Being an Extern

Here are some things I was told were good...and bad...when I was an extern. No one will remember to do all of them, and no one will remember to even look for them, but if you strive to do most of this, you will be noted as likely being good resident material barring any egregious character flaws or horrible slip ups.

In general

- always ask the resident how they want you to function. Programs vary widely in how much of the paperwork and hands on activities you are able to do and have a variety of quirks (e.g. one program I went to, the students were never allowed to apply tourniquets...but could do anything else)
- do not expect to suture or do procedures, sometimes the resident needs practice himself, sometimes the attending is in a rush, sometimes it just isn't really allowed...then again some places will allow you to do a case skin to skin...or multiple cases...etc. Btw...if you get to do a case skin to skin, they most likely want you...badly...
- when pimped if you don't know say "I don't know, I'll look it up" (and make sure you do...)
- you may say "I think it's," but if you don't know...you don't know...
- don't gun...you can't hide it, word travels fast, and everyone will know
- be nice and polite to everyone from janitor on up...you never know who knows (or is a patient of) who
- if a resident tells you to go home...go...they aren't testing you or playing mind games...
- if you mess up take responsibility and apologize to the wronged person...no excuses...
- do not get upset when you can't answer all pimp questions...you are not expected to know everything
- don't commit...give reasonable ranges, e.g. depth of 1st MCJ "between 2-3 cm" not "2.2." The calcaneal inclination angle is "decreased" not 70. The HAV deformity is "moderate" with a possible IMA of 14-15 and TSP of 4-5, etc.
- if asked to describe an x-ray or MRI, focus on the "clinical picture" e.g. pt w/right foot wound...go...don't talk about the mild HAV and HTs...focus on the gas and osteo.
- if given a study with no other info, read it all. ST to bone, then distal to proximal
    - standard script:
        - XR = this is a (DP/MO/LO/etc.) view of the (R/L) foot of a (skeletally mature/immature) individual. Radiodensity c/w inc. ST density at 1st MTPJ, radiolucencies c/w gouty arthropathy of 1st MTPJ including medial Martel's sign and overhanging margins. Things are radiolucent or radiodense which matches a dx.
        - MRI = this is a (sagittal/coronal/transverse) (T1/T2) image of a (R/L) foot. Areas of (increased/decreased) signal intensity c/w (depends on view)
        - CT = this is a (sagittal/coronal/transverse) image of a (R/L) foot. Otherwise follows XR (radiolucencies/densities).
        - Bone Scans = areas of increased/decreased uptake...complicated topic...

On Floors...

Things for your pockets

Dressing supplies like 4x4s and Kerlix are too bulky to carry around and are usually easily available so are a waste of valuable pocket space. Here are some essentials that are often unavailable on the floors and their purposes. You will make a tired 1st year on floor work happy if one of these is needed and it is instantaneously pulled from your pocket w/o a fruitless trip to a variety of supply closets. Said 1st year will remember you as "useful, resourceful, and a hard worker," all good things to be written in your file...

Note: other than culture swabs no one cares where any of this stuff came from as long as it's still sterile
(just don't advertise it)

Also when stocking up or if asked by a nurse, never just say you need these things for your pocket, there's <u>always a patient on this floor</u> for which you need the item (wink). At some facilities nsg will be annoyed you're "stealing" supplies from "their" unit
Technique tip: put everything in one of those 1 qt biohazard bags from clinic so you can easily pull it out and see what you have available

Q-tips

- used to probe wounds
- usually have ruler on wrapper = no need for separate paper rulers

saline flushes

- for saline wet-to-dry, flushing wounds, etc.
- remove cap then pull plunger towards you to break seal
- otherwise it will spray all over everyone/thing
- often only found in "medicine room" vs "clean supply" or lying about in general

2/3" silver tape

- less annoying than smaller/larger sizes
- rip off multiple pieces and stick to windowsill/table/etc. before gloving
- after gloving it's annoying and sticks to everything and it makes it more efficient to have it avail

wound culturette tubes

- make sure the tubes used are from that hospital/system!
- white = aerobic
- elaborate vacuum system/blue tip = anaerobic
- green tip = fungal; red tip = nasal; etc...likely will not be used...

suture removal kits

- cutting dsg for rooms on contact, applying packing, and occasionally *actually removing sutures*

packing (any size but preferably ¼" or ½"

- iodoform or "antimicrobial"
- if in jar use fresh suture removal kit so as to not contaminate the whole thing

blades (#10, #15, #11)

- #10 and #15 are the best, try to have both
- #11 if you are some sort of overachiever...unlikely to be used...

betadine swabs

- painting macerated wounds, painting dry gangrene, etc.

alcohol prep pads

- wiping instruments, wiping nails s/p nail c/s

Adaptic (or no-name version = Vaseline/petroleum/etc. non-adherent dsg)

- only cut piece big enough for wound
- do not fold over → maceration

Xeroform (or no-name version)

- NOT THE SAME AS ADAPTIC!
- do not fold over → maceration

Steri-Strips + Mastazol

- any size, but preferably the small ones
- mastazol (the "glue") if possible, can be hard to locate (check OR supply closet), in glass crush tubes

Tools

- penlight = if room is dark hold to illuminate wound for attg/rez
- pen = multiple, not too nice as likely to be stolen by attg leading to awkward confrontations...
- bandage scissors = trauma shears = better + cheaper than all metal ones
- nail nippers
- granola bars/food/money for food
- no-doz (or jet-alert, it's cheaper partner)

GENERAL TIPS FOR ROUNDING

- ANTICIPATE NEEDS OF RESIDENT = implies you can anticipate needs of attgs = good candidate for residency!
- rip off the pieces of tape!
- turn on lights
- if you didn't have time to stock the rooms, put supplies in a wash bin and carry with you
- prepare dsg as needed (open packages, soak in saline or betadine, cut pieces of adaptic, etc.)
- roll up ACEs for re-use (fold Velcro side down away from you so it's on the right side when unrolling)
- know where the wound is before you start cutting down a dsg
- when cutting down a dsg preserve as much as possible and tape together if an attg is coming to see it later (so you don't have to change it 2x's and waste supplies)
- disgusting weeping/bleeding wound? put down a chuck!
- when applying santyl, silvidene, triple, Bactroban etc. remember NICKLE thickness...more = maceration = bad!
- have tools ready (nail nippers, bandage scissors, suture removal kit, etc.)
- chart hunt if permitted a list
- hold leg (gently!) (try to do it on same side so you don't throw out your back)
- hold free ends of dsg down for taping
- get enough supplies for today and for tomorrow (especially if on a Friday)
- always be friendly and polite to everyone
- always introduce yourself and delineate your role
- "please" + "thank you"
- don't be afraid to say "I don't know" or "that's a better question for the resident/attg," the patient may think *you* are the doctor and if you say the wrong thing it'll make it awkward for everyone
- don't ask stupid inane questions which supposedly show your intelligence, if you have a legitimiate question, ask, but don't waste time/annoy the attgs/residents with inane questions, it's a negative

Dealing With Residents

- be yourself...if you have something in common great, if not, still ok...most residents would rather not talk about work, but are happy to answer questions as needed
- don't suck up, we know when it's happening and it's just ridiculous
- you won't like everyone and everyone won't like you...is what it is
- always be polite and don't get too comfortable, remember this is a month long job interview and it's not "in the bag" yet
- just be aware that as a student there will pretty much always be a wall between you and the residents that only comes down once you become a resident yourself. It's not to be mean, it's just to be professional...and unfortunately it's the best way to do it. The more they like you, the more you will get to see through the wall.

Dealing With Attendings

- note: do not suck up to the director, once again, just ridiculous and obnoxious
- in general, I feel it's best to respond to attendings if asked, but not to ask them anything unless you have a good level of comfort with them, once again, you don't want to be the annoying one...

Dealing With Other Students

- don't gun/be nice, the student(s) on rotation with you may end up being your co-residents (did to me...)
- if you don't like someone be professional and keep your thoughts to yourself about how much you hate them/how stupid they are
- try to help your fellow students...even if they don't appreciate it people will notice
- in residency you may have to deal with attendings/other residents/etc. that are horrible people, so stay quiet, professional, and don't throw anyone under the bus no matter how much you want to...it has lost people programs.

So You Like The Program!

- romancing a program is like romancing a member of the opposite sex...you wouldn't take them on a date then never talk to them again (unless you weren't interested)
- if the program is legitimately your first pick, tell them...note that a lot of residents across programs do cross check w/each other so if you tell a few programs you're picking them #1...well just be careful...this is something to make known closer to interviews, not in July...on your first externship...
- if it's a top 2/3/5/etc., also tell them, or just say, "I don't know yet, but you are up there..."
- visit! usually academics are best as everyone (all residents/attgs/director) is there, but you can come in for a day or a weekend, etc. if it works better
- if you have a good rapport with a resident, you can always text questions/etc anytime throughout the year.

NAIL C/S

- do not make the patient bleed
- to repeat, do not make the patient bleed
- cut off the obvious long part of the nail and minimize sharp areas or if pt has specific complaint about an area digging in
- "sterilize" nipper before and after use on pt...your nipper is always "sterile"...
- when completing c/s → "pt to f/u as outpt for definitive debridement"
- just remember you are in a hospital where you can't use a burr, etc. and the main concern is removing a painful nail or nails that catch on socks, not making them look pretty (that's for your office...if you don't think you're above it)
- put down a chuck b/c it's bad enough being in the hospital w/o there being pieces of mycotic nails in your bed too (not to mention it's unsanitary)
- wipe nails down with some alcohol prep pads to get rid of the dust
- put nice lotion on their feet or order AmLactin if they have dry skin
- remember that like it or not nails are the bread and butter of our profession. sorry. so get good at doing them b/c if you end up cutting everyone...no humiliating yet quite lucrative nsg home jobs for you...

OR

Perioperative + Setting Up & Breaking Down

- lights = (graphical representation, view is looking from pt's perspective on bed looking up) [_O O_]
- local = will be on "pref card" → nsg will bring it out...label syringes w/mix...ask if LA bottles are reused; always draw up at least 20...if b/l 40 cc...fill w/18 (pink) gauge or a "fill" needle (red); inject w/25 gauge 1.5"/2" (long ones, blue)
- your gloves + resident gloves = your concern...give to sx tech...
    - "whites" = normal latex gloves
    - "orthos" = thicker latex gloves
    - gloves also be thin for more sensation, non-latex if allergy, etc.
    - if latex allergy = non-latex period...no orthos etc.
    - some residents are quite particular about gloves so keep track of who wears what (like literally...a list)
- tourniquette
    - no more than 3 x around w/webrill in any given spot
    - thigh often need foam tape/surgilube/both to keep from sliding
    - ankle = red @ 250 mmHg
    - thigh = brown @ 350 mmHg
    - some facilities dispose of tourniquets after one use and others reprocess...check w/nsg...

- attg's gloves = pulled by nsg = not your problem
- x-rays = usually residents or attgs have them in a pile, change with each case...not the highest priority...
- other considerations
- EAT. even if you aren't hungry.
- if you're feeling like you are going to faint ask for a stool...sooner than later...it really does happen to everyone...
- again, if you see the white light, stool!
- don't think you are too good to pick up trash, clean up, etc.
- help everyone gown and glove if not scrubbing
- help move pt to bed, move bed in and out of room
- always have a few pairs of gloves in back pocket for moving the pt, cleaning up, etc.
- make bump or acquire one and cover w/chuck; also, put another chuck on the floor at end of bed
- rip off extra pieces of tape (still have to put a dressing at the end of sx which is held with...tape!)
- write your name and position on the board (and the resident too...don't be afraid to ask their name), e.g. John Smith PMS-IV, Roy Snerza DPM PGY-1
- 1st scrub of the day is w/water and CHG/betadine/etc...subsequent can be w/sterilium/avagard/etc.

Assisting

- don't ask a million questions, only if there is a lull in activity, the last thing you want to do is distract everyone from the case, I personally would not ask anything unless between cases
- follow lead of resident...don't want to be annoying and in way but also don't just stand there
- prep as needed or instructed
- hold leg for exsanguination
- be ready with bovie → always bovie coming up (that is, when touching the stat, on the underside versus the top)
- use suction to remove bovie smoke
- if encouraged to anticipate do it (e.g. lapidus you will need 2 curved mosquitoes at beginning to ligate vessels, ask scrub tech for them, skin hooks for a toe a-plasty, senns for bunions, etc.)
- pass instruments back if obviously no longer in use
- wipe instruments on field down
- be ready w/raytech or lap to wipe rongeur/pickups/etc. of debris when used for debridement
- when retracting your retractor should be perpendicular to the incision if possible
- suction but don't get in the way; make sure you suction fluids from basin s/p lavage
- get fresh laps/raytechs if needed
- ready to close? get suture scissors!
- if using prolene gently hold tail away from field (has a lot of memory)
- if using monocryl help the resident by "following" (look it up on youtube...) also, get curved stat for end
- tails → generally skin are longer (like 1 cm), and deep are short (1-2 mm)...some like longer vicryl tails b/c it swells and then you get a hematoma b/c it popped b/c they're too short blah blah blah but if they're too long then you get an abscess blah blah blah...just don't cut the knot...
- when cutting suture drop hand down to skin then rotate slightly so scissor blades are not touching skin (do not want to compromise skin by shearing it off)
- if not scrubbed in: NEVER look/play on phone unless expressly asked to do so. NEVER leave the room unless you have to do something (e.g. get more supplies), help as needed; some say don't sit ever...but if you are sitting b/c you are going to pass out...sit...otherwise stand and at least try to feign interest (we all have done it/been there...)
- get warm blankets for pts coming out of anesthesia (usually 2, in workroom between ORs in refrigerator looking thing)
- get fresh raytechs (sponges) or laps (big sponges) prn
- if a raytech or lap falls to the floor (or any instrument) tell the scrub tech/nsg (e.g. raytech down!)
- help clean up...grab all the discarded drapes etc...some places like you to say "bovie site clear" upon removal of pad from leg and noting there are no burns...just pay attention to what people do and say...
- if you have a bunch of cases in a row, grab all of the needed gloves for yourself and resident(s)
- ensure there are enough gowns...always pick XL...

The Card

- Ask your resident if they would like a 3x5 notecard w/ SAPPAHEMIC, or a photocopy of the post-op note. Some want different things
- 3x5 in chart w/pt ID sticker, date, facility, in/outpt
- why it matters: used by resident to dictate the case...same info goes on post op note...
- SAPPAHEMIC
    - Surgeon: John Smith, DPM
    - Assistant: Roy Snerza, DPM; Jane Doe, PMS-IV
    - Pre-op dx: reason for sx, keep it simple (e.g. 2nd toe infected wound, R foot abscess, HAV, HT, ankle DJD...)
    - Post-op dx: same (unless wildly different)
    - Procedure: once again KISS...R2nd toe amputation, ankle fusion c exfix, R foot I&D, L foot HAV correction
    - Pathology: bone and soft tissue right 2nd toe, anaerobic + aerobic wcx
    - Anesthesia: local c MAC, 13 cc 1:1 1% lido p + 0.5% marc p (or GA...spinal c MAC...pop block c MAC...etc.)
    - Hemostasis: none, anatomic dissection, ankle/thigh tourniquette @ 250/350 mmHg x (however many) minutes
    - Estimated Blood Loss: usually minimal or < 250 mL...if they have to count a pile of blood soaked laps/raytechs check w/anesthesia
    - Materials: only things left inside pt! e.g. prolene, wound vac, screws (just diameter), plates (type, #holes), bone cement, bone graft, packing, drains, etc...if a k-wire was used for temp fixation or whatever...doesn't count! You can ask the rep or nurse to look at the charge sheet where they put down all the hardware utilized (just don't include anything not inside pt)
    - Injectables: anything injected DURING or AFTER the surgery (but NOT the initial LA admin)
    - Complications: none (unless told otherwise...)

Peri-operative Paperwork

- if pt is in house, usually nothing needs to be done except orders and post op SAPPPPAHEMIC note
- if outpt, need to complete a pre-op note which is a "problem-focused H&P," below is a basic guideline
- it is usually completed on a special sheet (ask resident to show you which one, or just use a normal progress note), there are also various other sheets for outpt sx that are facility dependent
- the pt usually has been cleared pre op by their PCP and there will be a normal H&P w/vitals, an EKG, labs, CXR, etc. all on the pts chart
- **example**
    - CC: L HAV
    - HPI: Pt has had sharp pain to L foot bump for past 6 months. She has attempted various conservative tx including padding/strapping/orthotics/shoe modifications but the pain is not improving and getting worse. She presents today for surgical correction.
    - PMHx: HTN, HLD PSxHx: chole, appy SocHx: no tob/Et-OH/drugs FHx: NC ALL: NKDA Meds: reviewed list
    - ROS: no N/V/F/C/CP/SOB, + L foot pain VS: T98.2 P60 RR 21 BP 122/84 POX 98 RA
    - PE: L DP/PT 2/4, CFT brisk, no calf TTP, no edema, no open skin lesions/calluses, +epicritic sensation, MMT 5/5, abduction deformity L hallux w/medial eminence, +TTP to medial eminence
    - LABS: WNL for sx EKG: WNL for sx
    - XR: inc. IMA, TSP 4, abd hallux
    - A/P 46 y.o. female w/L HAV
    - to OR today for surgical correction. NPO past MN, consent signed/on chart, pt aware of all alternatives/risks/benefits/complications of proposed procedure and wishes to proceed. All questions and concerns addressed. Will D/W attg/resident.
    - (signature) John Doe, PMS-IV

Hospital SOAP Notes

- Pod Sx – Student Note
- Pt seen @ BS/HD/etc. No N/V/F/C/CP/SOB. Pain intermittent to L foot, controlled.
- VS: T, Tmax, P, RR, BP, POX (get from computer/chart/resident, or can just do vital signs stable/VSS, afebrile, if told ok to do so).

- PE: as a student, be thorough...as a resident you will get to slack. Things to look at:
    - DSG clean/dry/intact (C/D/I), no strikethough (or sanguinous/serous), evidence of mild/mod/severe sang/ser/pur drg
    - Vascular DP/PT, CFT, calf TTP, edema, erythema, foot temp (cold/cool/warm/hot), cyanosis, etc.
    - Derm wound submet 2 w/hyperkeratotic rim, probe to bone, malodor, seropulrulent drainage, assoc. eryth/edema, no fluctulence
    - Neuro +epicritic sensation, no protective sensation
    - Ortho prior amputation 1st ray, R BKA
- Labs: CBC, BMP, ESR/CRP, vanco trough (can put a "P" in a circle if pending...may not be ordered daily)
- Micro: 4/20/13 L foot wcx: GPC/GNR (or MRSA/MSSA, etc.)
- Rad: XR = osseous erosion 2nd met head, MRI = osteo 2nd met head, bone scan = osteo 2nd met head, etc. in appropriate terminology
- A/P
- DSG Δ w/ DSD, adaptic/ACE
- will D/W resident/attg. (the resident/attg will flesh out the plan)
- (signature) John Doe, PMS-IV

Consults

- more or less the same as what you do for a pre-op note/H&P

Post Op Orders (ADC VANDILMAX...really VANDILAXM)

- Admit from OR → PACU, D/C home when criteria met (outpt) or Admit from OR → GMF under service of Dr. (primary)
- Dx: s/p L foot sx
- Condition: stable
- Vitals: per protocol
- Activity: WBAT sx shoe, NWB, etc. (ask resident)
- NSG: reinforce dsg prn strikethrough, NV status check to R/L LE q15 min in PACU, ice/elevation to R/L LE (if an elective case, e.g. non limb salvage)
- Diet: resume pre-op as tolerated
- IVF: D/C once PO tol (outpt), or flush q shift, HL p PO tol (inpt)
- Labs: none (outpt) or CBC, BMP, PT/PTT/INR next AM, sometimes stat H+H if pt bled out (in pt)
- Ancillary: resume all pre-op c/s, disp #1 sx shoe to R/L ext (or DARCO, etc.)
- Xray: 3 views R/L foot re: s/p foot sx
- Meds: if in pt, all of them that they're on, outpt can be Perc 5/325 2 x once prn pain, Zofran 4 mg IV x once prn N/V, goes last b/c it's the longest