# Tips for MTU

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June 14, 2024

1. *General Tips:*
    a. Show up early and be interested. I typically showed up between 15-30 minutes before morning rounds/dividing the patient list to print the list for the team and check the latest values/overnight events for my patients.
    b. See all of your patients before running the list as a team in the afternoon. We usually ran the list around 1:30-2 PM each day. A workflow that worked well for me was to call all consultants first thing after dividing the list, writing progress notes for all my patients, seeing my patients, then finishing the note.
    c. Each day I would update the handoff section in Epic as well as the hospital course so that discharge summaries could be easily completed as needed.
    d. Read around your cases. Each time I didn't know something, I would search it up on AMBOSS, UpToDate, DynaMed, clinical guidelines, etc.
    e. Be proactive in creating plans and reaching out to consultants. As well, make sure to update families if requested, ask whether patients have a family physician prior to discharge, and give a heads up for discharges for patients so they aren't blindsided.
    f. When seeing patients, I would go see the sickest ones first, then the ones for discharge, then the ones with lower acuity.

2. *Approach to progress notes:*
    a. The key is to have a systematic approach. I typically looked at the latest labs, then imaging, then orders. I looked through every order each day and asked myself whether or not things should be discontinued, modified, started, or held.
    b. I typically always checked CV, respiratory, abdo, volume, and peripherals in my physical exam, and add any others as needed for patients.
    c. I would use a template obtained from a resident to start the progress note.
    d. All problems on the progress notes should be in order of urgency.
    e. There is no need to have bloated progress notes—make sure to delete anything that is resolved and trivial (while ensuring updated discharge notes/hospital course notes), move items to the investigations part of your note. If multiple problems have the same management, just say "as above" or "as per problem X" rather than repeating yourself.
    f. Make sure to note days of antibiotics (i.e., when they started, when is the proposed end date, dosing, transitioning).
    g. Always check vitals, DVTp, diet, recurring orders, etc. These are easily missed if you don't specifically look for them.

3. *Approach to consults:*
    a. I would do a thorough chart review on every patient before seeing them. This included going through their previous medical record for prior admissions, consult notes, discharge summaries, relevant imaging, relevant procedures, medication list, etc. I would also review the ED course and any consultant services that saw the patient before me. I would start the patient note with a template I got from a resident. This would take ~20-30 minutes.
    b. I would get a focused history from the patient, do a physical exam, and finish my note. During the history, try to get a good timeline of events for the HPI, social history, functional status at home, relevant family history, and others as indicated.
    c. When presenting, try to have a consistent problem-based approach ranked by order of problem.
    d. Don't forget to review all investigations ordered. Although patients usually have a chief complaint (e.g., heart failure exacerbation), ensure to also look at all other potential issues (e.g., uncompensated respiratory alkalosis, anemia, UTI).
    e. Ensure that for every problem you have a (suspected) etiology and ranked differential by likelihood, e.g., aLOC 2/2 urosepsis vs medications vs seizure. As investigations return, make sure to update the etiology appropriately.

4. *Approach to call shifts:*
    a. Call at my hospital would either be until 11 PM or until after rounds the next day (26-hour call). On 26-hour call shifts, prioritize ward issues and then see consults. It is important to get as much sleep as possible during these shifts. Any time I wasn't seeing a new consult or managing ward issues, I would return to my call room and try to get rest. Make sure to stay hydrated and eat dinner!
    b. For every ward issue, I would make a note of it on a piece of paper, including patient name, issue, and what I did. This made it easier in the morning for handoff to my team.
    c. I would present all new admits to my team in the morning during handoff.

5. *Approach to studying:*
    a. Other than reading around patient cases, I would do Anki every day. I mainly used the AnKing v12 deck. I would also do 10-20 Step 2CK UWorld questions each day during the week and 60-100 questions each day during the weekend.
    b. For anything I felt weak on, I would review that condition using Toronto Notes, UpToDate, or the clinical guidelines themselves.
    c. I tried to read around my patients and their conditions.

6. *Use electronic resources:* I used the following resources to prepare and study for and during this rotation.

a. Toronto Notes.
b. AMBOSS.
c. UpToDate.
d. Guidelines for specific conditions (e.g., heart failure).
e. Great YouTube videos:
    i. Dirty Medicine “How to Present a Patient to Attendings”: https://www.youtube.com/watch?v=pEVQirClQwI&list=WL&index=5&ab_channel=DirtyMedicine
    ii. Monica Jeong “For Medical Students” and “For Residents” playlists: https://www.youtube.com/@MonicaJeong/playlists.