Shadowing A Physician

Shadowing a physician is a great way to learn about a specialty. Following are some tips on shadowing a physician.

**Arrive on time:** Arriving on time is being respectful to the physician who has taken the time to accommodate you in their busy schedules. It’s better to be early than late.

**Dress Professionally:** Clean professional attire is expected along with your student white coats.

**Observation:** Your role is to observe and any participation is under the direction of the physician you are shadowing.

**Be Respectful:** Remember that patients are allowing you into their personal lives – you must respect that. Therefore privacy of information is an essential code of conduct.

**Be Grateful:** Remember to thank each patient that you encounter, and at the end of your shadowing session thank the physician whom you shadowed.

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It can't be...I'm not ready. I simply don't know enough yet. Won't the patients see that I don't have an MD after my name? Won't they recognize the fact that I have a short coat? In a word: nope. Generally, patients treat me as they would any doctor— with respect, concern, and an expectation for answers. However, the biggest difference that I notice between those with an MD and those without, is that, well, I don't have answers per say. Sure, I studied until I couldn't cram any more information into my head for my USMLE Step 1 exam and passed with flying colors, but often times I feel as if I don't know anything at all— at least not what I need to know in order to be a physician. Alas, it's too late because the last five weeks, I have been working at the Kaiser Permanente on Sunset Blvd as a family practitioner. During our third year of medical school, there is no designation between short coats and long coats on our care team. Many times, I have been responsible for an entire patient interaction, including history, physical exam, diagnosis, plan, procedures, prescriptions, imaging and referrals if necessary (under the supervision of my preceptors of course). I've seen young patients and old patients, given acute care and chronic care, and improved my medical Spanish about ten fold. Along with students from Keck, UCLA, and Western, our short coats walk the halls of the clinic each weekday. Assigned to a different attending each morning and evening, we work one-on-one to help the health of the community a single patient at a time.

Many different patients already know me as Dr. Cohen. Initially I felt the need to correct them, but eventually I accepted that patients often can't tell the difference between medical students and doctors— we both wear white coats, carry way too many books and odd contraptions in our pockets, have stern but friendly looks on our faces, and have the infamous and inescapable stethoscope draped around our neck. Each day brings a new encounter. First, there are the easy questions which I have a hard time answering— "Doc, what's wrong with my neck?" "What's this thing on my arm?" "How much does that cost?" "Will you prescribe me Januvia/why won't you prescribe me Januvia/why haven't I yet been prescribed Januvia?" "Can I go to Pasadena Kaiser?" etc. Then there are the hard questions that I find easier to answer— "What is diabetes?" "Why is my cholesterol high?" "How can I stop smoking?" "How do I lose weight?" etc. Family medicine definitely has a wide range of conditions which it sees, anything from deliveries to ear infections to a-fib to osteoporosis. Due to the extended scope of medicine, family practitioners always have to have a lot of information in their head at a single moment in time, and every family doc has the same thinking process. First, what's the worst thing that this could be and what would I do. Secondly, what is the most likely thing that this is and what should I do. And lastly, now that the patient is here, what else can be done to ensure that they can "thrive" in life (Kaiser’s motto if you haven’t heard it on the radio).

Continued on page 4, see Cohen
Third Year Blog

Ashley Prosper, MSIII
Pediatric Rotation

“Reflexes”

Primitive reflexes. You study them in neuro, you relearn them via FirstAid, and you even manage to reproduce all of this information on your boards, but you don’t fully appreciate them until you have elicited them in a newborn. Take the Babinski sign for example. Decades ago, Dr. Babinski, a Polish neurologist, practicing in France, discovered that when the lateral sole of a healthy patient’s foot was rubbed with a pointed object, their big toe flexed downward. Patients with upper motor neuron defects, on the other hand, would extend their big toes upward while the rest of their toes splayed outward. How he managed to discover this reaction, I wish I knew.

After making what seems like hundreds of attempts over the course of two years of ICM I managed to see one up-going big toe, and it was a semi-convincing one at that. At the time, of course, each negative finding was a relief. An up-going Babinski in the ICM patient population, made up invariably of adults, is a troubling sign of neurological compromise. Still, witnessing an up-going big toe for the first time was an exciting event, as I was finally convinced the response existed. Imagine my delight, then, when in the newborn nursery this week, each and every baby’s foot produced a brisk up-going Babinski, a reflex perfectly normal and expected of their day-old baby brains.

As a newly promoted third year medical student, freshly planted on the wards, I have begun to realize that I have quite a few newly discovered reflexes of my own. Some of these are just plain ridiculous: The sound of a pager going off makes me reach for my coat pocket, despite the fact that 9 times out of 10 it is a resident three feet away being paged and not me. When asked a question by my attending on morning rounds I immediately look down at my notes, despite the fact that if I gave myself just one second to think, I would be able to recall the answer from memory. Hearing a code called over the intercom in the cafeteria, I stop talking mid-conversation and listen as if they’re going to call me in an emergency. Laughable, yes, I know. Other reflexes cause me to second guess myself despite the fact that I’m following orders. Seeing a patient cry with each needle stick makes me question my need for additional labs and waking a child from sleep at five in the morning makes me feel absolutely villainous. Then there are the reflexes that let me know an emotionally trying day is ahead. Walking into a pediatric patient’s room and seeing that they’re handcuffed in bed with a sheriff at their side puts a knot in my stomach. Realizing that a child’s injuries are of non-accidental origin at the hands of their caretaker elicits simultaneous sensations of nausea and rage.

Some of these reflexes will likely go the way of the Babinski, briskly positive in my newly minted third year state, soon to become negative with maturity. In the case of my reflexive instinct to glance at my jam-packed clipboard during rounds, I’m hoping for sooner than later. Other reflexes of mine, I feel will linger much longer if not indefinitely. The incarcerated minor I cared for and the battered children I examined are unfortunately unlikely to be the last I encounter. While training at a large metropolitan county hospital I know that I will bear witness to wounds physical, psychological and social in nature that the majority of society hopes never to have to think about. One way to cope with seeing and treating these wounds day in and day out is to develop a thick skin and become calloused to them. Maybe that coping mechanism is inevitable and my current reflex responses are indeed primitive. For the time being, though, I plan on keeping these up-going Babinski’s of mine. ☺
Cohen, Continued from page 2

Many of the interventions focus on prevention: obesity, smoking, dyslipidemia, high blood pressure, etc. The numbers and parameters are mind boggling, as after certain ages patients must be screened for colon cancer, breast cancer, cervical cancer hyperlipidemia, diabetes, hypertension etc. I can’t tell you how many practice exam questions I’ve gotten wrong considering these things. Imagine having to remember that all patients have to get a pap smear every year, but some say every two years, but every 6 months if they have ASCUS with positive HPV, but may be every 2 weeks if they have ASCUS without HPV testing available, or if they’ve had 3 serial negative paps with lack of sexual history, or simply not until they have had intercourse for the first time within three years, or until they reach 21 whichever comes first...you get the point.

Another area which has been a pleasant surprise is getting acquainted with and using the Kaiser EMR (Electronic Medical Records) system. At Kaiser, with the click of a button physicians can access prior visit notes, labs, imaging, current problem lists, prior diagnoses and active medications taken (no more, "I take so many pills, I don’t remember what they are!") to better coordinate care. Also, every room is equipped with a computer of its own, providing useful information with the minor consequence of awkward patient interaction. Often times I would ask relevant past medical history questions, only for the patient to say,” isn’t that in your computer?” Also, while I think that I’m a decent multitasker, writing a progress note in front of the patient can provide some strange interaction. I mean, how much can a patient stay quiet and listen to the clutter clatter of the keyboard before asking, “What are you writing?” If only we had an ICM workshop on how to deal with computers in the exam room! Regardless, while I know much of nothing and yet quite something about medicine, it’s clear that EMR will be incorporated into any health care reform. From what I understand, the future EMR and even the medical system will resemble much of what Kaiser has already implemented. From the way that I look at it, I’m simply being trained in preparation for treating the generation of information. If only I had time to befriend all my patients on Facebook and Tweet them their prescriptions...*sigh* I wonder what it will be like to be a physician of the future. ✌

Opportunities

Campagna Scholarship

Campagna Scholarship is for medical students in their first or second year of training who are intending a career in neurological surgery. The selected student participates in a 10-Week Summer Research program with neurosurgery faculty at Oregon Health & Science University.
For more information, please visit: www.ohsu.edu/neurosugery
Applications are due no later than February 26, 2010.

American College of Surgeons

Are you interested in Surgery? The American College of Surgeons (ACS) will be hosting their Medical Student Program on:
October 11-13, 2009
McCormick Place West
Chicago, Illinois
For more information, please visit: http://www.facs.org/clincon2009/registration/index.html