HOUSE OFFICIERS' SURVIVAL MANUAL

"YOU GUYS NEVER LISTEN" - A REBUTTAL

DEDICATION

To Dr. Silen, a great surgeon and teacher,

without whom there would be no need for this manual.

The following collection of random ideas has been gathered without effort at any specific organization. An attempt to assist the house officier searching for information on a specific subject has been made by entitling each entry with the main subject of that entry.

BANDAGES AND DRESSINGS

DO NOT TOUCH ANY DRESSING WITHOUT DR. SILEN'S EXPRESSION PERMISSION AND KNOWLEDGE OF SUCH.

As there is no bleeding intraoperatively, it is not necessary to use a large bulky postop dressing. Several layers of 4x4's are adequate. The skin surrounding the wound is painted with benzoin (don't use the spray benzoin) and after it gets tacky the wound may be dressed with either adhesive tape if you;re in the OR or paper tape if you're on the floor.

In biliary surgery, drain sites are dressed separately such that the dressing over the drain can be lifted up and the drain slipped out at the 24-36th hour post-op (if it is not draining bile).

CHOLANGIOGRAMS

A. Diagnostic cholangiograms - as stated later under xray preps, there is no such thing as a routine prep. Specifically, there is no prep usually ordered for the T-tube cholangiogram and the so-called "routine" prep prescribed by the xray dept. is an atom bomb compared with the gentle prep of MOM that Dr. Silen's usually prefers.

B. OR cholangiogram -

a. The requisition - be sure to fill this out before coming to the OR - at least before the operation commences. Forge-ting to do this kills much time in the OR, much running around, and alot of gastric secretion on both the part of Dr. Silen and his resident.

b. Positioning of patients for intra-operative cholangiograms -

1. Check to see that the grid is on the OR table - before the patient is on same.
2. Draw an imaginary line starting at the right mid-clavicular point until it crosses the right costal margin. At its intersection with the right costal margin draw a 2nd line perpendicular to the 1st - this second line should be the mid-point of the xray plate (most xray grids have an eye-screw with a string or adhesive tape marker on their sides to mark this mid-point.)
3. The patient must be over to the right so that he is almost flush with the side of the gird.

DRAINS

Drains do not stop bleeding. Drains are to be used only for specific purposes - as in biliary tract surgery, to drain bile.

Drains should not drain blood.

Drains are bug chutes.

THE EIGHT O'CLOCK CALL

After 8 p.m. when the 8 o'clock temps are supposed to be taken but never are make rounds to collect these temps (usually this means requesting that they be taken on Dr. Silen's patients) and make quicky rounds on the patients.

A call at 9 p.m. will be made to Dr. Silen to report this information; be prepared to bring him up-to-date on important I & O's.

Do hct's on those patients whose fluid balance is tenuous or rapidly changing.

HISTORY

"If you listen, the patient will tell you what's the matter with him."

I & O

Every patient on IV's and beginning oral alimentation should have an I&O summary sheet filled out by the HO himself. ... by the HO ...

Weight should be recorded daily - when pertinent, hcts, lytes, etc. ... should also be noted on the sheet.

Keep the sheet up-to-date - besides the fact that Dr. Silen insists on it, you can't write for fluids accurately without the info it collects for you.

Don't leave the filling out of this sheet until the last minute before rounds in the morning because invariably there is one I&O - always on your sickest patient, the one with the most tubes plus an ileostomy - which requires some deciferring. In general, it is best to get this task done as soon after 12MN as possible, so that the appropriate nightingale can be called and asked to explain her contribution to the confusion.

Keep a running total of the mEq. of Na and K given in the course of the day - there are spaces for this on the sheet under Intake.

A word of advice: when the 3 holes on the sheet wear out and the sheet is found floating free in the chart, attach gummed reenforcements before it gets lost (it will for sure - then you're stuck with the choice of catching hell for letting it get lost or the monumentous task of redoing the sheet from the old I&O's.

INSTRUMENTS

1. Dressing forceps - in the OR, do not use them. Use instead a long straight clamp. With dressing forceps you are unable to clamp any bleeders; they are bulky; they slow you up.
2. The clamp - the clamp referred to above is not to be used to poke - sooner or later you'll poke a hole through the bowel.
3. Kelly clamps - "All good surgical house officiers have Kelly clamps."
   A. In the OR, a Kelly is not a Kelly, it is a Mayo.
4. Scissors - "All good surgical house officiers have bandage scissors."

MEDEX

The medex is to be checked each and every morning before rounds for every patient noting the type and frequency of medications.

Note particularly the frequency of pain meds and also the time of day it is given -if it is being given the same time every day, this suggest that it is the nursing staff passing out meds rather than the patient requesting

Check especially that all important meds such as antibiotics have been give

Pain and sleep meds should be written on a day to day basis - no standing orders permitted initially in the patient's hospital course - this is subject to change later.

Meds which have a changing dosage schedule such as steroids should be written for on a daily basis writing for the dose for the following day the preceding morning, thus Tuesday's dose is written for on Monday morning.

IN THE OR

1. Arteries - large arteries (and ducts) are ligated with 00 silk plus a 000 silk suture ligature.

B. Drapes
1. The drape itself - drapes are used as they come from the sterile pack - folded in half - folding and refolding drapes is a waste of time and lends itself to contamination.
2. Draping - drapes folded in half as they are straight out of the pack are placed on the operative field - on cases in which xrays may be taken, they are sewn in place using a heavy cutting needle. In tying these drapes down, the resident is reportedly contaminated invariably by himself.
While draping the betadine sterile prep is left alone.
Dr. Silen does not use sticky drapes and does not go through the rigamarol of blotting off the betadine.
3. Skin drapes - Dr. Silen uses two skin drapes around the abdominal wound and these are either sewn in or clamped with towel clips to the skin.
a. Technique - Hold a toothed forceps in one hand and grasp the edge of the skin; feed the towel to the skin edge so that it may then be fix in place.

C. Hemostasis - when vessel are clamped, the hold the clamp as it is placed on the vessel - don't twist the clamp around.

D. The appropriate hesitation - it is appropriate, indeed, mandatory that one hesitate after pulling a needle thru tissue - this enables Dr. Silen to grasp the tail of the suture that is within the eye of the needle and begin tying his knot smoothly.
a. It is also mandatory that one hesitate before removing a clamp on a vessel - this is necessary so that you are sure he has placed his knot securely.

E. The incision - as Dr. Silen makes his incision one should have in his left hand a sponge to provide traction and in his right hand a snap - a straight snap - always keep a straight snap or some instrument in your right hand.
a. As the incision is made gentle traction is placed on the skin.
b. Be sure not to place too much traction on the skin or he will accuse you of skewing the wound.
c. In the are of the xiphoid, extending the skin incision for an inch above the tip of the xiphoid is a key manuever - "in this are, an inch is worth a mile."

F. Packing off the wound - In packing off a wound, as in all other aspects of life, position is everything.
a. Do not use too many packs and do not wad the pack into the wound.

G. Prep table - sterile towels should be placed around the edges of the prep table and while the anesthetist is messing around, the prep table is brought over to the operating table and the resident stands posed to begin his scrub as soon as the intubation is complete.

H. Surgical scrub - 2 sterile towels should be placed on either side of the patient running from the axilla along the mid-axillary line down as far they will go.
a. 10 minute prep - a GENTLE 10 minute by the clock surgical scrub with betadine should be performed by the resident. The resident need not have scrubbed himself first before doing the surgical prep. If he has not scrubbed yet, he merely wears a pair of sterile gloves and scrubs himself afterwards while Dr. Silen is draping the patient. If he has already scrubbed, he should then gown and glove and do the 10 minute prep and then change gown and gloves.
1. After the 10 minute prep, 2 dry towels are used to blot the moisted skin.

2. One cannot over-emphasize the gentleness of this prep because too vigorous scrubbing of the skin causes hyperemia and excessive bleeding - "I'll lose more blood on the skin incision than the rest of the operation."

I. Sponging - when sponging the wound, do not wipe but tamp the area.

J. Sterile technique - breech of sterile technique drives him bananas.
   a. From the resident's point of view, keep in mind the following - only the "strike zone" is an area of sterility; that is, from the top of the shoulders to the waist
   b. Do not fold the arms and place gloved hands in the axillae.
   c. It is acceptable to place the hands in the pouches of the gowns, but these gowns are being phased out with the purchase of new ones which do not have pouches - there is the risk that the cloth hidden from view may be defective.

K. Suction - Put a Mayo (Kelley) clamp on the suction tubing so that it does not hiss throughout the case when it is not needed.

L. What to do - "Don't just stand there, do something!"

ORDERS

A. Orders are to be written so that they are idiot-proof.

B. Orders should be written well beneath the preceding orders so that no new orders are missed.

C. Orders should be numbered and a line skipped between each new numbered order.

D. Orders which are important or out of the ordinary should be brought to the attention of the head nurse and the nurse who will be carrying out that order.

E. Pre-op orders should include an order to have the patient void at 5a.m. and weighed in at that time on the morning of the operation.
   a. Note: you should plan to put in all IVs, CVPs, Foleys, NG tubes, etc. at this time too.

F. Anesthesia pre-op orders need to be checked carefully - they sometimes get carried away with their doseages of pre-meds compounding the post-op problems created by their intra-operative poisons.

G. Pre-op orders are to be written so that they can be checked by Dr. Silen on rounds the morning prior to the day of surgery (but not too soon, or the nightingales will screw it up - not earlier than midnight the night before the morning prior to the day of the surgery).

PRE-OP PREPARATION

A. Re: the johnny and the IV - a pet peeve of the Dr. Silen's is to have the IV inserted with the patient's arm still within the sleeve of the johnny on the morning of the operation - thus, the patient arrives in the OR and a lot of dancing around ensues while extracating the patient and his IV bottles and lines from the clutches of the johnny

B. The prep - check to see that the patient has been prepped before he leaves his room.
   a. On all abdominal cases, include nipples to groin.

POST-OP CARE

A. Oxygen - almost every patient with an upper abdominal incision is to have face mask O_2 for 24 hours post-op.

B. Voiding - it is the resident's responsibility to see and encourage and stimulate the patient to void post-operatively - he must visit the patient every 30-45 minutes until he has voided or until you and Dr. Silen are convinced that it is a lost cause and a Foley is called for
   a. God help the resident who has to cath a "neglected" patient.

b. Check that the patient is not distended and does not have the desire to void on supra-pubic compression.
c. Dr. Silen will be irritated with you even if you are with him himself doing something that is necessary and appropriate whenn he realizes that a post-op patient hasn't been attending to.
1. It is better to excuse yourself and the check the patient - rarely he will absolve you of this responsibility.

PROGRESS NOTES

A. Each progress note is to be headed by the date, time, and post-op day number.
B. If available the 8p.m. temp should be included in the heading.
C. The following categories are suggested:
a. Sx - include how the patient feels and other subjective items
b. P.E. - lungs, all sites of current and past IVs, plus the area of the pathology
c. Lab data - heme, bacti, chem, xray, EKG
d. Impression - how you put it all together with the pros and cons
e. Plans
f. Signature - if a medical student has written this note it is necessary to read it and countersign it prior to morning rounds
D. Notes in the chart reflect one's thimking.

PACKING

Dr. Silen dislikes (abhors) the "pernicious practice of post-operative packing."

ROUNDS

A. Morning rounds should be made prior to Dr. Silen's arrival at 6a.m. Mondays thru Saturdays and at 9a/m/ on Sundays and holidays.
a. It is suggested that you begin no later than 5a.m. on non-operating days and no later than 4a.m. on operating days until you get the hang of it.
B. A Check-list is helpful with the following items to be accomplished for each patient: 1. check the I&O summary sheet,2. make sure a 5a.m. weight is available for round,3. write all orders,4. check the medex, 5. countersign all student notes; 6. do P.E. on each patient
a. Additional task may be necessary in special instances like irrigating a tube, changing a dressing as in an AP resection, etc.
C. Re: the P.E. - don't forget to scrutinize the patient for phebitis = Dr. Silen is a bug on this - it is also a great cop-out for an unexplaine fever
D. Re: I&O - have an approximate idea the I&O from MN to the beginning of rounds
E. Keep a list of all lab data ordered - Dr. Silen will ask what they are on evening rounds even tho the lab sheets aren't back yet from the labs
a. This necessitates calling the lab during the day after the desired test has been run
b. It is easiest when students are on the service to assign each student a patient and make that patient and everything about him that student's responsibility - this way you have some one person to ask what and why not - he should get the lab data he orders on his patient and whatever he doesn't do by a reasonable time, just do yourself - this approach saves a lot of hell on the resident and gives the student his crack at carrying the ball - if he blows then you have to step in to save yourself (and the patient)

by a dressing cart you can pick up a debridemont set, gloves, 4x4's, betadine, steri-strips, benzoin, etc., etc. on the way to the patient's room - this saves a lot of leg work.

G. Try to see all xrays before Dr. Silen does - he loves to pick up things that HOs and radiologists miss.

THE SERMONS

A. The pre-op sermon - the sermon is a speech given to each patient pre-operatively - it is designed to explained what the respiratory problem is post-op and how best to avoid problems. There is also a small demonstration showing the patient how the respiratory effort is increased after abdominal incisions and showing him how to exercise his legs.

a. The Sermon:

1. Why the problem - secretions collect in the lungs and plug bronchia tubes which leads to atelectasis and pneumonia.
2. How to avoid the problem - take 10 deep breathes and cough x 3 ever hour to raise phlegm. Remind the patient that nonproductive coughi is still important and shows what a good job he is doing in clearin his secretions.
3. Will my stitches break? - every patient worries about this post-operatively and this is something which should not worry the patient. Assure him that he will not bust open, even with the most vigorous coughing.
4. Post-op discomfort (N.B.: avoid using the word pain) - medicine will be available for incisional discomfort which may occur during deep breathing and coughing - this discomfort is not harmful -the medicine will take the edge off the discomfort but don't expect it to abolish the discomfort.
5. Demonstration - have the patient take a deep breathe lying relaxed in bed. Then have him lift his head off the pillow and take a deep breathe. Comment that this restriction in respiratory effort is very similar to that experienced post-operatively.
6. Leg exercises - dorsiflex the feet and wiggle the legs 30 or so times an hour.

B. The discharge sermon - specific instructions may vary with varying procedures but in general the following are applicable to all abdominal cases:

a. Do what you feel what to doing including driving (mention that driving should be put off until the patient feels that fear of incisional disfomfort is pretty much gone - being afraid to turn around to see what's coming because of pain is a relative contraindication to driving)

b. Do not lift anything heavier than your (wife's) pocketbook for 6 weeks

c. Anticipate that you will get tired easily

d. Don't bathe until at least 12-14 days post-op, and/or until the sutures have been removed (including retentions).

SUTURES

A. Skin suture - placing of

a. Skin sutures should be placed one cm. apart and one cm. in width.

b. They should be alternating - simple and mattress sutures.

c. There should be no tension with a skin suture.

B. Suture removal

a. When removing sutures as well as stays, the wound is first painted with betadine, st riley of course.

b. The sutures are then individually cut , each away from the knot.

c. The para-wound area is painted with benzoin.
d. Then with steri-strips ready, the sutures are removed one at a time and steri-strips are applied as you go.

C. As long as there are any sutures in the the wound, a dressing is employed.

TUBOLOGY

A. Tubology is the art and science of handling tubes, specifically in this context, the NG tube.

B. Type of tube - for nasogastric intubation, a #14 Levine tube is used
   a. For decompression in the usual situations, this tube is adequate and as comfortable as you can get - larger tubes for routine use are unnecessarily uncomfortable.
   b. In the bleeding patient or patient with food in the stomach, even an #18 is too small to empty the stomach - an Ewald tube is then used.

C. Passing the tube - in general, a tube is passed while allowing the patient to have sips of water.

D. Taping the tube to patient - use ½" tape (adhesive), long enough to run from the forehead, down the nose, and onto the tube for a couple of inches.
   a. At the point where the tape begins to run over the tube, split the tape in two and wrap the tails around the tube in opposite directions.

E. Connection the tube up - the tube is usually connected to a Gomco suction machine. The following points are worthy of note as they drive him nuts when he sees they are overlooked.
   a. Check that the glass rubber junction where the tube fits over the glass connector is not a spot for kinking of the tube - be sure that the tube is well seated on the glass connector to avoid this.
   b. Check to see that the machine itself is a working number - there are several units which never work and never get fixed.

F. Positioning the tube - position is everything in life and this is true in tubology also.
   a. Starting at the anterior nares, roughly two black lines should be visible. This has proved to be an excellent guideline.

G. Irrigating the tube - unnecessary!!
   a. Irrigation is necessary only when there is food or clot in the stomach - see above.

H. Malfunctioning tubes - check to see that you are hooked up to a working Gomco and that there is no kinking in the lines esp. at the glass-rubbe junction.

XRAYS

A. Seeing them - look at <u>all</u> available xrays on every patient
   a. You'll be amased what others have missed.

B. Prepping for them - nothing is routine - remember this and you make out alright.

GLOTZERY OF TERMS, QUOTES, AND MISC.

Silen's First Law: "Doctors are dangerous."

Rosoff's Corollary: "Some more so than others."

Surgery: "Surgery is all detail."

The Scrub Nurse: "the chastity belt of the OR."

Flea: Mope: Swarmi: medical man or internist.

Flea Circus: Medical service.

Fat Boy: basically term of endearment - - note tone though.

Big Boy: same as Fat Boy.

Halstead

Red cell: that which should not be seen in the OR.

ERBCL = Estimated Red Blood Cell Loss: Silen's version of the EBL.

Nuggerin': a descriptive term of an action or motion which Dr. Silen interprets as indecisive, inept, inappropriate, unecessary, dangerous, wasteful, repetitious, mistimed, miscalculated, unadvisable, stupid

Sitting on it: "Stay on it, sit on it, don't play with it."

"I feel a memorandum coming on."

"There are no mysteries in medicine, just mysterious doctors."

"Do it in your spare time."

"Make the anastomosis in heaven and the patient goes to hell."

"Pull up a loose stool."

"Come into my orifice."

"If I could only be my own first assistant."

"The New England Journal of, excuse the expression, Medicine."

"Hell, he lost less blood during that operation than he would if he underwent a medical work-up."

"Iatrogenesis imperfecta profunda."

"Get the light somewhere in the vicinity of Massachusetts."

"Just like night follows day."

"B.S." = before Silen.

"Better to be lucky than smart."

"Get that damn fleatern down here and show him what a real gallbladder looks like."

"If you're a good boy..."

"You guys never listen!" - IF YOU STILL BELIEVE THAT, DR. SILEN, SEE THE ABOVE!