of motion
Neurologic:	Fainting, blackouts, headache, seizures, loss of balance, weakness, pain, tingling, loss of hearing, memory loss, pins & needles, not able to feel

Closing

- Thank the patient for coming in
- Provide appropriate encouragement
- Ask about final questions
- Clarify the plan
- Ensure that the patient understands the plan
- Ensure that the patient agrees to the plan
- Define follow-up

MEDICINE

Description of Rotation: Medicine is divided into an inpatient and outpatient rotation. The inpatient rotation is 8 weeks with 4 being at UCIMC and 4 weeks at LBVA. At UCIMC you take call every 4th night (q4) but there is no in-house call. The team stops taking admissions at 8pm. At LBVA your team will be on q4 call as well but you have to stay in the hospital and take admissions overnight. The 4 day schedule for each team is long call, postcall, short call, precall. The outpatient rotation is 4 weeks and is done individually with various preceptors around the area. Make sure you speak to Loretta early if you have preferences for a specific preceptor or location.

Books:

1. Blueprints in Medicine - very popular and very easy to read in 6 wks; read it during your inpatient block for a general understanding of internal medicine.
2. First Aid in Medicine – outline format, concise and very easy to read more than once.
3. NMS Medicine – outline format, too much information and not really a good synopsis of the important topics.
4. Cecil's The Essentials of Medicine - the required text, but NOT manageable in 8 wks. Lots of excellent tables and charts but in small print. Requires dedication to complete. Good if considering internal medicine. Use only for reference.
5. Fishman's Medicine - Many prefer this excellent outline of medicine over Cecil's since it's shorter and more readable. Manageable within 8 weeks.
6. Current Medical Diagnosis and Treatment. Excellent reference book, good for reading in more detail on the issues presented by your patients.
7. Ferri's Care of the Medical Patient - excellent pocketbook for medicine and other rotations. Fantastic section on differential diagnosis
8. Washington Manual (Univ. of Washington's Manual of Medical Therapeutics) - a somewhat lengthy pocket manual. Used mainly by residents, and Ferri may be a better choice for 3rd year.
9. Dubin's Rapid Interpretation of EKG's - the beginner's guide. Casual 3-5 day reading but not necessary reading.

Other sources:

1. **Up-to-date online: If the hospital still has a subscription, go to utdol.com. It is by far the best source for looking up general information on topics of interest, and it has the most current information available.**
2. **For the exam: get a copy of the MKSAP questions and answers. They are very difficult and long questions but will prepare you extremely well for the exam. If you are really motivated, get a copy of Med-Study, the outline review of all internal medicine that complements the MKSAP.**

Complete History and Physical
You will never do this H & P after your 3rd year of medical school, but it's a good reference.

Chief Complaint (CC): One major symptom (in patient's words), and duration.

History of Present Illness (HPI): Chronological account of patient's problems. Include problem, setting in which developed, manifestations, treatments already tried or received, type of onset (sudden or insidious), previous medications or therapy, disability caused by the problem.
Describe symptoms in terms of: 1) location 2) quantity 3) quality (including intermittency & radiation) 4) timing 5) setting 6) factors that aggravate or relieve symptoms 7) associated manifestations. Also include pertinent negatives (for example lack of smoking history in a patient admitted for shortness of breath), lab reports, exposures, risk factors or precipitating events, constitutional symptoms and all medications.

Past Medical History (PMHx): Important to ask about diabetes, hypertension, myocardial infarction, peptic ulcer disease, asthma, emphysema, thyroid and kidney disease, hemophilia, cancer and tuberculosis.
General health: Patient's statement, previous physicals.
Illnesses & Hospitalizations: give dates, names of hospitals, diagnoses & treatment.
Injuries: give dates, nature of injury.

Past Surgical History (PSHx):
Operations: give dates and nature of operations

Medications: all present medications (both prescription and non-prescription drugs). Write dosing for each medication and note whether patient has been compliant with meds.

Allergies: Drug and food reactions, hay fever, hives (NKDA = no known drug allergies).

Family History (FH): Health or cause of death of grandparents, parents, brothers & sisters, with current ages or ages at death; important to ask about cancer, tuberculosis, allergy, asthma, myocardial infarction, hypertension, thyroid disease, kidney disease, ulcers, diabetes and bleeding disorders. Also, the presence of rheumatic disease, endocrine disorders, stroke, anemia, epilepsy, neurologic or muscular disorders, mental illness, alcoholism or symptoms similar to the patient's.

Personal & Social History (SH):
1) birthplace, residence, years in United States.
2) marital status and children.
3) habits, including: tobacco, alcohol, drugs, sleep, tea, coffee.
4) diet: usual 24 hour intake.
5) exercise and leisure activities.
6) occupation(s), job history, conditions at work, education, socioeconomic status, special financial problems
7) environmental factors: epidemics, exposure to contagious diseases, infected animals, water & milk supply, sewage, recent travel or visitors, any unusual or raw foods eaten.

General: usual weight & recent change, weakness, fatigue, fever, chills
Skin: rashes, lumps, sores, itching, dryness, color change, changes in hair/nails
Head: headaches, migraines, trauma, dizziness, vertigo
Eyes: vision (glasses or contacts), color blindness, diplopia, pain, lacrimation, redness, scotomata , glaucoma, cataracts
Ears: hearing, tinnitus, earaches, discharge, infection
Nose: frequent colds, stuffiness, obstruction, discharge, epistaxis, hay fever, sinus pain/trouble, anosmia
Throat & mouth: dental difficulties, sore throat, hoarseness, dysphagia, bleeding
Neck: stiffness, pain, tenderness, masses, goiter
Lymph nodes: local or general enlargement or tenderness, draining sinuses
Breasts: lumps, tenderness, swelling, nipple discharge, gynecomastia in men
Respiratory system: chest pain, shortness of breath, cough, hemoptysis, sputum (amount and description), wheezing, pneumonia, TB, asthma, emphysema, bronchitis, pleurisy, fever, night sweats
Cardiovascular system: chest pain, palpitations, heart murmurs, hypertension, dyspnea (exertional? how many blocks can the patient walk?), orthopnea, paroxysmal nocturnal dyspnea, edema, ascites, cyanosis, varicosities, phlebitis, intermittent claudication. Rheumatic fever, chorea, syphilis, diphtheria history.
Gastrointestinal: abdominal pain, appetite & digestion, heartburn, nausea, vomiting, hematemesis, jaundice, frequency of bowel movements, abnormal stools (color, bloody, odor, frequency, consistency), steatorrhea, constipation, diarrhea, hemorrhoids, change in bowel habits, food idiosyncracy, hernia, flatulence or eructation, known liver disease, hepatitis, gallstones, ulcer
Urinary: frequency, urgency, dysuria, nocturia, hematuria, polyuria, oliguria, color or urine, hesitancy (difficulty in starting stream), size of stream, acute retention, incontinence, kidney or bladder inflammation or infection, stones, facial edema
Male reproductive: libido, potency, genital sores, discharge, hernias, testicular pain or masses, sexual interest & function, infertility, satisfaction
Female reproductive: libido, genital sores, discharge, itching. Age at menarche, regularity, frequency & duration of menses, amount of bleeding, bleeding between menses or during intercourse, last normal menses, dysmenorrhea, premenstrual tension, age at menopause, postmenopausal symptoms, # pregnancies, deliveries, abortions, miscarriages, stillbirths, complications of pregnancies, birth control, sexual interest & function, dyspareunia, infertility, satisfaction
Musculoskeletal: pain, migratory distribution, swelling, redness, heat, stiffness, function, arthritis, gout, backache, weakness, atrophy, cramps, fractures, dislocations, sprains, degree of disability
Metabolic: polydypsia, polyphagia, polyuria, asthenia, hormone therapy, diabetes, Δ in body configuration or weight, Δ in size of hand, feet, head, hair distribution incl. hirsutism, skin pigmentation, goiter, exophthalmos, dry skin/hair, tremor, heat/cold intolerance
Hematologic: anemia, pallor, bleeding tendency, easy bruising, transfusions & rxn's, Rh
Neuropsychiatric: convulsions, tremor, paralysis, paresthesia, hyperesthesia, hypesthesia, anesthesia, incoordination, involuntary movements, syncope, insomnia, vertigo, epilepsy. ANS: incontinence, sweating, erythema, cyanosis, pallor, reaction to heat & cold. Difficulties with memory, speech, special senses, gait. Anxiety, depression, nervousness, mania, psychiatric Dx

Physical Exam

SITTING

Vital signs: temperature, pulse, respiratory rate (count after taking pulse while still holding arm), blood pressure (both sides)
General: impressions (WD/WN = well developed/well nourished), weight, assess level of distress (mild, moderate, severe, or NAD (no acute distress))
Skin: pigmentation, birthmarks, lesions, color, turgor, texture, mucous membranes moist
HEENT: NC/AT (normocephalic/atraumatic), palpate head, scalp, nodes
- Eyes: inspect sclera and conjunctivae, visual acuity, PERRLA (pupils equally round & reactive to light & accommodation), EOMI (extraocular movements intact), visual fields, fundoscopic (may dilate eyes now, and do fundoscopic at end of exam), corneal reflex
- Ears: inspect externally, acuity with finger rub, Weber, Rinne, otoscopic
- Nose: rhinoscopic, septum deviation, obstruction, sinus tenderness, rhinorrhea
- Throat: inspect mouth thoroughly, palpate for induration, tenderness, check uvula movement as patient says "ash", gag reflex
- Neck: supple vs. rigid, palpate for nodes, palpate thyroid from behind. ROM (range of motion) of neck and shoulders

Back (from behind pt.): palpate spine, CVAT (costovertebral angle tenderness), sharp/dull sensory testing of back
Posterior Thorax: (behind pt.) inspect, palpate (fremitus), percuss, auscultate (egophony, whispered pectoriloquy), check diaphragmatic excursion, symmetry of chest, observe work of breathing
Breasts: look for dimpling, check in the arms up, hands on hips, and leaning forward positions.

LAYING:

Check for jugular venous distension. Palpate all 4 quadrants & axilla of each breast.
Anterior Thorax: inspect, palpate, percuss, auscultate (breath sounds, rales, ronchi, wheezes, whispered pectoriloquy, egophony, bronchophony)
Cardiovascular: inspect; palpate PMI (point of maximal impulse), thrills, heaves; auscultate for rate & rhythm, murmurs, split S1 or S2, S3, S4, clicks, friction rubs, *carotid bruits*, etc.; palpate carotid pulses, measure CVP
Abdomen: Auscultate first for bowel sounds & bruits. Palpate for softness, tenderness (direct & rebound), distension. Palpate and percuss liver, spleen, kidneys, any masses. Check abdominal reflexes. Fluid wave and shifting dullness for ascites.
Extremities: check brachial, radial, ulnar, and femoral pulses, popliteal, posterior tibial, dorsalis pedis pulses; palpate muscles for atrophy, tenderness, Homan's sign; check for edema, varicosities, ulcers, color changes of feet, palpable venous cords; inspect toes & nails; ROM of legs
Neuro: muscle strength, heel to shin, Babinski, sharp/dull sensation of torso & legs

Neuro:
Mental status: behavior, attitude, consciousness, orientation (alert and oriented x 4 = person, place, time, situation), mood & affect, speech, thought form & content, attention (digit recall), concentration, memory (immediate, recent, remote), abstraction, calculations, constructions, judgement, insight, fund of knowledge

Cranial nerves (CN's): 5 (sensory of face, clench jaw), 7 (T-raise eyebrows, Z-close eyes, B-show upper teeth, M-show lower teeth, C-tense neck), 12 (stick out tongue), 11(turn head against resistance, shrug shoulder). Other CN's tested elsewhere except 1 (olfactory).

Arms: ROM, sharp/dull sensation, strength

Reflexes: biceps (C5-6), triceps (C6-8), brachioradialis (C5-6), patellar (L2-4), ankle (S1-2)

Cerebellar: finger to nose, rapid alternating movements (dysdiadochokinesis)

STANDING:

Neuro: Romberg, pronator drift, gait (away, towards, tandem, on heels, toes), ROM spine
Genital: Men: palpate testes, spermatic cord, vas deferens, penis; hernia exam
Rectal: palpate for induration, tenderness, masses, prostate(Grade 1, 2, or 3, also check for symmetry, tenderness and consistency whether it is soft, nodular or hard), sphincter tone; occult blood

Insert A3

COMPREHENSIVE HISTORY: ADULT PATIENT

Date and Time of History. The date is always important, and in rapidly changing circumstances it is always wise to document the time. (This is increasingly important to regulatory agencies.)

Identifying Data, including age, gender, marital status, and occupation

Source of History or Referral, such as patient, family, friend, officer, consultant, medical record. It helps the reader to assess the purpose of the history or referral.

Reliability, if relevant. For example, "The patient is consistent about the description of her symptoms but vague about when they began."

Chief Complaints, when possible in the patient's own words. "My stomach hurts and I feel awful." Sometimes patients have no overt complaints; ascertain their goals instead. "I have come for my regular checkup" or "I've been admitted for a thorough evaluation of my heart."

Present Illness
This section is a clear, chronologic account of the problems for which the patient is seeking care. *The data come from the patient, but the organization is yours.* The narrative should include the onset of the problem, the setting in which it developed, its manifestations, and any treatments. The principle symptoms should be described in terms of (1) location, (2) quality, (3) quantity or severity, (4) timing (i.e., onset, duration, and frequency), (5) the setting in which they occur, (6) factors that have aggravated or relieved them, and (7) associated manifestations. Also note significant negatives (the absence of certain symptoms that will aid in differential diagnosis). Other relevant information should be brought in to the present illness section, such as risk factors for coronary artery disease if the chief complaint is chest pain, and current medications in a patient with syncope. A present illness description should also include patient's responses to his or her own symptoms and what effect the illness has had on the patient's life.

Current Medications, including dose and frequency of use. Also include home remedies, nonprescription drugs, vitamin/mineral or herbal supplements, birth control, and medicines borrowed from family members or friends. It is a good idea to ask patients to bring in all their medications and show you exactly what they take.

Allergies, including the specific reaction

Past History

Childhood Illnesses, such as measles, rubella, mumps, whooping cough, chickenpox, rheumatic fever, scarlet fever, polio

Adult Illnesses, including *Medical* (such as diabetes, hypertension, hepatitis, asthma, HIV disease, and information about hospitalizations); *Surgical* (include dates, indication, and outcome); *Obstetric/Gynecologic* (include obstetric history and menstrual history, birth control, number and gender of partners, at-risk practices); and *Psychiatric* (include dates, diagnoses, hospitalizations, treatments). Also includes *Accidents and Injuries* and *Transfusions.*

Current Health Status

Tobacco, including the type used (e.g., cigarettes, chewing tobacco) and amount and duration of use. Cigarette smoking is often reported in pack-years (a person who has smoked 1-1/2 packs a day for 12 years has an 18 pack-year history). If someone has quit, note for how long.

Alcohol, Drugs, and Related Substances. See p. 17 for suggested methods of inquiry.

Exercise and Diet, including frequency of exercise, usual daily food intake, and any dietary supplements or restrictions. Ask about coffee, tea, and other caffeine-containing beverages.

Immunizations, such as tetanus, pertussis, diphtheria, polio, measles, rubella, mumps, influenza, hepatitis B, *Haemophilus influenzae* type b, and pneumococcal vaccine. Usually obtainable from medical records.

Screening Tests appropriate to the patient, such as tuberculin tests, Pap smears, mammograms, stools for occult blood, and cholesterol tests, together with the results and the dates they were last performed. The patient may not know this information. You may need to refer to the chart or get the patient's permission to obtain old medical records.

Safety Measures, such as use on nonuse of seat belts, bicycle helmets, sunblock, smoke detectors, and other devices related to specific hazards.

Family History
Note the age and health, or age and cause of death, of each immediate family member (i.e., parents, siblings, spouse, and children). Data on grandparents or grandchildren may also be useful.

Note the occurrence within the family of any of the following conditions, diabetes, heart disease, hypercholesterolemia, high blood pressure, stroke, kidney disease, tuberculosis, cancer, arthritis, anemia, allergies, asthma, headaches, epilepsy, mental illness, alcoholism, drug addiction, and symptoms like those of the patient.

It may be useful to record this information in a diagram called a pedigree or genogram.

Personal and Social History
This is an outline or narrative-description that captures the important and relevant information about the patient as a person, lifestyle issues that create risk or promote health, and health maintenance measures.

Occupation and Education

Home Situation and Significant Others

Daily Life, particularly important in elderly patients or patients with disabilities to establish their baseline level of function. Can include sleep patterns, including times that the person goes to bed and awakens, day-time naps, and any difficulties in falling asleep or staying asleep.

Important Experiences, including upbringing, schooling, military service, job history, financial situation, marriage, recreation, retirement

Leisure Activities/Hobbies (may be a clue to environmental exposures)

Religious Affiliation and Beliefs, relevant to perceptions of health, illness, and treatment

Review of Systems

General. Usual weight, recent weight change, any clothes that fit tighter or looser than before. Weakness, fatigue, fever

Skin. Rashes, lumps, sores, itching, dryness, color change, changes in hair or nails

Head. Headache, head injury, dizziness, lightheadedness

Eyes, Vision, glasses or contact lenses, last examination, pain, redness, excessive tearing, double vision, blurred vision, spots, specks, flashing lights, glaucoma, cataracts

Ears. Hearing, tinnitus, vertigo, earaches, infection, discharge. If hearing is decreased, use or nonuse of hearing aids

Nose and Sinuses. Frequent colds, nasal stuffiness, discharge, or itching, hay fever, nosebleeds, sinus trouble

Mouth and Throat. Condition of teeth, gums, bleeding gums, dentures, if any, and how they fit, last dental examination, sore tongue, dry mouth, frequent sore throats, hoarseness

Neck. Lumps, "swollen glands," goiter, pain, or stiffness in the neck

Breasts. Lumps, pain or discomfort, nipple discharge, self-examination practices

Respiratory. Cough, sputum (color, quantity), hemoptysis, dyspnea, wheezing, asthma, bronchitis, emphysema, pneumonia, tuberculosis, pleurisy, last chest x-ray

Cardiac. Heart trouble, high blood pressure, rheumatic fever, heart murmurs, chest pain or discomfort, palpitations, dyspnea, orthopnea, paroxysmal nocturnal dyspnea, edema, past electrocardiogram or other heart test results

Gastrointestinal. Trouble swallowing, heartburn, appetite, nausea, vomiting, regurgitation, vomiting of blood, indigestion. Frequency of bowel movements, color and size of stools, change in bowel habits, rectal bleeding or black tarry stools, hemorrhoids, constipation, diarrhea. Abdominal pain, food intolerance, excessive belching or passing of gas, jaundice, liver or gallbladder trouble, hepatitis

Urinary. Frequency of urination, polyuria, nocturia, burning or pain on urination, hematuria, urgency, reduced caliber or force of the urinary stream, hesitancy, dribbling, incontinence, urinary infections, stones

Genital

Male. Hernias, discharge from or sores on the penis, testicular pain or masses, history of sexually transmitted diseases and their treatments. Sexual preference, interest, function, satisfaction, birth control methods, condom use, and problems. Exposure to HIV infection.

Female. Age at menarche; regularity, frequency, and duration of periods; amount of bleeding, bleeding between periods or after intercourse, last menstrual period; dysmenorrheal, premenstrual tension; age at menopause, menopausal symptoms, postmenopausal bleeding. If the patient was born before 1971, exposure to DES (diethylstilbestrol) from maternal use during pregnancy. Discharge, itching, sores, lumps, sexually transmitted diseases and treatments. Number of pregnancies, number and type of deliveries, number of abortions (spontaneous and induced); complications of pregnancy; birth control methods. Sexual preference, interest, function, satisfaction, any problems, including dyspareunia. Exposure to HIV infection.

Peripheral Vascular. Intermittent claudication, leg cramps, varicose veins, past clots in the veins.

Musculoskeletal. Muscle or joint pains, stiffness, arthritis, gout, backache. If present, describe location and symptoms (e.g., swelling, redness, pain, tenderness, stiffness, weakness, limitation of motion or activity).

Neurologic. Fainting, blackouts, seizures, weakness, paralysis, numbness or loss of sensation, tingling of "pins and needles," tremors or other involuntary movements.

Hematologic. Anemia, easy bruising or bleeding, past transfusions and any reactions to them.

Endocrine. Thyroid trouble, heat or cold intolerance, excessive sweating, diabetes, excessive thirst or hunger, polyuria

Psychiatric. Nervousness, tension, mood including depression, memory

University of California, Irvine
Inpatient Medicine Clerkship
Department of Medicine

I. Required Attendance

A. Work Rounds

B. Attending Rounds

C. Vignettes

D. Grand Rounds (Tuesday @ 12PM, UCIMC & LBVA)

E. Noon Conference

F. Call

G. Ambulatory Care Experience (see Ambulatory Medicine packet)

H. All Conferences listed in your schedule

II. Clinical Expectations (Pass Range)

A. Carry 2-3 patients at any time

B. Work-up 1 patient each long and short call

III. Pearls

A. Case presentation: READ THE ARTICLE, PRACTICE

B. Be available, show enthusiasm, teach

C. Teamwork is the key

D. Read about your patients

E. Begin early to prepare for oral

F. Ask for feedback early and often

G. Take advantage of learning opportunities

H. Establish expectations early

I. Identify and report problems early

University of California, Irvine
Inpatient Medicine Clerkship
Department of Medicine

Documentation Requirements for Internal Medicine Ward Services at UCIMC

All notes must be legible and clear.

All signatures must be legible, and must include your name printed below the signature, your level or role: for example: MS3, MS4, R1, R2, R3, A. It is also a good idea to include your pager number for further ease of identification or contact.

Do not allow anyone else to use your computer access code.

Students:

- Do not remove any documents, notes, order sheets or any other materials from the chart.
- All student orders and notes must be co-signed by senior resident
- Do not enter any orders into the computer using your resident's or attending's computer access code.
- Document any patient education, explanation, or instruction, which you perform. (See attachment on "documenting conversation with patients and families").

Residents:

- All student notes must be co-signed.
- All verbal orders must be signed within 48 hours except orders for restraints, which must be signed within 24 hours.
- Sign all verbal orders each day. You will see a prompt to sign when you log onto the computer
- Remind your attendings about any and all patients who are their responsibility. Attendings must write or dictate notes on every patient on your service every day.
- Dictate discharge summaries at the time of discharge. Any medical records deficiencies which are greater than 14 days old will lead to suspension.
- All procedure notes must be signed by your attending, either at the time of the procedure or as soon as possible after.

Attendings:

- You are responsible for a dictated note on each patient, every day of your assignment.
- All student notes must be co-signed by you and your resident.
- You must co-sign the initial H&P and all consent. Please make sure that your resident makes you aware of all consents.
- Do not allow anyone else to use your computer access code.
- All verbal orders must be signed within 48 hours. Verbal orders for restraints must be signed within 24 hours and renewed every 24 hours.
- DNR requires the DNR order sheet completed by the attending, front and back.

University of California, Irvine
Inpatient Medicine Clerkship
Department of Medicine

Documenting Conversation with Patients and Families

A. Description of important discussions with the patient and/or family/friends (especially surrogate decision makers) in which the plan and goals of care are addressed. It should include a description of the topics of conversation, any issues/questions/concerns the patient/family raised and how they were or will be addressed and any decisions made or other outcomes.

Initial note format for notations on discussions of issues of prognosis, ethics, consent or concern. This should stand on its own:

1. List those present for the discussion and identify the decision maker
2. Identify the decision maker (with legal authority)
3. Description of medical condition offered, including diagnoses, prognosis, short-term goals, long-term goals
4. Questions or concerns raised by anyone present
5. Diagnoses and prognosis offered
6. Preferences expressed by health care providers and patient/family.
7. Current goals for the patient and family with respect to psychosocial, support, ethical or prognosis issues
8. Decisions made (including when/if these decisions will be reassessed later)

B. A daily or otherwise regular overall picture of the patient's situation given the medical findings (e.g. patient progressing well with x treatment or prognosis remains uncertain or poor) Continue to incorporate these issues into the daily notes as the discussions evolve.

C. Based on that overall picture, an assessment of the current goals of care and an indication of how the treatments offered and provided address those goals.

University of California, Irvine
Inpatient Medicine Clerkship
Department of Medicine

Re: Patient Confidentiality

Students,

For all write-ups, please do not identify patients in your paperwork.
This is a violation of patient confidentiality.

Thank you.

Alpesh Amin, M.D.
Director, Junior Medicine Clerkship

UCI MEDICAL CENTER
MEMORANDUM

TO: UCIMC Medical Staff and Residents

FROM: Thomas Cesario, M.D., Dean
Harry Skinner, M.D., President Medical Staff

DATE: November 27, 2001

RE: **Physician Handwriting Legibility**

It has been brought to the attention of the Medical Center and the Medical Staff that JCAHO is taking a closer look at physician documentation in the patient's record. Illegible documentation could result in two Type I recommendations IM.7.10, 7.10.1 and MS 8.2.3. The Institute of Medicine's report of medical errors and the role that illegible handwriting plays in the commission of such errors, has prompted the JCAHO to pay particular attention to physician documentation. If a surveyor request a physician or other healthcare professional to read an order or a progress note and they can't, then clearly legibility is a concern.

In light of this and the fact that illegible documentation can result in a misinterpretation of orders and/or progress notes UCIMC will be implementing a monitoring system. Charts will be reviewed on a random basis. If the reviewer has difficulty reading orders, progress notes, etc. the responsible practitioner will be notified and the matter discussed. If an effort is not made for improvement, corrective action may be taken. We encourage each of you to take a moment when writing your documentation to remember that someone else has to move forward with the patient's care based on what you have written.

While it is important to adhere to JCAHO standards, it is more important that we provide quality patient care. Illegible documentation could hinder this process.

We would like to thank you in advance for your cooperation and support in helping to improve our documentation and patient care process.

INPATIENT

student	attending UCI	resident UCI	vignette UCI	(2) mini-CEX UCI	(2) H&P/Progress Notes UCI	attending LBVA	resident LBVA	vignette LBVA	(2) mini-CEX LBVA	(2) H&P/ Progress Notes LBVA	Oral exam	Inpatient Patient log	Inpatient Procedure logs	Urinary Catheter Assignment	Values Assignment	e-Doc. Curriculum
contacts:	Med Ed	Med Ed	Med Ed	student	student	Med Ed	Med Ed	Med Ed	student	student	Med Ed	Student completed online	student	student	student	Student completed online

Inpatient Medicine Rotation
Patient Log

Dear 3rd years:

Thank you all very much for trying out the patient log. It was a big hit with the directors at the meeting today and they are expecting you to use it starting next week. You will notice I added two fields to the log. "English speaking" and "age groups". Both of these are of interest to the clerkships so we know a bit about the diversity you are seeing.

A few guidelines to help you out...

1. PLEASE do NOT put the patient's full name anywhere. I need to keep this as deidentified as possible. The MR# will be used to ensure accuracy and responsibility.

2. For the "Brief Description of Care" you will not need to continue to put a full SOAP note in there, that was just for Foundations. However, you will need to tell us what you did with the patient so we understand what went on in that encounter. You can keep it brief, just give us the details.

3. Every field needs an answer. You won't save otherwise. If you don't remember something you can put in a "holder" and go look it up. You will be able to edit these later (it IS you log) although we will know if you are editing "frequently." =)

4. We expect you to be going to this log at least a few times a week and likely on a daily basis when you are on a clinic rotation. Don't fall behind or it will become a daunting task. Just jump in and log for a few minutes a day if necessary. An email and a page will go out to individuals who are not entering data on a regular basis. Be smart!

5. You can login from ANYWHERE as long as you have your username and password handy. If there is ever a case when you can see someone else's data please page me IMMEDIATELY so I can fix the problem. Only Course Directors and Meded should be able to see the big view. You should only see your entries.

That's it. By my count it should only take 1-3 minutes to complete a patient entry. Don't kill yourself on it, just be a regular contributor. By the end of the year I think you will be shocked about how many patients you actually see and I know the clerkships are eager to find out about the detail this log will provide.

If there are questions please email me or page me (paging is probably better.) Also, I will be deleting your Foundations entries over the weekend so don't be surprised if it is gone on Monday. I am teaching the Clerkship Directors about this log too so be nice to them, you guys have a 3-week advantage on them!

Very best regards,

Inpatient Medicine Rotation
Procedure Log

Name:_____
Dates: _____

Patient Initials	Site	Procedure

Please return to Program Representative – UCIMC, Building 22A, Room 2108

IV. TOPICS

SITES/CONFERENCES

	Orientation	Doctoring Rounds	Geriatrics Lectures	Geriatrics Vignettes	Fam. Med Vignettes	Work Rounds	Attending Rounds	CEX		M & M Rounds	Grand Rounds	Ward Patients	Ambulatory Orientation	Ambulatory Rotation	Ambulatory Rounds	Self-Study
Abd Pain				X												
Adeno CA of Undetermined Origin					X											
Adolescent Problems History			X													
Altered Mental Status/Dementia			X													
Acute M.I.				X												
Anemia				X	X						X					X
Antibiotics												X				
Ascites				X							X					X
Back Pain		X			X											
Cancer																
1. Breast		X														
2. Lung			X													X
3. Colorectal				X												X
4. Prostate				X												X
Chest Pain		X		X												
CHF				X							X					
COPD/Asthma				X								X				X
Cough					X											
CRF Renal Failure, Chronic				X												
Depression					X											
Diabetes Mellitus		X		X	X											X
Diarrhea, Acute					X											X
Diarrhea, Bloody				X												
Difficult Patient					X											
Domestic Violence					X											
Durable Power of Attorney					X											
DVT/Leg Swelling		X										X				
Dyspepsia				X	X											
Dyspnea				X												
Endocarditis				X												
Fluid, Lytes, Acid Base				X												

FUO				X												

SITES/CONFERENCES

IV. TOPICS (continued)	Orientation	Doctoring Rounds	Geriatrics Lectures	Geriatrics Vignettes	Fam. Med Vignettes	Work Rounds	Attending Rounds	CEX	M & M Rounds	Grand Patients	Ward Orientation	Ambulatory Rotation	Ambulatory Rounds	Ambulatory	Self-Study
GI Bleeding										X					X
Geriatrics												X	X		
1. Polypharmacy			X	X											
2. Incontinence			X												
3. Dementia			X												
Headache					X										
HIV				X											
Hospice Care										X		X	X		
Hypertension		X			X										X
Impotence					X										
Inflammatory Bowel Disease					X										
IVDA Complications				X											
Joint Pain				X										X	
Lipids		X		X										X	
Liver Disease				X						X					
Malabsorption				X											
Nosocomial Infections										X					X
Obesity					X										
Pain/Palliative Care										X		X	X		
Pleural Effusion				X											
Pneumonia		X													
Prevention and Screening													X	X	X
Prostatitis				X	X										
Renal Failure, Acute				X											
Rheumatoid Arthritis				X											X
Sepsis				X											
SLE				X										X	
Smoking Cessation					X										
Solitary Pulmonary Nodule					X										
Substance Abuse		X								X					
Sycope					X										
URI-Sinusitis					X										
UTI		X													
Vaccination, Adult				X									X		

FUO				X												

SITES/CONFERENCES

IV. TOPICS (continued)	Orientation	Doctoring Rounds	Geriatrics Lectures	Geriatrics Vignettes	Fam. Med Vignettes	Work Rounds	Attending Rounds	CEX	M & M Rounds	Grand Rounds	Ward Patients	Ambulatory Orientation	Ambulatory Rotation	Ambulatory Rounds	Self-Study
GI Bleeding											X				X
Geriatrics													X	X	
1. Polypharmacy			X	X											
2. Incontinence			X												
3. Dementia			X												
Headache					X										
HIV				X											
Hospice Care											X		X	X	
Hypertension		X			X										X
Impotence					X										
Inflammatory Bowel Disease					X										
IVDA Complications				X											
Joint Pain				X											X
Lipids		X		X											X
Liver Disease				X							X				
Malabsorption				X											
Nosocomial Infections											X				X
Obesity					X										
Pain/Palliative Care											X		X	X	
Pleural Effusion				X											
Pneumonia		X													
Prevention and Screening														X	X	X
Prostatitis				X	X										
Renal Failure, Acute				X											
Rheumatoid Arthritis				X											X
Sepsis				X											
SLE				X											X
Smoking Cessation					X										
Solitary Pulmonary Nodule					X										
Substance Abuse		X									X				
Sycope					X										
URI-Sinusitis					X										
UTI		X													
Vaccination, Adult				X										X	

Policies & Procedures

Exceptional Absence Voucher:

As a courtesy, the Senior Administration of the University of California, Irvine College of Medicine will allow each student to have two flexible exceptional absence days off from clinical responsibilities for legitimate reasons as described below. You will receive two vouchers to be excused from your clinical activities on the two days of your choice for important events that can be anticipated in advance and for which no suitable alternative arrangement exists.

1. You must write on the voucher the reason for needing the day off.
2. Vouchers cannot be used for days when call is scheduled.
3. You must notify the Clerkship Coordinator 30 days prior to the beginning of the rotation if you need to be on a special call schedule.
4. It is your responsibility to keep track of the vouchers. They are not transferable, and they cannot be carried over into the next year. **Replacement vouchers will not be issued for those that are lost.**

These vouchers are not to be used casually and they are not a guarantee for a day off. In addition, two extra days off are not the goal. You cannot take the days off unless you have a legitimate and significant reason. Examples of appropriate use of the vouchers include

1. **A personal religious holiday not on the University calendar.**
2. **A wedding or other important family event.**
3. **A doctor's visit or other personal health care need which cannot be scheduled on your regular day off.**
4. **Residency interviewing which cannot be accommodated during the usual vacation schedule.**
5. **Attending an academic meeting.**

Examples of inappropriate use of the Vouchers:

1. **A mental health day.**
2. **An extra day to study for an exam.**
3. **A laundry day.**
4. **To extend a long weekend.**
5. **Because you have a voucher left at the end of the year and you want to use it.**

You should use your regular days off for these latter activities. You must notify the course director and the student coordinator a minimum of 30 days in advance of intent to use the voucher. This will allow the clinic schedules to be developed accordingly and not cause difficulty in patient care. **Requests made less than 30 days in advance will be honored only if they are not disruptive to existing schedules and patient care.**

Once the course director has signed off on the voucher, the course director will forward it to the Medical Education office in Building 22A, Room 2108 for tracking purposes. Please note that an attempt to duplicate the vouchers or use more than two is in violation of the honor code and will cause disciplinary action. You may not sell, trade, or otherwise convey your voucher privileges to another student. It is a violation of the Honor Code to falsity the justification for using the voucher.

Although this option has been made available to you, it is not a valid option when you have direct patient care (Sub I, Emergency Medicine or Substance Abuse). When you are on these rotations you will work the exact

Policies & Procedures (Continued)

Policy on the Requirement to Pass the Specialty-Specific NBME Shelf Exam, 6/2000

Preamble

The standardized shelf exam prepared by the National Board of Medical Examiners is one measure of medical student accomplishment and acquisition of knowledge. Although other measures can be applied, the shelf examine has the virtue of consistency and validity across institutions. These exams are also predictive of students' ability to pass the mandatory licensing exam. Finally, the exams may identify students with learning or testing disabilities. For these reasons, the UCI COM believes that students should take these exams on all appropriate core clerkships and that the exam results should serve as one component of the overall grade. In addition, we believe that a minimum level of competence on this exam must be achieved to pass the clerkship.

Policy

1. Clerkship Directors should use the shelf exam for their specialty as a component of the final grade for their rotation.

2. The exam may count for 10% to 50% of the final grade.

3. Students who fail the shelf exam 2 times will receive an "F" on their transcript and be required to retake all or a portion of the clerkship. The Course Director and the Associate Dean of Student Affairs will determine the length of time the student must spend re-enrolled in the clerkship. The length of the repeat clerkship will not be less than 4 weeks nor longer than the original clerkship

4. If a student does not achieve the 6th percentile on any given exam, the student will be required to retake the exam within 2 weeks of the end of the rotation in which the student learns that he or she has failed the exam and achieve that percentile.

5. The Department responsible for the clerkship will pay for the first exam. The Dean's Office will pay for the second exam. The student will pay for the third exam or subsequent exams.

6. Further action will be at the discretion of the Associate Dean for Student Affairs in consultation with the clerkship director. However, in all cases the student must achieve the 6th percentile.

7. The Clerkships that must require the Shelf Exams are Internal Medicine, Pediatrics, Obstetrics and Gynecology, Surgery, Psychiatry, and Family Medicine.

Holidays & Other Important Dates

The following are official holidays and important dates for students:

Independence Day*	July 5, 2010
Labor Day Holiday*	September 6, 2010
Veterans Day*	November 11, 2010
Thanksgiving Break*	November 25 & 26, 2010
Winter Break*	December 13, 2010 – January 7, 2011
Martin Luther King Holiday*	January 17, 2011
Presidents' Holiday*	February 21, 2011
Match Day Event	March 17, 2011
Cesar Chavez Holiday*	March 25, 2011
Memorial Day*	May 30, 2011
Honor's Evening Ceremony	TBA
Hooding Ceremony	June 4, 2011
Diploma Date	June 11, 2011

*UCI Holiday Accommodation

UCI Holidays are indicated with an asterisk (*) above. Students will be released from clinical duties at 6:00 p.m. the night before the holiday and return at 6:00 a.m. the day after the holiday. Easter is not considered a holiday so any student wishing to take Easter off must use one of his/her vouchers. However, if a student is scheduled for a rotation with direct patient care (Sub I or Emergency Medicine) he/she will work the exact schedule that the team works. Therefore, anyone who does not want to be on call the night before a specific holiday, or on a specific holiday, make sure not to schedule a Sub I or Emergency Medicine Rotation during that time.

Shelf Exam Special Accommodations

You must inform the Student Coordinator when you are requesting your clerkship location preferences if you need special test accommodations for the Shelf Examination because of a documented disability. It is your responsibility to inform the coordinators with an official letter from the Ron Blosser's office, noting that accommodation is required. Accommodations will not be granted unless an official letter is received 30 days prior to the beginning of the rotation.

Call Schedule before Examinations

Students should be released from all clinical responsibilities by 10:00 p.m. the night before an examination that counts for more than 10% of their grade or is required for graduation from medical school. These examinations include: clerkship shelf examinations, CPX, Family Medicine CPX and Family Medicine Shelf examination. The departments responsible for administering the examinations will notify the course directors of the dates of the examination a minimum of 30 days prior to the beginning of the rotation so that schedule may be arranged to accommodate the policy.

Illness

You must call the department Clerkship coordinator and ask that all involved faculty and residents be notified if you will be out ill. (DO NOT GIVE MESSAGES TO BE DELIVERED BY FRIENDS) If you miss too many days of a rotation, you may be required to make up part of the Clerkship. The department will make arrangements for the make up. Both the student and the department coordinator will contact Dora Thompson to inform her of the arrangements.

MATCH DAY & PICNIC ACCOMMODATIONS

Students will be released from clinical duties at 6:00 p.m. the night before Match Day and return at 6:00 a.m. the day after the Match. All students will be allowed to attend the Match Day Ceremony and picnic on the UCI Campus.

HONOR'S EVENING ACCOMMODATIONS

Students will be released from clinical duties at 3:00 p.m. the day of the Honor's Evening Banquet. Students are expected to return to regular assignments at 6:00 a.m. the following day. However, if a student is scheduled for a rotation with direct patient care (Sub I, Emergency Medicine, or Substance Abuse), he/she will work the exact schedule that the team works. Therefore, anyone who does not want to be on call the night before a specific holiday, or on a specific holiday, make sure not schedule the Senior Sub I, Emergency Medicine, or Substance Abuse rotation during that time.

Vacation Time

Please note that third year students have a total of six weeks of vacation time during the third year. All students will be given a four-week winter break and a two-week break directly following their Psychiatry rotation. If preferred, students can schedule fourth year electives or core requirements during their vacation time. Note that students do not have to complete the core work before participating in an elective, except Inpatient and Ambulatory Medicine must be completed before enrolling in the Senior Sub Internship. Students will be given an opportunity to schedule electives during their vacation time on a first come, first served basis after all current fourth year students have completed their schedules.

Mailboxes & E-mail

Although your third year schedule is very busy, it is expected that you will check both your mailboxes at the Medical Center and your e-mail on a regular basis. Because you will be at various sites, Medical Education uses e-mail as the primary means of communication with you. However, not all departments distribute information this way, so it is your responsibility to check your mailbox (and actually read the information put in it) on a regular basis. It is your responsibility to meet deadlines; being at another hospital is not a valid excuse.

USMLE Step 1 and Step 2

Successful passage of Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) is required for graduation at UCI-COM. If USMLE Step 1 or Step 2 are not passed you will be referred to the Promotions and Honors Committee (P&H). If you do not successfully pass the examination within three attempts, P&H may recommend dismissal from the College of Medicine. It is highly recommended that all students schedule vacation time prior to the administration of the examinations for preparation to ensure successful passage.

The Step 2 examination is in computer format and is offered throughout the year. In computer format, Step 2 is a one-day examination. Sylvan Prometric will provide computer-testing services for USMLE. You will take Step 2 at a Sylvan Technology Center.

Please note that on your application form you must select a three-month period during which you prefer to take the examination. Please take your testing date into consideration when choosing your schedule.

You will be required to inform the Medical Education Office of your examination date. Please note that there is a one-month waiting period to retake the examination. In addition, you must give Sylvan a three-month block of time to schedule you for the exam.

The Committee on Curriculum and Educational Policy in conjunction with the Office of Student Affairs requires all medical students to sign up and schedule USMLE Step 1 by December 31 of the third year, Step 2 CK by December 31 of the senior

year, and Step 2 CS by March 1 of the senior year. This policy allows enough time for any student who does not pass an exam to reschedule and take the examination and to have the results available before graduation.

Any exceptions to this policy must be petitioned and approved by the Committee on Promotions and Honors in consultation with the Associate Dean of Student Affairs.

You may take off the day before the exam for material review. The Course Directors must be informed of your test date a minimum of 30-days prior to the beginning of your rotation so that the schedule can be developed accordingly. You will only be allowed to miss the day before the examination and the day of the examination from your rotation.

University of California, Irvine
Inpatient Medicine Clerkship
Department of Medicine

UCI COM Policy and Procedures Following Occupational Exposure to Blood/Body Fluids
Ref: UCI COM Student Handbook, September 1998

There are two sections to this guide. Please refer to the section that is relevant to your health insurance needs.

I. Medical Students who are covered by the Graduate and International Student Health Insurance Plan (GSHIP)

II. Medical Students who are covered under a private health insurance program

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I. What to do in case of occupational exposure and I have Graduate and International Student Health Insurance (GSHIP)

If you come in contact with another person's blood or body fluid (e.g. through a needlestick injury contact with skin or mucous membrane splash), take the following steps:

1. Immediately clean wound site with antiseptic soap. Flush area with water (gently expressing blood if it is a percutaneous injury).

2. All students who have been exposed to blood or body fluid from a patient who is known to be or suspected to be HIV positive, must call or be seen immediately within 1-hour post-exposure to obtain the most effective early prophylaxis. See below for locations.

3. Any student who has been exposed to blood or body fluid from a patient and does not know the patient's status but who is concerned regarding exposure must also call or be seen within 1-hour post-exposure to obtain the most effective early prophylaxis. See below for locations.

- **At UCI**: Go directly to the Emergency Room for an initial, immediate evaluation and care post-exposure.
- **At LBVAMC**: Go directly to the Emergency Room for an initial, immediate evaluation and care post-exposure.
- **At LB Memorial**: Go directly to the Emergency Room for an initial, immediate evaluation and care post-exposure.
- **Outside Rotation:** Go directly to the Emergency Room for an initial, immediate evaluation and care post-exposure.

4. You must document the date and time, patient's name, identification number, and the unit and clinical site in which the exposure occurred. You must also keep this information in a secure place. In addition, immediately contact the nursing supervisor and provide the supervisor with this information. The nursing supervisor will request and obtain a source patient blood sample for Hepatitis B Surface Antigen, Hepatitis C, and consent for HIV testing if the patient's status is not known. The nursing supervisor is authorized to release the results of the blood tests to the student. The student is responsible for contacting the supervisor to obtain this information.

5. Contact Beth, at (949) 824-2388[1] within 24 hours so that insurance coverage will be authorized and post-exposure follow-up with the Student Health Service Medical Clinic can be arranged. If the exposure occurs while Student Health Services is closed, please leave a message and follow-up during normal office hours. If you do not do so, the insurance provider is not obligated to cover the cost of your initial urgent or immediate evaluation and care post-exposure.

6. If ZDV is to be given, baseline CBC, platelet count, LFT's, BUN, creatinine, CPK, UA, and a confidential pregnancy test (if appropriate) should be completed. ZDV will be given at 200mg three times a day for 14 days. Repeat blood screen will be obtained in two weeks. If you are tolerating the initial ZDV regimen, you may take the medication for an additional 14 days. Depending on the risk assessment, additional medication may be recommended.

7. You must follow-up at Student Health Services through "window period" as appropriate: six weeks, three months, six months, and twelve months. At that time, baseline blood tests including but not limited to the following will be authorized:

   HBV chronic panel, HCV antibody, and HIV antibody and subsequently at 6 weeks, 3 months, 6 months and 12 months for post-needlestick injury counseling and follow-up.

   The lab at Student Health can perform a 10-minute HIV-1 antibody test on your blood.

8. The student must contact Student Health Services if any of the tests are positive and must provide them with the supporting documentation. Post-test counseling and appropriate intervention or follow-up will be provided by Student Health Center. All students should contact the Center to arrange an appointment for an initial counseling session.

Please note that students covered under the Graduate and International Student Health Insurance Plan are responsible for their annual $50.00 deductible and all non-covered benefits.

II. What to do in case of occupational exposure and I have a private health insurance program:

If you come in contact with another person's blood or body fluid (e.g. through a needlestick injury contact with skin or mucous membrane splash), take the following steps:

1. Immediately clean wound site with antiseptic soap. Flush area with water (gently expressing blood if it is a percutaneous injury).

2. All students who have been exposed to blood or body fluid from a patient who is known to be or suspected to be HIV positive, must call or be seen immediately within 1-hour post-exposure to obtain the most effective early prophylaxis. See below for locations.

3. Any student who has been exposed to blood or body fluid from a patient and does not know the patient's status but who is concerned regarding exposure must also call or be seen within 1-hour post-exposure to obtain the most effective early prophylaxis. See below for locations.

[1] Updated contact 3/2000

- **At UCI**: Go directly to the Emergency Room for an initial, immediate evaluation and care post-exposure.
- **At LBVAMC**: Go directly to the Emergency Room for an initial, immediate evaluation and care post-exposure.
- **At LB Memorial**: Go directly to the Emergency Room for an initial, immediate evaluation and care post-exposure.
- **Outside Rotation:** Go directly to the Emergency Room for an initial, immediate evaluation and care post-exposure.

4. You must document the date and time, patient's name, identification number, and the unit and clinical site in which the exposure occurred. You must also keep this information in a secure place. In addition, immediately contact the nursing supervisor and provide the supervisor with this information. The nursing supervisor will request and obtain a source patient blood sample for Hepatitis B Surface Antigen, Hepatitis C, and consent for HIV testing if the patient's status is not known. The nursing supervisor is authorized to release the results of the blood tests to the student. The student is responsible for contacting the supervisor to obtain this information.

5. It is your responsibility to be familiar with the insurance benefits, exclusions and limitations. Most insurance plans have provisions which include the need to report the injury to the insurance company within a brief period after the injury

   For those students who require follow-up, the Student Health Center will provide initial, immediate evaluation and counseling, in which case the Center will bill your private insurance carrier. However, if your insurance will not accept the Center's services, you must follow your carrier's accepted protocol. If you use the Center's services and your carrier will not cover the expenses, you will be responsible for the cost. Again, it is your responsibility to know your benefits.

6. If ZDV is to be given, baseline CBC, platelet count, LFT's, BUN, creatinine, CPK, UA, and a confidential pregnancy test (if appropriate) should be completed. ZDV will be given at 200mg three times a day for 14 days. Repeat blood screen should be obtained in two weeks. If you are tolerating the initial ZDV regimen, you may take the medication for an additional 14 days. Depending on the risk assessment, additional medication may be recommended.

7. You must follow-up with your private physician through "window period" as appropriate: six weeks, three months, six months, and twelve months. At that time, baseline blood tests including but not limited to the following are advised:

   HBV chronic panel, HCV antibody, and HIV antibody and subsequently at 6 weeks, 3 months, 6 months and 12 months for post-needlestick injury counseling and follow-up.

The student must contact their private physician if any of the tests are positive and must provide them with the supporting documentation. Your private physician should provide post-test counseling and appropriate intervention.

-----Original Message-----
From: mailsvc@alpha.ddm.uci.edu [mailto:mailsvc@alpha.ddm.uci.edu] On Behalf Of Marion Mallory, Hospital Compliance Officer
Sent: Tuesday, October 09, 2007 10:20 PM
Subject: Access to Patient Information

It is the responsibility of all of us to protect the privacy and confidentiality of all our patients, including patients who are also our colleagues and coworkers, as well as our families and friends. We are all responsible to only access the information on patients for whom we are providing care, or for whom we need information to complete job functions. We are also responsible for only accessing and using the minimum amount of information for these purposes.

As a reminder, it is a violation of patient privacy to look up any information on coworkers, colleagues, family members, and friends without their express written authorization in either paper or electronic systems, ie. TDS, Invision, Signature, Quest, IDX, etc.

As healthcare workers, we are always concerned about the welfare of our colleagues and friends, however, they are also our patients, and we must respect their privacy. Violations of this policy can result in disciplinary action up to and including termination.

If you have any questions regarding this policy, please contact the Compliance and Privacy Office at Ext. 3674.

Marion Mallory,
Hospital & Privacy Compliance Officer

UPDATED: GUIDELINES FOR DOCUMENTATION: DO NOT USE ABBREVIATIONS

I. **All documentation must be legible.**

II. **Use of abbreviations in the medical record is strongly discouraged.** Abbreviations with multiple meanings must be made clear by the entry context, or they cannot be used.

III. **The Do Not Use List applies to all documentation in the medical record; i.e., orders, notes, prescriptions, in the inpatient and outpatient setting.**

IV. **Do Not Use List**

Abbreviation	Potential Problem	Preferred Term
U (for unit)	Mistaken as zero, four or cc.	Write "unit"
IU (for international unit)	Mistaken as IV (intravenous) or 10 (ten).	Write "international unit"
Q.D. Q.O.D. (Latin abbreviation for daily, or for every other day)	Mistaken for each other. The period after the "Q" can be mistaken for an "I". The "O" can be mistaken for an "I".	Write "daily" and "every other day"
Trailing zero (X.0 mg) Lack of leading zero (.X mg)	Decimal point is missed.	Never write a zero by itself after a decimal point, write "X mg" instead. Always use a zero before a decimal point, write "0.X mg".
MS MSO4 MgSO4	Confused for one another. Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" or "magnesium sulfate"
µg (for microgram)	**Mistaken for mg (milligrams) resulting in 1,000-fold dosing overdose**	**Write "mcg"**
T.I.W. (for three times a week)	**Mistaken for three times a day or twice weekly resulting in an overdose.**	**Write "3 times weekly" or "three times weekly"**
A.S., A.D., A.U. (Latin abbreviation for left, right, or both ears)	**Mistaken for OS, OD, and OU, etc.**	**Write "left ear", "right ear", or "both ears"**

An abbreviation on the Do Not Use List should not be used in any of its forms – upper or lower case, with or without periods. For example, Q.D. can't be used for QD or qd. Any of those variations are confusing and can be misinterpreted.

V. **OTHER GUIDELINES**

1. "prn" orders MUST include specific parameters for administration (i.e., Tylenol No. 3, 1 tab po q4hr prn pain).
2. For dosage ranges, the highest possible dose should not be more than double the lowest possible dose (i.e., Morphine 2 – 4 mg IV q3hr prn pain is acceptable; Morphine 2 – 10 mg IV q3hr prn pain is NOT acceptable).

VI. **Three additional abbreviations have been added, as required by JCAHO. They are µg (for microgram), T.I.W. (for three times a week), and A.S., A.D., A.U. (Latin abbreviation for left, right, or both ears).**