Schulich School of Medicine and Dentistry

Guide to Ace Clerkship

"The student begins with the patient, continues with the patient, and ends his studies with the patient, using books and lectures as tools, as means to an end."

- Sir William Osler, 1905

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Contents

Useful Resources for Clerkship

The decision of what books to buy in clerkship is controversial. Most medical students already have a wide assortment that will serve them well. These days, many of you will be studying online copies of textbooks on your laptop/iPad and using a smartphone instead of pocket references.

We advise basing your decision to buy books on what specialty you plan to enter and how much time you will actually spend reading during clerkship. Each rotation will present you with a list of their own departmental recommendations – some good, some not so good. Also remember, if you are hesitant about paying money for new books before getting a good look at them, try searching the UWO library system or borrowing from a friend. There are plenty of free resources available!

Smartphone Resources

The usefulness of a smartphone in clerkship should not be underestimated. There are literally hundreds of medical apps available for your use. With that being said, its easy to download twenty apps, and use none of them. Here we've listed a few apps which have been useful to us during the 2015-16 clerkship year.

1) *Medscape*
   This free app is a mobile version of the eMedicine site, and concisely summarizes a large variety of medical conditions as a quick summary to reference on the go. Also good for quickly referencing the class and dosage of a large variety of medications.

2) *Lab Values*
   This free app gives a listing of over 300 lab values for on-the-go reference. Also provides some interpretation for abnormal results.

3) *Qx Calculator*
   Pretty exhaustive calculator for anything you will need in clerkship.

Other digital resources can be found at this Western Libraries link:
http://guides.lib.uwo.ca/c.php?g=270742&p=1840044

Books

The key for using textbooks in clerkship is to find reference books which neatly summarize information and allow you to learn the basics. You will not have time to read detailed specialty specific textbooks on each rotation. There are several very good textbooks available, which are not listed here. However, we provide a list of textbooks which are commonly used by clerks due to their readable, succinct style.

1) *Toronto Notes*
   This book is good as a topic review before beginning rotations, and when reviewing for exams. The clinical handbook is compact and can be very useful on new rotations. Comprehensive, accessible, effective.

2) *The Stanford Guide to Antimicrobial Therapy*
   This small reference book is an authoritative manual on pathogens and antibiotics (the next best thing to a face-to-face conversation with an ID specialist!) Somewhat cryptic, but if used well can give you a handle on infectious disease on par (or superior to) many residents.

3) *Tarascon Pocket Pharmacopeia*
   Contains almost all the drugs ordered on your rotations, with information regarding indications and CANADIAN dosages. There are many free smartphone apps that serve the same purpose, but for those of you wanting a hard copy, this is a universally recommended resource.

Other Textbooks Recommended by Prior Classes:

- *The Calgary Black Book*
- *Care of the Medical Patient*
- *The Oxford Handbook of Clinical Medicine*
- *Cecil's Essentials of Internal Medicine*
- *Current diagnosis and treatment in Surgery*
- *Recall Series*
- *On-Call Series (Principles & Protocols, Surgery, Medicine)*
- *Lange Casefiles Series*
- *NMS Review Series*
- *The Intern's Pocket Survival Guide*
- *Essentials of Clinical Examination Handbook (concise guide from U of T)*
- *Pocket Medicine (Massachusetts General Hospital Handbook of Internal Medicine)*
- *Clinical Microbiology Made Ridiculously Simple*

One of the best resources for finding really good books is your resident(s). See what they would suggest.

To save money, share pocket references with classmates who have a different rotation schedule than you!

If you are more comfortable with electronic devices, you can find PDF versions of these textbooks and have them handy on your smartphone or tablet. Make sure that the PDF is searchable and that you use a PDF viewer with good search functionality.

Online Resources

Most of your clerkship will be spent in centers with ready access to the internet. **Being able to access online information quickly (using a computer or your phone) is a crucial skill to polish.** You will likely find it much more useful in clinical practice than in the pre-clinical years. Some useful sites for this include:

1) *American Academy of Family Physicians* – *www.aafp.org*
   Quick search of a large library of handy review articles

2) *CMA* – *www.cma.ca*
   Included with your CMA membership is online access to MD Consult as well as OVID online access to a ton of full text journals (ensure you have your CMA number)

3) *Medscape* – *www.medscape.com*
   Medical news, articles, and a medical student section full of handy resources

4) *eMedicine* – *www.emedicine.com*
   Free, reliable, online textbooks by medical professionals for medical professionals

5) *Wikipedia* – *www.wikipedia.org*
   Usually the fastest way to get answers to questions

6) *UpToDate* – *www.uptodate.com*
   Great for evidence-based information. Also useful for printing out patient information handouts. NOW REQUIRES A SUBSCRIPTION. Is it worth it? We can't answer that for you. Some people love it and are willing to fork over $$$, others are happy with free resources.

Again, a great way to get access to subscription-only websites is through Western Library's clinical outreach page: http://www.lib.uwo.ca/programs/clinicaloutreach/

Approach to the Many Types of 'Rounds'

There are different types of rounds. Your first day, the resident you are with may ask you to show up tomorrow at 7:00am for "rounds". Rounds vary somewhat from specialty to specialty with regards to who is present (residents and staff vs. residents only) and length (orthopedics rounds = 15 patients in 30 minutes vs. medicine rounds = 10 patients in 3 hours). In general, the main forms of rounds are:

1) **Patient Rounds** – This involves seeing patients assigned to your team (there is usually a team list on PowerChart) with the residents and clerks +\- consultant, and dealing with any issues left over from the evening and making plans for the day.

   Clerk's Role – Consider showing up 5-10 minutes early to print out the team list for each resident. Try to track down a cart and load up the binders (aka charts) for all the patients your team rounds on. When the team has arrived you will begin to round. Take along the cart and keep up with the team as you move from patient to patient. Push the chart rack down the hall. Grab the patient's charts when going in to see them. Grab the patient's bedside chart containing vital signs, and write a progress note (SOAP format explained later). Usually these responsibilities will be divided up among clerks/junior residents who are rounding. During your Medicine and Pediatric (CTU) rotations you will be given the responsibility of following your own patients. Make sure you know their medical issues, current lab-work and investigations and plan forwards and backwards before rounds, as the consultant/chief resident will usually ask you a question or two regarding the status and plan for your patients.

2) **Team Rounds** – A staple of medicine, often with social work, PT/OT, and/or pharmacy. You meet with the team and go over patient progress, and management plans. This may occur either before, after, or instead of patient rounds. Often referred to as "running the list" when done quickly.

   Clerk's Role – Know your assigned patients. Know their meds, any changes overnight, the plan for the day, and the overall plan.

3) **Site Rounds** – Are not a large part of clerkship. Usually held after patient rounds or at lunch-time. All teams at a certain site meet to discuss patients (as in mortality and morbidity [M&M] rounds), discuss case presentations, or discuss a topic). Questions are often asked of the clerks in this setting.

   Clerk's Role – Read around the topic of the day, and be prepared to answer questions. Say "I don't know" if you don't know the answer. NEVER EVER SHOW SOMEONE UP. If you know the answer to a question asked of someone else and they obviously don't know the answer wait until you are asked or the group is asked to answer. When food is available show up early to avoid interrupting the flow of rounds if possible (and to ensure you get the food).

4) **Grand Rounds** – Usually held weekly or monthly. All teams from all sites in a specialty meet and discuss case presentations or other topics. These rounds are somewhat hierarchical with consultants sitting up front. Clerks are generally not asked questions during grand rounds.

   Clerk's Role – Drink your free coffee, eat your muffin and pay attention to what's being said as it may turn up during the day's discussion in the OR, on the ward, etc.

How to do Clinical Notes Well

There are a large variety of clinical notes which you will be asked to dictate or write throughout clerkship. Broadly, there are four types of notes. The first type is the daily progress note written in patient charts whilst rounding on in-patients in surgery, pediatrics, ob-gyn, and internal medicine. The second and third types are the admission and discharge notes which are frequently dictated and transcribed into an online document listed on the patient's record on PowerChart. The fourth type of notes are clinical notes, which are typically dictated for out-patients seen in clinic follow-up. All of these note types are highly variable between services, and most residents will be very happy to outline what their service would like to see in various notes.

NOTE THAT IT CAN BE EXTREMELY HELPFUL TO SCAN THROUGH A FEW PATIENT'S NOTES WHEN YOU COME ON SERVICE TO GET A SENSE FOR WHAT IS APPROPRIATE AND EXPECTED. TRY TO FIND JUNIOR RESIDENT NOTES, THESE ARE GENERALLY MOST "BY THE BOOK".

Progress Notes

These are the notes written in the patient's chart each day of their stay as an in-patient in hospital.

Medicine:

Your note will be a slightly scaled down version of your admission note. It should have a patient ID and active problems list. Use the **S.O.A.P. format** to record your note.

S (subjective) includes how the patient is feeling (use quotes if necessary).
O (objective) encompasses your physical exam, labs, and imaging.
A is assessment and will change based on S & O.
P is plan, including next steps and discharge planning.

A popular option is the "issue-based" note. Instead of A/P, you can list the active issues and write the assessment/plan for each issue individually.

Alternatively, you can list the issues and write the entire S/O/A/P in a few lines as it pertains to each issue. Continue including an "inactive issues" or "resolved issues" list, especially if patients are in hospital for a long time.

Surgery:

Your notes will be very brief, usually scrawled very quickly during morning rounds. You will catch onto the important things. Here is an example of a standard surgical progress note:

62 yo M POD#2 right hemicolectomy with diverting loop ileostomy

S – Feeling much better than yesterday
Pain well-controlled on PCA
Ostomy output appropriate, passing ++ flatus
Hungry
O – AVSS (*list vitals if resident prefers*)
u/o = 56mls/hr
IV input = 50cc/hr (d/c'd at 4am)
Abdomen soft, NT, ND (*non-tender, non-distended*)
A/P – Stable
Advance diet as tolerated
D/C PCA and switch to Tylenol #3 1-2 tabs q4-6h prn

Signed Betta GetBetta, M3

Admission Notes

Admission notes are dictated on some services (i.e. surgery, pediatrics) but written on others (ob-gyn). Here is an outline of a typical/standard admission note. Note that the level of details is again dependent on the service you are on. Some services (such as OB-GYN) have very specific formats for their admission notes due to the specific details on history which are critical for deliveries in hospital (i.e. pre-natal work-up, maternal serology, maternal blood type etc. etc.). OB-GYN will provide you with an orange booklet outlining the various formats they would like to have you use while on service.

a) **Patient ID.** No more than 2 sentences and usually has age, sex, and current living situation. Sometimes you will include occupation, geographical location, ethnicity, or handedness.

b) **Chief Complaint**, or "reason for referral", or tentative diagnosis.

c) **History of Presenting Illness**. Try to stick to pertinent positives and negatives. Brief sentences in point form will make it easier for others to skim your note.

d) **Past Medical History.** Often, this will be divided into categories (Medical History, Surgical History, Obstetrical History, Gynecologic History, Psychiatric History, Developmental History, Perinatal History, etc.) depending on which specialty you are writing the note for. As a rule of thumb, separate this section into a specialty-specific past history and a general medical history. This section of the note is very important because it puts the rest of the note into context. You might consider writing this section as an Problems List with active and inactive problems separated.

e) **Medications**. Dosage and frequency. Make note of patient compliance if you are getting the details from medication bottles or an ODB profile. Don't forget to ask about OTC medications or complementary and alternative medicine products.

f) **Allergies**. Note the drug and the type of reaction. Note that most 'drug allergies' endorsed by patients are sensitivities, and therefore documenting the specific reaction helps the team to understand the specific risks of giving a patient a specific drug.

g) **Social History**. Bare minimum is smoking, alcohol, and illicit drug use. Details of living situation are usually helpful. In Psychiatry, this will often be more elaborate (e.g. Forensic history, Life Stressors, etc.). In Pediatrics, a developmental history could be put under social history or under past medical history.

h) **Family History**. Should be very short, stick to what is pertinent.

i) **Physical Examination**. Start with vitals. With time you will figure out which pertinent positives and negatives are the most important to report. However, early on you might find it easier to describe your findings by system in a head-to-toe fashion. Underline or highlight the key findings.

j) **Investigations**. Generally it is helpful to list a date for a specific investigation, with a concise description of the pertinent information yielded by that investigation. Example:

> Head CT (June 22, 2016). Head CT shows presence of chronic diffuse perforator infarctions, no evidence for new/acute intracranial findings.

k) **Impression and Plan.** This section is a brief summary of the patient's story, outlines your impression of his/her problems, details your thought process concisely, and provides a plan for your patient going forward. It is worth noting that this is often the only section read by family doctors and other physicians, so it is important to convey key messages here. Try to be crisp, organized, and action-oriented in this section. This section will usually require a conversation with your senior resident or staff to ensure that your dictation is reflective of your superior's opinions/plans for the patient.

l) **Sign Off.** Sign your note with your name, followed by "(M3)" to indicate your position.

Obstetrics & Gynecology

General Introduction

This rotation is divided up into three 2-week blocks:

1) Delivery Room, with call and night float
2) OR (Gynecology & Gyn Onc), with call
3) Outpatient Obs/Gyn Clinic, without call

At the start of your OB/GYN rotation, you should be provided with a small booklet.
Treat this book like gold. It will help you with notes, orders, and save you at 3AM when you haven't slept and writing your 5th admission note of the night.

Preparation

1) Casefiles Obs/Gyne is absolutely essential for preparation and the exam, download online or buy a copy!!! This is still an NBME and the notes/Canadian guide lines do not apply for the exam.
2) Read the two relevant Toronto Notes chapters for a more in-depth preparation concerning Obs/Gyne if you have the time.

Delivery Room

Deliveries are highlight of the rotation. Opportunities varying depending on location and time of year. You might have to be somewhat aggressive to get your opportunity. Senior residents are less interested in low risk births, but the junior residents are trying to deliver as many babies as possible.

Admission History Note For Delivery/C-Section

YOU ARE RESPONSIBLE FOR ADMISSION HISTORIES WHEN ON DELIVERY OR ON CALL. If a pregnant woman has just come to the floor to labour, she will need an admission history. The longer you take, the longer she waits to get an epidural. This is an example of the admission note you are expected to write. Please keep this somewhere you can pull up until you have it memorized that you can just do it yourself!

Grab a lined paper with an orange side tab, usually found in their chart under the admissions tab in the binder

ID: age, GTPAL @ # wks GA (gestational age); Delivery Date via T1 U/S. LMP.
RFA (reason for admission): Labour or SROM (spontaneous rupture of membranes aka broke your water) or PIH (Pregnancy Induced HTN)

CC (chief complaint): Contractions (start time, frequency [# per minute]), fetal movements present (yes or no), **PVB** (per vaginal blood loss; bleeding lots is bad), **LOF** (loss of fluids aka water broke or not)

HPP (hx of presenting preg, status of all of these):

Blood type	Rh Antibody +/-	GBS	Rubella Immunity
HBs Ag	VDRL	HIV	

IPS: 1/x, AFP, (comment on normal or abnormal maternal genetic testing and/or U/S)

RFs (risk factors): Look at Antenatal Record I in the chart, any comments or exposures

U/S: Date, how many wks. +d, placenta position, anatomy normal or abn, BPP

OBHx: Year of Birth + Gender SVD or C/S or SA (spontaneous abortion) #wks & Lbs. Complications (pre or post-delivery)

PMHx: (list off of Antenatal Record or PowerChart)

Surgical Hx: (Abdo surgeries are pertinent to note, also a good time to ask about any complications from general anesthesia)

SOC Hx: Find out a little about what they do for a living, employed or not, family around to help with the baby, where do they live etc. We want to support mom/family the best we can. Smoking and alcohol history are relevant but sensitive topics that need to be addressed.

Medications (list off 1, 2, 3…):

Allergies (list off 1, 2, 3…):

On Physical Exam:

HR, BP, TEMP, RR (all MOM's), ask the nurse and she will direct you or read off the monitors.

FHR, note any accelerations or decelerations

Vertex Presentation (or any other presentation baby might be in)

Investigations (get from PowerChart):

WBC, Hb, Plt

Impression:

Summarize, this is a ___ year old nulli/multiparous woman, GTPAL, who is healthy and labour is progressing. -OR- List any RFs or exposures or allergies or bad experiences with anesthetics here.

Plan (can leave empty until you get a hold of your resident or attending) but fill it in if you can:

Term Labour or C/s

IA for FHR

Epidural yes or no

Continuous fetal monitoring

If GBS + => make sure antibiotics are running

ALL OF THE ABOVE IS NEEDED FOR THE ADMISSION NOTE, IF YOU KNOW SOMEONE IS ABOUT TO BE ADMITTED WRITE EVERYTHING FROM POWERCHART AS MUCH AS YOU CAN. Write it down ahead of time to quickly pull this list up.

If you're on call with an R1 they'll try their best to steal your delivery opportunities. The best thing you can do is be nearby when a delivery is imminent. Nurses will sometimes forget to call you in the middle of the night, so you can't always rely on a page to get you there in time.

The two weeks of delivery room are highly variable. Sometimes the floor will be packed with labouring patients and you will barely have time to eat. Other times, you will be able to study for hours each day. You will be responsible for admission notes and for helping with OB triage (which is essentially an ER for pregnant patients).

You will also have the opportunity to assist with C-sections, and often will be offered a chance to suture. You will want to learn your hand ties and know how to do sub-cutaneous running stitches for C-sections.

Each morning you will round on post-c-section OB patients. You will be able to see patients on your own, write a brief note, and analyze labwork. Key points to ask: pain?, sleep?, flatus?, eating/drinking?. Don't forget to look at vitals, check labs on the computer (especially hemoglobin), and look at the wound site.

Two Important Sensitivity Points

1) You will sometimes notice that a door to a patient room has a small crocheted colourful butterfly on the door. This symbol denotes a perinatal loss. Thus, be sensitive when entering a room like this.
2) Also be sensitive if a new mom has her baby in the neonatal intensive care unit. You are not expected to answer questions regarding the baby's status.

Operating Room

You will spend one week doing gynecology operations (usually urogynecology). You will spend a second week doing gynecologic oncology, which tend to be more varied surgeries. You will round as a team in the morning, and clerks generally serve as the scribe for the team while senior residents do the history and physical. Make sure to label notes clearly (with ID, POD#, and type of surgery). In the OR, you will be responsible for cutting knots, retracting, and not interfering with the surgeon. If you show an interest most of the gynecologists will indulge your curiosity. When there is no OR scheduled, you might spend time at the Cancer Centre doing outpatient visits. These two weeks will be the longest hours of the rotation (~7AM to 6PM).

Outpatient Clinics

Most clerks find the two outpatient weeks highly enjoyable and somewhat relaxing. You will get very familiar with the antenatal 1 and 2 sheets and get comfortable with standard prenatal visit very quickly. You will get to find the fetal heart, measure SFH, and perform Leopold's maneuvers at each prenatal appointment. You will also get lots of one-on-one time with consultants, so take advantage of the teaching.

You will also spend a little bit of time in gynecology clinics. Although many clerks find assessing incontinence and prolapse unpleasant, these clinics usually have the most variability and teaching opportunities.

In most clinics, you might see the patient on your own, have the consultant trust your exam without repetition, and then do a dictation if necessary. Some physicians will do dictations for you. Some will repeat your prenatal physical exam and let you know how you're doing. Enjoy these two weeks, especially the lighter hours (expect ~ 9am – 4pm except when there is morning lectures).

The Pelvic Exam

It is important that clerks become accustomed to the speculum and bimanual exam. During the second year OB/GYN clinical method session there is much "hoopla" surrounding this often awkward and anxiety ridden part of the clinical exam (for both patient and medical student alike!). Many students (particularly male students) often comment that they feel intimidated of this whole examination process following this session. While it is very important to be cognizant of the feelings of your patients (remember FIFE!), it is equally important that students do not just skip this important part of the clinical examination. That being said, it is always important to:

1) ASK PERMISSION OF THE PATIENT.
2) ONLY DO A SPECULUM/BIMANUAL EXAM IF THE CONSULTANT OR RESIDENT IS PRESENT IN THE ROOM WITH YOU!
3) SPEAK TO THE PATIENT AS YOU ARE PERFORMING THE EXAM – explaining what is happening, as it is an invasive process. But do not give too many details; it can be uncomfortable or scary.

Often the consultant will want to confirm your findings and it is awkward and inconsiderate to ask a patient if you can repeat a pelvic examination. By having both of you in the room, the patient need only go through this process once. You will find that the majority of patients, particularly women who have already had children, will consent to having the student be part of the examination process.

SPECULUM TIP: If a woman is obese and the vaginal vault walls are caving in on the speculum (obscuring your view of the cervix), <u>try putting a condom on the speculum and cutting a hole in the end of it.</u>

On Call

There is usually 2 clerks on call (one red team, one blue team), which starts at 5PM and ends at 9AM the next morning; technically handover is at 7-730am, however, you are expected to do morning rounds with the team. Obstetrics call consists of admitting patients for labour and delivery and following them while they are progressing through labour. This can be very busy, so don't count on a great sleep. Gynaecology call requires you to see patients in the emergency department and decide their proper treatment,

although don't count on a lot of exposure to this. You will have the opportunity to scrub-in for emergency C-sections. Additionally, you will be asked to see patients in OB triage for your team.

If you want to get the most out of your night on call, which may include more opportunity in doing deliveries, make sure you follow the patients closely. Ask the nurse to tell you when she will be performing the next cervical check so that you can do one at the same time. The more times you peek your head into the birthing room to see how your patient's labour is progressing, the more comfortable she and the other staff will be about letting you take more responsibility during the delivery. Generally, it is not considered great form to rush in when a patient is 10cm dilated and ready to push and expect to be allowed to do the delivery if you have not even so much as introduced yourself to the patient prior to this point.

Tips Summarized

1) Prewrite as much of the admissions history as possible; most information is often available in PowerChart.
2) Women with contractions have to wait for your history before they can get an epidural, so if you can complete most of the history before seeing them, verify it, and only spend 5-10 minutes talking to them, they'll appreciate it.
3) Always remind the nurses/residents to page you if someone starts delivering, otherwise they forget to sometimes. And when they do page you, RUN, just in case. Sometimes babies come fast, really fast.
4) Get sleep early - babies love to come in the middle of the night and all at the same time. You will regret not taking that nap at 6 pm when you had the chance.

Ob/Gyn Exam

The NBME reflects the more general primary care practice of Obs/Gyn in the U.S., whereas Canada is more subspecialized. So, read up on STIs, ER cases, delayed puberty, and female health maintenance. READ CASEFILES INSIDE OUTSIDE, all other notes are not helpful.

As with all NBMEs, expect to walk out feeling like crap. You'll pass. Just ensure you manage your time properly.

Paediatrics

General Introduction

Kids are funny! They will make this rotation fun, but when they cry they can ruin your day. You need to be prepared to make kids cry. They can't understand why you're doing whatever you are doing, and the hospital seems like torture when you have to wait and you are ill. Remember, they have a short memory.

Your exam should be from least uncomfortable to most uncomfortable (finish up with throat and ears). If you know the kid is going to be cranky then the best bet is to go for where the money is on exam. Go straight for the part that you think is causing the problem. When dealing with very young and sleeping children, auscultate as soon as possible upon entering the room before they begin to cry.

Try to be playful and fun when dealing with kids. Sit down when you can. Don't forget to address children directly and make them feel at ease. Parents will watch how you interact with their children, and use that as a direct indication of your competence as a medical student.

Parents can be very irritable, edgy, and demanding when their children are ill in hospital. This can be frustrating and draining but do your best to empathize with their concerns. Picture yourself in their shoes. A few minutes of simply listening to a parent's concerns can solve a multitude of problems, and build rapport dramatically.

Teaching Rounds

Some teaching rounds are tremendous, others can be overly detailed and specific. Show up to all of them, listen well, and take away what you can from each lecture. The afternoons can get quite long so bring some coffee if that's your thing. **Amrit (PGY2 Pediatrics) may also offer review sessions. These are very helpful and highly recommended by the 2017 class.**

Pediatric Emergency

Most people enjoy their pediatric emergency rotations. This rotation is fast-paced, interesting, and varied. You will see a large number of pediatric viral infections, a number of rashes, some MSK/laceration type-stuff, and a few very ill children coming in by EMS. The ratio of staff to students is quite disproportionate, so be prepared to wait patiently to review cases with staff. Use this time to formulate a ddx and a good management plan. Note that pediatric emergency is not a rotation available in Windsor but a lot of pediatric emergency cases will come through Windsor Regional Hospital Metropolitan Campus on your emergency rotation.

Topics to Review

1) ASTHMA! – chronic management and exacerbations
2) Ear infections
3) Pneumonia + empyema
4) Common pediatric viruses
5) Meningitis
6) Pediatric fractures
7) Developmental milestones
8) Febrile neutropenia
9) Approach to fever of unknown origin
10) Febrile seizures & epilepsy
11) The septic work-up
12) The thorough pediatrics history (milestones, immunizations, etc.)
13) Newborn exam

Commonly seen in Paeds ER: asthma, croup, viral URTI, MSK injuries especially wrist and ankle (always assess neurovascular), gastroenteritis, babies with a fever (have a good ddx), abdominal pain. Head injury and C-spine post hockey games present a LOT (so know what to do to clear a c-spine).

Commonly seen in Paeds CTU: asthma exacerbation, ingestion (jimson weed, Tylenol, etc.), neonatal sepsis, meningitis, neonatal jaundice, UTI in a baby <3 mos, and some rare stuff which is not worth preparing for in advance. If you start on paeds CTU, understand what a baby's daily intake requirements are (total fluid intake), how to do a newborn exam, and especially what the normal range for vitals is in a neonate, 3 mos old, 1 yr old, 6 yr old, etc.

Useful Resources

1) Case Files Pediatrics
2) Lime green book of drugs given at beginning of rotation
3) Nelson's Pediatrics
4) **Amrit's web application****

Pediatrics Call

Pediatric call is quite interesting and you will see a variety of floor issues if you ask to stay up with the resident to see them. Many residents are too nice and will simply let you sleep if you so choose. However, if you want to learn a ton, ask to go with them! Aside from that, your only responsibility as a clerk is to take admission H&P's. Be sure to have notes of your admission with you in the morning at team rounds, as you will be presenting your case(s) to the team. Pediatrics, like internal medicine, is very detail-oriented.

Residents will ask you very specific questions about your patients, so try to have as comprehensive a history/physical as possible. This may take extra time, but that's ok!

Miscellaneous Tips

1) Babies are a lot less fragile than they seem. Be careful, but don't be too careful so as to limit your exam.
2) Sepsis is on the differential for a neonate with ANY complaint.
3) Bribery with stickers or popsicles is a failsafe way to get kids to cooperate, and is considered fully acceptable. Sometimes blowing an exam glove into a balloon, or handing them a tongue depressor is enough to distract them.
4) Paeds ER will be the fewest hours/week you will work for the entire year. Enjoy the free time!

Pediatrics Admission Note Example

ID: 18 month of female, previously well.
CC: Fever x8 days
HPI:
May 4: onset of fever (38.5 C)
May 5: onset of bilateral, non-purulent conjunctivitis and generalized erythematous rash; visit to family MD and prescribed Amoxil for query scarlet fever
May 6-10: continued fever, increasing irritability, decreased appetite, decreased fluid intake, conjunctivitis resolved
Today: bilateral hand and foot swelling, more prominent in the feet. Mother mentions she is unable to put patient's shoes on.
PMHx: nil
PSHx: nil
Meds: none
Allergies: NKDA
Perinatal History: Uncomplicated pregnancy, SVD, term, BW = 8lbs 4 oz. Apgars unknown. Did require some resuscitation and post-natal antibiotics. Jaundiced ++ at discharge.
Development: Appropriate, no parenteral concerns. Normal social functioning, mobility appropriate.
Immunizations: UTD (last MMR 10 days ago)
Feeding Hx: 8 to 12 oz. homo milk by cup per day; good intake of all other foods incl. meats, fruits and vegetables.
Family Hx:
Paternal aunt: congenital deafness
Maternal grandfather: osteogenesis imperfecta
SHx:
Lives in Oshawa with mom, dad and two sisters

mom stays at home with children, dad works as computer programmer lots of family supports. No financial concerns

On Physical Exam:

Weight: 10.8 kg (50th %ile) Length: 83 cm (75th %ile) HC: 47 cm (50th %ile)

VS: T = 39.2 C ax, HR 140, RR 36/min, BP 70/P

HEENT: ant. Fontanelle closed, N TM's, + red reflex, no conjunctivitis, lips and tongue swollen/erythematous, no ulcers, generalized cervical lymphadenopathy, neck supple

CVS: N S1S2, no S3 S4, PPP, cap. refill < 2 sec., well perfused

RESP: good A/E bilaterally, no crackles, no wheezes ABDO: + BS, soft, non-tender, no HSmegaly, no masses GU: normal external genitalia

DERM: deneralized erythematous maculopapular rash, esp. in groin palmar and pedal erythema bilaterally, some peeling of fingertips

MSK: generalized non-pitting edema of feet > hands, no dactylitis

NEURO: PERRL, reflexes symmetrical, 2+ bilaterally. Cranial nerve II-XII grossly intact. No motor deficits

Investigations:

Bloodwork – list the relevant BW

EKG – Normal sinus rhythm, no axis deviation, regular, no ST-T changes etc.

Impression:

18 month old child, previously well, presenting with an eight day history of fever and 4/5 criteria for Kawasaki's disease

Plan:

Admit to ward

IV fluids - 20 mEq KCl/L @ 50 cc/hr

IVIG

Rheumatology consult

Echo tomorrow

Signed Super Clerk, M3

Pediatrics Exams

Like other rotations, pediatrics has an oral exam and a written exam. The written exam is somewhat easier than a typical NBME, and is department written. The exam covers topics listed in the objectives and so going through those can be very helpful. Be sure to know rashes, viral syndromes, common infections, developmental delay issues, and other things focused on in teaching.

The oral exam is a little bit challenging. It consists of two cases given to you, each of which are timed. When answering the questions, you have the option of returning to things you previously missed so if you get hung up, ask to move on, and come back to a question.

Surgery

General Introduction

The surgery rotation really gives you a chance to become a part of a team and feel like you're "making a difference" in the hospital. You will have quite a bit of responsibility on this rotation – make the most of it! That includes helping with rounds in the early morning (writing progress notes on patients), seeing patients in the ER, consulting on the wards, and taking care of problems on the ward. Sometimes this can leave clerks feeling overwhelmed and alone, but your resident is always there to help you out in a bind. Don't be afraid to call them. Just know your limits and stretch your wings a bit.

At the beginning of the rotation you will receive a surgery 'cheat sheet' book that will fit in the pocket of your scrubs. This has lots of concise information about writing notes, common drugs, orders, procedures and presentations.

Don't take things personally. Surgeons can be an 'interesting' bunch and often dispense with the normal social pleasantries that we are all accustomed to. Be friendly to the nursing staff and to your team members and things should go pretty well.

Rounds

Rounds on surgery are fast-paced, and as efficient as possible. Unlike rounds in other rotations, surgery rounds are meant to be finished quickly so as to allow time to review with staff, and show up on time in the OR or clinic.

As a clerk, you are expected to arrive 5-10 minutes early, print copies of patients lists for the team, and stack patient's charts onto a trolley cart stored at the nurse's station. During rounding, your job is to grab the patient's chart, open it up, and prepare to write a surgical SOAP note (see below). As a bonus grab the vitals chart and hand it to the resident. Listen closely during the resident's conversation with the patient, and document orders in the 'Plan' section of your SOAP note.

Teaching Seminars

Clerk teaching is really good in surgery. The best way to get a lot out of these sessions is to read the night before. You don't have to read a textbook's worth of information, just skim a concise text or get previous student's notes. If you know the content of the lecture you'll look good for the consultant and learn more in the process. These are small seminar sessions. Sometimes there will be a Powerpoint presentation, but often it is a discussion around the table. Questions are always welcomed.

Grand Rounds

Sit at the back for grand rounds and morbidity & mortality rounds. You will see the residents get grilled and you don't want to be in the line of fire. There is often a schedule of topics. It's good to read up since the material may be over your head, and it's easy to fall asleep if you get lost. For grand rounds (occur once a month), you are expected to wear business clothes. Double check with your residents the day before if you're not sure! For the rest of the rounds, scrubs are perfectly acceptable.

Call (London)

Unlike internal medicine where clerks take first call for floor issues, surgery call is often done in conjunction with a junior resident. New consults are generally given to junior residents, who will often in turn page you to go down and perform your history and physical on the patient. When finished, you will generally page the resident who comes down to see the patient themselves before reporting back to a senior/staff. While on call, it can be very good for your own learning to ask floor nurses to page you as first call for non-emergency issues. When assessing new consults or patients on the floor, try to formulate your own management plan for the patient for presenting to the resident. This begins the process of transitioning to a first year resident, and looks professional to those you are working with. Call on surgery selectives is variable. Some services with request you perform a minimum number of call shifts, others simply leave it to you to arrange call shifts if you are interested.

Call (Windsor)

Call is home call. Again it will be just you and the attending usually. As such you will be notified by your attending when there is a consult and you will do it. Sometimes they will have you be first call for consults. You will do the consults and then you will review with you attending. Try to have a plan and try to decide if you think it is surgical or not they like the initiative even if they already know if it will be surgical or not. Make sure you give your number to the OR ward clerk and tell her who you are on call with so that you can get the 30 minute notification for surgeries that happen overnight. Your attending will usually notify you as well. Also make sure you let your attending know that you would like to be called for cases and consults overnight that way you get the most out of your surgery experience.

The Operating Room (OR)

The OR floor is a new and unfamiliar place initially, but within a few days you will notice your comfort level climb dramatically. A few helpful hints include:

1) When entering the OR hallways (i.e. the areas behind the locker rooms), be sure to wear an OR cap (either the poufy bouffant hat if you have longer hair or the tighter cap if you have short hair). When

entering the OR, always wear a facemask unless you are certain there is no longer a sterile field in the room.

2) When you are attending a surgical case, walk into the OR (with cap and mask), introduce yourself to the nurses, write your name followed by "(M3)" on the white board or the OR list by the nurse's station, and jot down your glove size. Remove your pager/stethoscope and leave those on the desk by the nurse's phone. Jewelry/watches etc. should have been left in your locker/bag in the locker-room, although leaving it in a tidy corner of the nurse's desk is also acceptable. If a Foley catheter is required, you can ask for the nurses to get the kit ready for you, or better yet, ask them where to find the kits so you can get it yourself the next time. If a Foley is required, you will put this in before scrubbing. You can also write the outline of the OR note (see below) and orders if you have time. Obviously you won't be able to fill in sections like 'post-op dx' or 'findings' before the surgery, but doing what you can prior to scrubbing will save you time afterwards.

3) Take your time with scrubbing. General etiquette for scrubbing is as follows: Scrub with or after the residents. Scrub for a little longer than the residents do. If multiple people are scrubbed up and waiting for surgical gowning/gloving, stand back and let them finish first. Keep your hands about a foot from your face and let the water drip off onto the floor. Do not touch anything with your scrubbed hands except the gown given you by the scrub nurse. AT ALL TIMES PAY ATTENTION TO OPEN BLUE STERILE SHEETS. This is crucially important as contaminating sterile fields can delay surgeries, or worse lead to post-operative infections. If you accidentally touch something with your gloves, arms, chest etc. while scrubbed in, let the scrub nurse know that you are contaminated and they are generally happy to help you re-gown. Often you won't have to rescrub, provided you carefully follow the nurse's instructions. Try to approach surgical sterility for each patient as if it was your own family member's outcome at stake.

4) Try to know the procedures that will be happening the next day so you can read up on the cases. Lists are available at the OR Communications desk the previous afternoon that list the next day's surgeries. Read up on anatomy (Surgical Recall is a great resource for this) and also read up on the patient. If you don't have time to read the night before about the particular patient or if it is an emergent surgery, sneak into the OR (with mask and cap on!) and read the patient's chart (age, past medical/surgical history, presentation, etc.).

Surgery Admission Note:

Patient ID: 65yo male presenting with 1 day hx of BRBPR
PMHx: CHF, COPD
PSHx: Appendectomy (1999), Cholecystectomy (1986)
Medications:
Ranitidine 150mg PO BID

Tylenol #3 1-2 tabs PO PRN q12
Ventolin 1-2 puffs QID PRN

Allergies: NKDA

Social History: 2 beers/week. 40 pack/year smoking. No other substances

Family History:

Father - colon CA age 56
Maternal aunt - pancreatic cancer age 72

HPI:

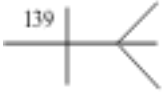
Pt presenting to ED with 3 episodes of BRPR in the last 24 hours. First episode at 2am this morning. Awoke from sleep with LLQ pain. Pain is sharp, focal, 10/10. No radiation. Not eased/exacerbated by anything. Non-fluctuating severity. Denies N/V, dysphagia. Passed large BM mixed with frank blood at 4am, and again at 7am. No previous similar presentations. Presented to ED at 10am with weakness/dizziness. No episodes of bleeding since. Patient denies LOC, CP, fevers, night sweats, unexplained weight loss. No symptoms in last few months. Last meal yesterday at 8:30pm.

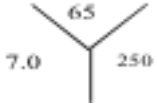
On Physical Exam:

HR 90, RR 22, BP = 140/86 lying, 136/80 standing, Sat 100% on RA, T=37.0
RESP: Good BS bilaterally, mild expiratory wheezes, no crackles, no indrawing
CVS: N S1S2, no S3/S4, no peripheral edema, PPPX4 (peripheral pulses palpable)
ABD: Soft, Mildly tender LLQ, no rebound tenderness, no masses/organomegaly, +BS(Bowel Sounds), no scars, Normal tympany
RECTAL: Normal Tone, Prostate Soft Mildly enlarged, BRB present, no masses

Investigations:

<u>Bloodwork</u>





Calcium = 2.04
Albumin = 35
INR / PTT = 1.1/60
ALT = 15
AST = 20
Group & Type = O+ GGT = 20
Alk Phos = 60
Lactate = 1.2
Cap Gas: pH=7.4 / PO2=96 / PCO2=37 / HCO3=23
Cardiac Enzymes: CK 85 & Troponin I < 0.5

<u>X-ray</u>

3 views Abdomen: no free air, no dilated bowel loops, diverticuli left colon
CXR: Normal Cardiac Silhouette, Clear Lung Fields

EKG
Normal Sinus Rhythm @ 86 bpm, Normal Axis, no ST-T changes
Assessment:
Stable 65 yo man with 1 day Hx of BRBPR. Mildly dehydrated
DDx: (1) Diverticulosis (2) Angiodysplasia (3) Colon Cancer (4) Volvulus
Plan:
Admit to Surg team 2
Rehydrate (2 large bore IV's)
Keep 4 units grouped & crossed @ all times
Transfuse 2 units PRBC
For colonoscopy tomorrow

Surgery Progress Note

Date/time (on side column)
General Surgery
POD #1
Colectomy with diverting loop ileostomy
No new patient concerns, eating, passing flatus, no BM
On Exam:
AVSS
Abd soft, NT, ND
Incision clean, dry, intact
Plan:
Mobilize
Advance DAT
Continue to follow

Surgery OR Note (General Surgery)

In surgery, you will also be required to write OR notes. This is the only record of the operative procedure between the operation and when the dictation service finally distributes your consultant's detailed operative note. Some consultants/residents prefer to write these brief notes for themselves, but at the very least you should know the format. Most of the time it is the clerk's job to write this note, especially if you aren't scrubbed in on the case. Your help with this is appreciated.

A mnemonic to help you remember most of the info required is PPP-SAFE-DISC (Preop dx, Postop dx, Procedure, Surgeon (& assistants), Anesthesia, Findings, EBL, Drains, IV Fluids, Specimen, Complications). Below is a sample (not exactly PPP-SAFE-DISC):

Pre-op Dx: cholecystitis
Post-op Dx: same
Procedure: laparoscopic cholecystectomy
Surgeon: Dr. (staff)
Assistants: Dr. (resident) PGY_ / (clerk) M3
Anesthesia: GA by ETT (general anesthesia by endotracheal tube), Dr. (staff)
Findings: none
Specimens: gallbladder with stones
EBL: minimal (estimated blood loss)
Complications: none
Drains: none
Counts: correct
Disposition: to PACU, extubated in stable condition.
Plan: discharge home when able. Or stable to PACU.

Topics to Review for General Surgery

1) Acute abdomen, peritonitis
2) Small Bowel Obstruction, including x-ray findings
3) Large Bowel Obstruction, including x-ray findings
4) DDx for RUQ and RLQ pain
5) DDx for upper GI bleeding and lower GI bleeding
6) Appendicitis
7) Diverticulitis
8) Gall bladder: know the differences between cholecystitis, biliary colic, choledocholithiasis, ascending cholangitis and various managements
9) PUD
10) Hernias
11) IBD
12) Colorectal cancer
13) Perianal disease
14) Hemorrhoids
15) Hernias
16) Ileus
17) Liver, causes of jaundice
18) Breast cancer
19) Thyroid dysfunction and cancer
20) Parathyroid dysfunction
21) GERD

Helpful Resources

1) Toronto Notes (concise and helpful)
2) Surgical Recall (concise and helpful)
3) Case Files for Surgery (concise and helpful)
4) Principles of Surgery
5) Essential Surgery
6) First Aid for Surgery Clerkship

Surgery Exams

Written Exam:

1) Study common diseases – there is a large emphasis on presentations you will encounter on your general surgery rotation
2) Know surgical and medical management for diseases. Many complaints of clerks who do surgery in the first blocks of the year are that they didn't expect the exam to have so many questions on non-operative management. Make sure you understand why your residents order certain medications or therapies. Consider calls to ward, consults and initial orders as practice for your exam and remember to read up on these components of disease management.

Oral Exam:

1) Consists of 3 questions based on seminar topics. The oral exam consists of 2 surgeons going through questions surrounding each case. Generally, the questions follow a logical sequence (ie. ddx, management plan, general knowledge questions on the topic at hand). Remember to always say the obvious things, such as complying with universal precautions, checking ABCs, vitals as these are important and they will buy you time in your answer.
2) Preparation for the oral exam is quite simple: show up to seminars and pay attention. Reading through Case Files can be helpful for understanding management of common surgical conditions

Anesthesia

General Introduction

Anesthesia is a fun and interesting rotation, and depending on the timing relative to your other surgical placements can be a good opportunity to catch a few more hours for taking care of yourself. If you are keen and proactive, you will have the opportunity to intubate, place LMA's, plan out induction routines (which is usually modified by staff/fellows), and get a lot of one-on-one teaching on fundamental concepts of human physiology.

Clerk Duties

Arrive each day approximately 30-45 minutes before the OR starts (usually ~8am) and look at the OR lists (can be found at the front OR desk). Your name will be jotted down for an OR for that day. Go to pre-op and find the patient's anesthetic record in their OR binder. Go through the anesthetic form as fully as possible with the patient. You will need to do a basic physical exam for medico-legal purposes and to r/o severe pathologies which may have arisen immediately before surgery. Generally, this involves assessing malampati score, estimating thyromental distance, and auscultating heart and lungs. Shortly before surgery begins, the anesthesia resident/fellow/attending you will be working with will arrive in pre-op. Introduce yourself as the clerk and review your progress on the anesthesia form. Once the fellow/staff has reviewed and dealt with all anesthesia concerns, you will go to the OR where the patient is due and wait for said fellow/staff to arrive as well. You will then prepare the induction drugs, intubation equipment etc. In OR's with more than one patient per day, you will often be asked to go and perform the above outlined pre-op anesthesia check on the next patient.

Notable Tips

1) The Anesthesia Primer you receive at the beginning of anesthesia is a very helpful manual. While some concepts are outdated, a few hours of reading will give you a solid basic understanding the drugs used in anesthesia.
2) Review some cardiac/respiratory physiology early in the rotation; anesthesia is primarily applied physiology.
3) Know these topics: malignant hyperthermia, anti-emetics, MAC (mean alveolar concentration)
4) Common drugs to read about are: propofol, midazolam, fentayl, morphine, inhaled anesthetics, roccuronium, succinylcholine
5) OFFER TO HELP, BE INTERESTED. IT WILL PAY OFF.
6) When giving drugs, think first, then administer decisively.
7) Take advantage of being let out early to catch up on things that you got behind on in the rest of your surgery rotation.

Medicine (CTU+ER)

General Introduction

Every clerk has 6 weeks of CTU on their schedule. It's the longest single rotation of the entire year. You will learn a lot on this rotation: not only about internal medicine problems, but about situations that will come up no matter what specialty you train in. There is a lot of work involved in dealing with general internal medicine patients, but to get the most out of the experience, you have to be pro-active. You will get a lot of teaching, but you can't rest on that. If you also reinforce your teaching with reading, practice, and feedback, you will come out with great diagnostic skills. At a minimum, make sure you ready around your cases. CTU is a chance to work with allied health professions (OT, PT, pharmacy, social work) who are also a great resource.

Preparation

This is an extremely difficult rotation to prepare for, simply because the knowledge base is so broad. If you paid attention for years 1 and 2, you should have more than enough of a knowledge base. Don't expect to know the answer to every question you are pimped on. Just make sure you don't get the same question wrong twice.

High-yield topics to brush up on include:

1) Fluids and electrolyte disturbances
2) Acid/base disorders
3) Anti-infective drugs

Many students find reading Casefiles prior to this rotation very good preparation. Using UpToDate and the Toronto Notes to read around cases is more than sufficient during your rotation. You might find an On Call book or a Pocket Medicine book a useful tool, especially if you plan to go into medicine.

Orientation

Victoria Hospital (Vic):
A very confusing place, expect to be A&O x 2 for the first week!
Call Room: next to C-Entrance, near Ivey (code: 4325*)
C400 connects to D100 on levels 4 to 7
Only use the stairwell between D and C (all other stairwells may lock you in unexpectedly)
Good parking – covered lot near "A" back entrance
Cafeteria closed on weekends after 7 pm. Tim Horton's open overnight on weeknights.
Vending machines open 24/7.

University Hospital (UH):
Call Room: 10th floor near epilepsy unit (code: 4325*)
The cafeteria is closed after 6:30pm on weekdays. Vending machines open 24/7.
Scrubs obtained from vending machine on 2nd floor near radiology.
Get scrub card from laundry room on main floor – bring $20.

Radiology is on the 2nd Floor at Vic and UH

Windsor Regional Hospital-Ouellette Campus:
CTU conference room is on the 5th floor within the Schulich Lounge. This is where you will meet for rounds every morning.
Much like in London the team is made up of 4-5 clerks, 3-4 Internal medicine R1s, 2-3 Internal Medicine R3s, a CTU pharmacist, some elective students.
With regards to scrubs for call shifts, you will get your scrubs from the ScrubX machine in the OR located on the second floor. There are multiple ways to get here the most common is to take the hospital main elevators to the second floor, take a left to the large glass door that requires your prox card for entry. Enter, there are two hallways go down the one farthest from the doors you entered through and turn left and follow the black tiles until they are no longer black and the ScrubX machine should be before you.
Food: There are a ton of restaurants around the hospital, vending machines for all time food. The Tims and cafeteria have varying hours depending on the day.

The Basics

There are three medicine teams at University Hospital, Team 1, 2, and 3 and there are three teams at Victoria Hospital, Blue, Gold and ACE (acute care of the elderly). There is one team at WRH- Ouellette Campus , with a team (a consultant) that takes ER consults during the day. Each team consists of an attending physician, a senior medical resident (usually a PGY-3), and 2-4 junior residents. The junior residents are a mix of on-service (ie. Internal Medicine Residents) and off-service (ie. Family Medicine, Neurology) PGY-1s. You will also have 2-3 clinical clerks and sometimes 1-2 keen elective students. Some of the teams also have a dedicated pharmacist. All of the teams have a patient care facilitator (PCF), who is usually a registered nurse, and who you want to become very friendly with. The PCF will help organize your patients' care, including coordinating care with other allied heal professionals, planning discharges and organizing family meetings.

You will be assigned a group of patients (usually 2-6) who you will be responsible for looking after in hospital. This means daily check-ups, following tests and bloodwork, dealing with active issues, talking with families, as well as writing discharge summaries. Each patient requires a daily progress note. You will need to get all of your orders cosigned by a resident.

Typical Day in CTU

1. **Pre-rounding.** Show up, check your patients' bloodwork from the night before, read progress notes in your patients' chart to see if there are any major issues that came up overnight. Not all clerks do this, but doing this work ahead of time will make you look good in team rounds and will help you start thinking about the day's problems from the very start. Also, print off a new patient list for your team from powerchart. Usually the first team member in prints copies of the list for everyone. Routine daily bloodwork is drawn at 5:00am, and will typically be on powerchart between 7-8am.
2. **Morning report.** Clerks and residents who were on call the night before present a case and someone will get pimped. Important teaching points will be explored, with the chief medical resident usually guides the discussion. At UH, Coffee may be provided.
3. **Seeing the new admits from emerge.** Get the chart for your senior as you are seeing each patient. Try to divide up duties when seeing patients as a team (someone write the note, someone write orders, etc). This is another time you may be pimped or asked to demonstrate physical exam skills.
4. **Team rounds.** Your team will "run the list". The team goes through each patient under your team's care and plans for the day. The person who was on call will update the team on any major changes for patients from the night before. At this time, all of the patients will be assigned to a specific member of the team. If a patient is assigned to you for the day, it is your responsibility to go see them, follow up on their tests and bloodwork, and monitor their active issues for that day. You will typically be assigned 2-6 patients. If you have looked up the bloodwork and pertinent investigations before the morning report for patients you regularly follow, you will be better prepared to ask questions about the plan for the day.

   Windsor: Blood work will typically be drawn around 6-7 am so it may not be available for you to check before rounds.
5. **Doing the work**. You need to prioritize your day to make sure you get everything done in time. Highest priority is patient discharges and calling for consultations.
   a) *Calling a consult*: Find out all the necessary information beforehand (patient's clinical presentation, relevant co-morbidities and meds, other related investigations, especially Cr if you are ordering a CT). Dial 53000 (locating) and page the service. Have the patient's chart and powerchart open in front of you for when they call back. Always keep in mind: why are we consulting this service? What question do we want answered? This takes practice. Fill out the top part of the consult form (diagnosis and clinical information) so it is ready for the consulting service when they arrive.
   b) *Discharging a patient*: Ideally, the day before or earlier, you should have organized all the necessary consults (OT, PT, social work, CCAC). Prepare the face sheet (close to front of chart. Write discharge scripts (ready for senior to sign). In general, you only need to write scripts for new medications that were started in hospital (and not for all their other meds). Arrange follow-up plans (with family doctor or specialists). This can usually be written as an order in the chart, but for specialists you should speak directly to the service about this before discharging the patient. Do not allow a patient's discharge to be delayed because you failed to do one of

the above tasks. Discharging a patient on time is one of the clerk's most important duties on the service. e.g. Discharge orders:

a. D/C home with scripts to go
b. D/C IV, Foley, Telemetry (anything that is connected to the patient) F/U with family doctor, neurology, etc.

Dictate the discharge summary the same day the patient is discharged. If you wait until the next day, the chart may be taken down to medical records and it could be more difficult to obtain. Press 6 to make the dictation STAT.

c) See your sickest patients first. History, physical, SOAP note. The most important part of the SOAP note is the plan. List the active issues in order of importance. For each issue, have a clear plan. Speak directly to the patient's nurse if you can, they are aware of all of the care a patient is currently receiving as well as the patient's current status.

d) Note: ECHOcardiogram reports have a habit of not appearing in your patient's chart, and they are not found on PowerChart. To get the result of an echo for your patient, go to the UH Echo lab on the 5th floor or the Vic Echo lab on the 2nd floor at the C-entrance near Ivey and they can print a copy for you. Windsor: Windsor Regional Hospital-Ouellette 4th floor

6. **Lunch rounds.** Teaching plus free food. Don't be too intimidated to participate. Be early to guarantee lots of food. Being late means an empty plate. These are encouraged but not mandatory (if, for example, you are in the middle of a family meeting). Sometimes your team will be responsible for presenting at lunch rounds.
7. **Afternoon.** Finish up with whatever you didn't get done during the morning (which can be a lot if your team works slowly). Usually it's best to leave dictations for the afternoon. This is also a good time for reading around your cases if you have nothing to do. Asking residents if they need any help always looks good, but be careful not to over-commit your time.
8. **PM Handover. Update the team on your patients' active issues, what was done that day, the plan, and complications that may occur overnight for the on call person. Make sure every order is co-signed by the end of the day. The nurses keep a list of non-urgent issues about all their patients which is usually good to check before you peace out. Many of the consultants will fit in an end-day lesson right before you leave.**

On Call

For weekdays, call begins at 5:00 pm and ends the next day whenever your team lets you go. It is the stated policy of UH, from the King himself that they want clerks to be able to leave by 10:00am as well, but not always happen.

Weekend call generally begins at 8 or 9 am and ends the next day at around 9 or 10 am. You will round on all the patients as a team (senior, consultant, post-call clerk/resident, on-call clerk/resident). The notes and plans from these team rounds will be brief and succinct, so be ready to go quickly.

Take cues from your team for what is acceptable to wear during days on call. Many people start the day wearing scrubs and comfortable shoes, others get changed after the day's work is done, around 5:00pm.

CTU call is about **floor issues** and **admitting patients from emerge**.

Floor Issues

Unless your team's senior is the senior medical resident for that night, you are the only member of your team who is in the hospital for the night. Consequently, try to ensure that your team does a good job of communicating issues that could become a problem during the night for different patients on your service.

Answering Pages

1. Write down the nurse's name on your patient list (that way when you go to see the patient or when they call you, you can say "hi [nurse's name]" and they will usually like that and be nicer to you).
2. Determine the acuity of the issue. Is the patient stable? What are vitals? Do I need to page my senior right away? Is this a new issue or one for which there is already an active plan? Is this an urgent issue that requires you to stop halfway through an admission? Is this an issue that can wait til morning?
3. Go see the patient. Assess. Generally, review the chart and gather all necessary info BEFORE paging your senior with your plan.
4. For routine, non-urgent stuff, you can either page a junior for a co-sign or simply carry around the orders. Make a list of all the orders you need co-signed so that if you happen to run into a resident on call (and they're not busy), you can quickly call in all the non-urgent co-signs at once. Residents can give verbal orders or verbal cosigns to nurses. A quick trip through ER will often reveal at least 1 resident on call.
5. For urgent/serious stuff or any issues that significantly affect management, always consult the senior. Don't be afraid to page them. Be afraid to NOT page them! If it's not crazy urgent, you should go assess the patient first yourself before paging the senior. Have the chart and powerchart open for when they call you back.

Common Floor Issues

- "Mr. Smith needs some Tylenol"- usually pre-writing Tylenol and Gravol PRN orders on charts (typically on the admission orders) will save you a hassle call at 2:00am. Also, make sure all of your orders have been co- signed before your team leaves the hospital, or you WILL be called.

- "Mr. Smith has a potassium of 3.3 instead of 3.5"- You will frequently get called regarding slight disturbances in lab values, oxygen sats, etc... Sometimes this can be annoying, but remember: it is the obligation of the nurses to report certain perturbations in values, and it is better for someone to be hypervigilant than it is to be negligent. Generally, potassium 3-3.5 is not concerning in patients with normal cardiac functioning. This can often be solved with a banana for patients who are not NPO. Call your resident if you are unsure. Oral K repletion: K Dur 20, 40, sometimes 80 mEq po X 1. IV K repletion: KCl 10 mEq/hr X 3.

- "Mr. Smith is having trouble breathing"- Acute issues related to your team will likely be called to you first, rather than your SMR. Try and assess the situation as best you can (ABCs, vitals, etc...), but don't hesitate to call for help if you feel over your head.

- "Mr. Smith is agitated"- Lots of old, frail, and sick patients get delirious and confused, often overnight. This may be solved by talking to the patient, or it may be solved by drugs. Be careful using sedatives in people who are not breathing well. Common pharmacological solutions include lorazepam (Ativan) 0.5-1 mg po/iv q2-4h prn, and haloperidol (haldol) 0.5-1 mg po q1-4h prn (note: these are conservative doses, usually you start low). Needless to say, restraints are a last resort.

ER Admissions

Your senior will page you with a new patient to admit from emerge. Here's an approach:

1. Write down exactly what the senior tells you about the patient. This will often be a succinct version of what the ER doctor has discovered and can guide your approach to the consult.
2. Read the emerge documents including the nurses and doctor's charts (if they're legible!). Review the investigations already done in the ER.
3. Log onto powerchart and look up the patient. Old discharge summaries and consultations reports are an excellent method for getting PMHx and sometimes Meds information before seeing the patient.
4. Spend a few minutes coming up with a differential for the chief complaint and if you have time, look up an approach to make sure you don't miss anything.
5. Do a history and physical. FIFE when indicated. If you realize that you have forgotten to ask or do something, don't be afraid to go back to the patient and finish your Hx and Px.
6. Once you have completed your history and physical, try to come up with a differential, appropriate investigations, and possible treatment options. You may, nay WILL, be wrong from time to time, but many residents appreciate the initiative and it will help you develop your skills as a budding internist.
7. If there is any uncertainty regarding important information (ie: what Meds is she/he taking, for how long, any recent changes, etc…), don't hesitate to call the pharmacy, their home, their nursing home, or anywhere you can to get what you need to do your job. ODSB has good records of drug claims and the Pod clerk can get this information for you. Some pharmacists clarify the medications the next morning and you can write an order for the pharmacist to clarify Meds in AM.
8. Your admission paper work will include (make sure it is all stamped):
    a. End-Of-Life Form (code status)
    b. Admission Note (1-3 double-sided pages)
    c. SMR Note
    d. Preprinted Orders (2 pages of medications and investigations)
    e. DVT Prophylaxis
    f. BPMH
9. Review with your SMR. Expect to learn tons.
10. Photocopy the admission note, SMR note, and orders so that you have this information to review with your team in the morning.

Other on-call tips:

- Bring plenty of fluid. Eat when you can. Stay hydrated. Carry around a snack if need be.
- Think of an approach to a patient's problem before going to see them.
- Always have a plan before calling the senior.

- If patient's code status is unclear when you're on call, clarify it. Things can change quickly and not knowing code status can make it more complicated to make decisions.
- Read about your cases before presenting them at morning report.
- 1 hour of sleep may be worse than none at all.
- When you are on-call, avoid making major changes to a patient's management. It's often better to wait till the morning to discuss with the team (especially for chronic issues like insulin management in DM).
- Bring a toothbrush, discover where the on call room is, and pick a pleasant beeper alarm sound.
- **Have a piece of paper and write down pager #, nurses name and issue, so if you are in ER doing an admission you don't forget by the time you get to the floor issue.**
- **Sometimes, call will be terrible (non-stop admits and floor issues). Other times, the floor will be silent and the senior might do an admission for you to let you get sleep. Enjoy the breaks when you can but don't be shocked if you have to work all night.**

Morning Rounds

After a night on call, you will be required to present an admission from emerge to the team. The more thorough you are during your admission, the more likely you will be able to answer your team's questions in the morning. Report the case like your admission note: ID, Chief Complaint/Reason for Referral, PMHx, Medications, HPI, Social Hx, FHx, ROS, Physical Exam, Investigations, Assessment, and Plan. Aim for less than 5 minutes, but don't worry if you are over-inclusive of unnecessary details when you start out.

For Past Medical History and Medications, group medical issues/meds together. For example, Patient X has a history of {condition} for which he takes {medication and medication}. List them in order of importance to the chief complaint.

For Physical Exam, always report vitals first. For physical exam and review of systems, the first few times you report a case, be thorough. After that it's usually enough to stick to *pertinent* positive and negatives – or you can just very quickly say no cough, no shortness of breath, no chest pain, no palpitations, etc.

For investigations, list abnormal lab values, pertinent negatives and always include imaging findings (like "Chest X-Ray was unremarkable, EKG showed normal sinus rhythm").

The most important part is the assessment and plan. In assessment, you can include a differential. For plan, list all active issues, in order of importance. It's often good to state what supports the diagnosis. For instance, issue:

1. Acute MI – ECG with ST elevation and inverted T waves, elevated CK and Troponin. Then say what you're going to do or already did. "We started them on Morphine, Oxygen, Nitrates and Aspirin, we ordered an echo, etc."

End each plan with code status and disposition. Everyone should get a code status. Disposition means discharge planning. Does the person need CCAC/OT/PT/Social Work before discharge? Will they be going home? To a nursing home? Discharge planning is extremely important on CTU. Inadequate discharge planning is a frequent cause of delayed discharge from the medicine units.

Selectives

Details for each selective are beyond the scope of this guide. As a rule, spend some time reviewing the subspecialty's material prior to the selective. For example, read the relevant Toronto Notes Chapter, review the relevant Case Files, or practice the specific physical exam skills you will need for that subspecialty. If you're really trying to impress, ask classmates who have done the selective before for advice on how to succeed.

Emergency Room

- You will have a relaxing 3-day training session prior to your first ER shift. There will be sessions at both hospitals which will go over approach to a few common conditions and run through scenarios as a group. This is one rotation for which you will have adequate orientation/preparation.
- WINDSOR: There is no orientation for this rotation. You will show up to the ER and look for your consultant. You will have 4 shifts at Windsor Regional Hospital-Ouellette Campus and 4 shifts at Windsor Regional Hospital- Metropolitan Campus. You will wear scrubs for all of your shifts.
- In the ER, the major objective is to rule out life-threatening causes. When you are reviewing cases with the consultant, demonstrate that you directed your history and physical to determine to rule out or raise the index of suspicion towards life-threatening causes.
- A lot of your shift is dictated by who your consultant is and their preferences. Some preceptors like you taking initiative and signing up for patients yourself while others prefer to assign you patients based on learning opportunities and acuity. Ask the doctor at the start of the shift how he/she wants to do things. Usually they'll tell you to sign up until the last 1-2 hours of the shift.
- WINDSOR: The consultant will usually tell you which patients to see or you can just continue to see patients again depending on the consultant's preference. You will likely continue to see knew patients until about 2 hours before the end of shift.
- Keep a running list of patients, what tests/work up was being done and what the results were. You can create a customized PowerChart list of patients that you are following during that shift.
- The nurses on emerge could be your best friends if you put in a little time to say hello to them and give them your name. If you want to do IV's and blood, just tell them!
- For a trauma or code, if you stand back you'll get to see but not do. If you want in on the action, put on some gloves and stand just out of the way enough to not be annoying but close enough that when the trauma resident needs you to pass her something, you're right there and able to jump in. The nurses will also help you get in if they know you're interested.
- WINDSOR: Resident teaching schedule will be sent out by Kylie Hamilton. This will change as some days may be busier than others. Residents will teach about important topics and will often as what it is the groups wants to learn about. There will be Internal Medicine rounds throughout the year look out for the emails about them from Kylie.
- Don't forget to eat!

Important topics to review for ER:

- Approach to:
    - Abdominal pain
    - SOB
    - Cough
    - Lower GI Bleed
    - Suicide/psychosis (Vic)
    - Lacerations
    - MSK injuries (wrist fractures, knee pain, etc.)
    - Toxicology and withdrawal
- Wells criteria, Canadian Head CT rules, Ottawa Ankle Rules
- Grand rounds are on Thursday morning from 9-10am, but resident teaching is from 8-9am and that may be more useful. It's typically Jeopardy style and they were open to clerks attending, They cover material that you get pimped on during shifts. They are "mandatory" but no attendance is taken.

The NBME Exam

This exam is pretty rough. Take heart in the fact that everyone's in the same boat. Often, there is an extremely long question stem for a quick, seemingly-unrelated question. Reading the question before the stem is a useful strategy. The last part is especially rough because as brain power diminishes they give you MCQ's with 10-15 choices on the last page. They really don't give you very much time (2hours 40mins), so time management is probably the most important aspect of this exam. No amount of studying will guarantee success (but studying never hurts). It has a standardized marking format so even though everyone feels like they fail, the majority will

Format: 100 multiple choice questions.
No penalty for wrong guesses. Most have 5 choices (A to E). Approximately 12 questions will have > 10 choices. The vast majority of questions have a chunky paragraph (100-150 words) which is mostly symptoms and signs with perhaps some lab values. All of the lab values are in **American units**, and a list of normal values is included at the front of the test.

Time: 2 hours, 40 minutes
Be disciplined and try to stick to 1-2 minutes per question. Don't let yourself get too far behind.

Content:

- Cardiovascular 15–20%
- Respiratory 15–20%
- Reproductive 10–15%
- Digestive 10–15%
- Hematology 5–10%
- Endocrine 5–10%
- Dermatology 5–10%
- Rheumatology 5–10%
- Neurology 5–10%
- Gynecology 1–5%
- Immunology 5–10%
- General Principles 1–5%

Concepts:

- Establishing a Diagnosis 40–45%
- Understanding Mechanisms of Disease 20–25
- Applying Principles of Management 20–25
- Promoting Health and Health Maintenance 10–15

How to Prepare:

1. INTERNAL MEDICINE SHELF EXAM REVIEW: http://som.uthscsa.edu/StudentAffairs/documents/HighYieldInternalMedicinecompatibleversion.pdf
2. Study common diseases - Much of what is on the exam is what you will see on the ward during your CTU rotation. A good way to prepare is to read around your patients, because odds are they will have common conditions. Most of the 'Management' questions were about common diseases.
3. Know important presentations - When you're on your medicine rotation, you will notice that the residents are spending a fair bit of their time ruling out important presentations, even though they are rare. As a general rule, if you notice your resident sweating a condition, reading about it will help you for this exam.

Resources:

1. Casefiles: a good way to prepare for your medicine rotation overall, but not detailed enough to cover everything you will need to know for the NBME
2. MKSAP: a great way to practice multiple choice questions with well-explained answers
3. First Aid for the Medicine Clerkship: useful if you want a thorough resource that will cover pretty much everything you need to know for this exam, definitely not a quick read
4. Step-up to Medicine- a good book to review common medicine diagnoses as well as the pathophysiology behind them
5. You can purchase NBME practice exams for $20 USD, you can do them timed to get a sense of how to manage your time for the exam. https://nsas.nbme.org/home

The Bottom Line

Be there and work hard. Think about management and long-term planning from the beginning. Keep on top of your patients. Talk to your residents and learn from them. Value your allied health professionals. Take advantage of teaching from your consultants. BE A TEAM PLAYER!

Psychiatry

The clerkship experience on psychiatry rotation is quite unique from the others, and will hone your ability to speak to vulnerable patients regarding very personal elements of their lives. This is a very consultant-dependent rotation. There also isn't a lot of resident contact so the consultant will do most of the teaching. The more you get involved, the more interesting it is. Sitting around interviewing inpatients at a long-term care facility can be coma-inducing, so show some initiative and you will do more interesting stuff. Acute care is more exciting, especially when you can interview. It's intimidating at first, but try to interview as much as possible, as psychiatry offers the BEST opportunity to develop interview skills that will be useful when dealing with patients (especially the difficult ones) on ANY service.

"Rounds"

Rounds on psychiatry aren't usually as formal as on other services as it is often just you and the consultant. You will divide tasks for the day and talk about your patients.

You will get to talk to the patients and find out how they are progressing. This format can vary quite a bit from site to site, as well as with individual psychiatrists. Do your best to present your cases in an organized fashion, as this is more difficult than it sounds, given that your interviews will not progress in a linear fashion. A general outline is shown below under "On call", based on a case write-up in the ED. You can leave out some information depending on how much time you want to spend in rounds. At a minimum, you should prepare a good impression, as that is the summary of the patients' situation. Adding CC, an HPI, psych history, and other pertinent positives in family/medical/social history will make it more thorough, depending on what they'll want from you.

Teaching Seminars

Usually Wednesday mornings from 8:30-11:30 at Victoria Hospital. These are variable, but cover the topics to be seen on the exam. Some of the lectures are interactive, but lots of didactic teaching as well. Some lectures are identical to what was presented in second year and others build off the lecture on a similar topic given during second year.

WINDSOR: Teaching occurs any day of the week and the schedule will be on one45. Check your email prior to lectures as they may change. Lectures are always before 9 am and after 4 pm so that you do not miss much clinic time.

On Call (London)

Call starts at 5pm on weeknights and at 9am on weekends. You will be post-call the day following your shift, though if you insist you can stay post-call. Generally, call shifts the day before weekly teaching end at midnight, and you will be expected to show up at 8:30 and have a full clinical day as well.

Psychiatry call is based out of the CEPS office at Vic Emerg. You will be called to see patients in the emergency department as they are referred. The only purposes of the interview are to decide if the patient should stay or go home and to gather information laid out on a form. No treatment is started in the ER.

On Call (Windsor)

Call starts at 4:30pm on weeknights and ends at 11:00 pm. Weekend call starts at 7:00 am until 7:00pm. There is no overnight call, but you also do not get a post-call day. You should contact the attending you are working with prior to your call shift and ask them what time they would like you to be there. Generally, you will meet them in the PAN (psychiatric assessment nurse) office in the ER at Windsor Regional Hospital Ouellette Campus which is also where the majority of your inpatient rotation will take place. You will interview patients and decide if they are to be admitted or if there is a specific follow up that can be set up and they will be able to go home. If you feel confident in your assessment, then you can fill out the admission sheet for your attending to sign after you have presented your case. But do not feel like you have to do this. You can always just fill it out after you have presented and discussed the case, this is usually the better option. Make sure you have an assessment and diagnosis as well as an idea of initial treatment for the patient in question.

You will be performing a comprehensive interview. Here's a general outline (this outline is taken from a psychiatric interview sheet that you must complete with every ED psych consult –it's very useful to help you remember all the components at 3am!):

ID: Include patient's age/name/marital status/source of income/how they presented to hospital/Form status/competency status. This information is CRUCIAL. E.g. if you can remember to always mention how someone presented (e.g. ambulance, self, police), you will look REALLY organized, as this is ALL important.
Chief Complaint: in patient's own words
HPI: not only what has led them up to this point, but their symptoms in relation to specific mental illness. A good acronym to make sure you don't forget anything is MOAPS: Mood (Depression/Mania), Organic (Drugs, Neurocognitive), Anxiety, Psychosis, Safety (SI, HI, ADLS).
Past Psychiatric Hx: **Past Medical Hx: Medications: Allergies:**
Substance Use: Family History:
Social History: (childhood, development, life events, prior trauma, forensic history)
Mental Status Exam: (the psych admission sheets will prompt you to remember the parts of the MSE) NEVER forget about suicidal and homicidal ideation!
Impression: A paragraph or so to summarize the patients presentation. Include their ID, brief psych history, CC, and most important details (e.g. actively suicidal/homicidal, psychotic features, etc…). If you can get good at summarizing patients like this, you'll look like a pro star. Critical is that you show here the basis of your reasoning on whether to admit or not, their risk to themselves/others, etc…
Diagnosis: DSM stuff – you'll learn this from books. You need to ask diagnostic questions in relation to the main +/- associated mental illnesses in order to make your diagnosis. This requires some memorization of DSM criteria, which can be skirted by using a DSM app, or a little handbook. The diagnosis will guide your decision to admit – if they're psychotic, and unable to care for themselves, they need to come in. If they're borderline personality disorder with chronic suicidality and no new plans, then they shouldn't come in, and likely will regress and do worse if they come in to hospital. (Although we no longer use the Axis try to remember them they are a good way of organizing your diagnosis).

You are usually not responsible for filling out the impression and diagnosis sections (the resident does this), but it is good to think about what you would put in these boxes. The resident will often ask you what your thoughts are regarding whether to admit/diagnosis/etc.

On The Floor

When following patients on an inpatient ward, sometimes it's hard to determine what you want to do with an interview (usually done every day). Don't worry, it takes time before you can get a good handle on what exactly needs to be asked. Here are some things that you might want to ask about:

1. Follow the patient's progress in hospital – how have they improved/worsened subjectively/staff reports (look at chart first!), asking about old/new symptoms (e.g. suicidal ideation, hallucinations, delusions, etc…)
2. Ask questions about information missing in the original assessment (there is a LOT of vital data, and it's hard to remember to ask it all)
3. Cover their understanding of why they're in hospital – this may change during the course of their hospitalization, especially if they're psychotic
4. Check their insight and judgement – e.g. if this is improving, they might change from involuntary to voluntary status.
5. Discuss treatment – goals, side effects, patient's beliefs in efficacy, their own objectives, etc…
6. Discuss long term follow-up - critical for discharge planning.

Get to know the affiliated health staff, as they can play an important role. People often assume that someone else is following the patients' care, but this is often untrue, and lots of them lose out on services that would be really beneficial (SW, OT, etc). If you can look out for your patients, and suggest services/alternative housing/addictions counseling/etc…, not only will you look like a superstar, but you'll make a huge difference in helping someone get better. No matter where you're located, you have a HUGE potential in psychiatry to do a whole lot of, by following your patients, and treating them with respect.

General Survival Tips

1. Study the big money conditions first. You'll see MUCH more patients with schizophrenia, bipolar, depression, and borderline personality disorder than anything else, so make sure that if you know these conditions. Prioritize your studying by what you'll be experiencing on the ward. Also, study the medications that are used to treat these conditions (typical/atypical antipsychotics, anticonvulsants, antidepressants, anxiolytics). If you know this minimum, you should get by most of your rotation.
2. Show interest, even if you have to fake it. Tell them you want to keep an open mind if they ask you, unless the staff/resident wishes to customize your learning to your specialty of choice. This should apply to ALL of your clerkship rotations. People will automatically treat you better, teach you more, and give you a better evaluation if they think you really want to be there.
3. Get to know the format of the mental status exam, the new patient write-up (see emerg note), and follow-up notes. If you have an approach before seeing someone, it makes remembering which questions to ask MUCH easier, and less stressful. This is the only thing that you should really look at before starting your rotation (unless you know nothing, then refer to #1).

4. The exam has a history of poorly written or off-the-wall questions, but the rotation director is making serious attempts to improve it. Despite some obscure questions, it's still fairly easy compared to Medicine.
5. What you need to know may vary from consultant to consultant. Some are all about the pharmacology (including side effects, doses, mechanisms), others about their area of research, while others focus on the DSM diagnoses. Be flexible if you want to shine, or don't if you just want to pass. They won't mind too much if you know the most basic stuff.
6. Enjoy psych. Even if you don't find it interesting, look forward to getting off early, easy call, and something quite different from anything else in medicine. The more you make an effort to enjoy psychiatry (or any rotation for that matter), the better time you'll have. Even surgery keeners have enjoyed their psych rotations, so chances are you will too as long as you keep an open mind.

The Exam

The exam is taken from a bank of questions. There doesn't seem to be a pattern to the questions they ask. Some groups had questions about sleep disorders, others somatoform and conversion disorders, personality disorders. Basically, if you understand depression, anxiety, psychosis, bipolar and their treatment as well as personality disorders and suicidality you have learned a great deal from this rotation. Below is a guide for studying, but the exam is often a bit of a surprise.

Topics to Review

- Mood Disorders
    - MDD, dysthymia, bipolar disorder, cyclothymia, mixed episodes, rapid cycling
    - SIGECAPS, DIGFAST
- Anxiety Disorders
    - GAD, Panic Disorder, PTSD, OCD, SAD, Phobias
- Psychotic Disorders
    - Criteria for Schizophrenia, and definitions of delusions, hallucinations, illusion
    - Types of delusions (reference, control, thought broadcasting, grandiosity)
- Suicidal Ideation
    - Risk stratification (SAD PERSONS)
- Substance Abuse
    - Criteria for substance abuse disorder, substance dependence
    - Management of alcohol, cocaine, heroin withdrawal
- Personality Disorders
    - Know the core features (not necessarily all criteria) for personality disorders / clusters
    - Facilitators will commonly ask you if you noticed anything unusual or if something "stood out" about a patient. This often indicated they have personality traits/disorder. If you're unsure which one, try to think of a cluster.
    - Cluster A = psychosis. Cluster B = mood. Cluster C = anxiety.
    - Borderline is the most common personality disorder you will encounter.

Lots of personality disorders! A resident told me something interesting: if you are talking to a patient and they just seem weird, they're probably Cluster A (Mad), if you are talking and they make you angry/annoyed, they are probably cluster B (Bad), if they seem endearing/complimentary/just a little sad, they're probably cluster C (Sad). There are a lot of personality disorder traits in psych patients and the docs are impressed if you can pick them up and include them in your diagnosis!

Paeds Psych

- ADHD criteria and common meds
- Autism and Mental Retardation criteria for developmental disabilities day
- Look at Pervasive Developmental Disorders before you do your Developmental Day!

Mental Status Exam: Know it well! Be able to rhyme off all the important points (ABC STAMPLICKER: appearance, behaviour, cooperation, speech, thought content and form, affect, mood, perception – auditory or visual or other hallucinations-, level of consciousness, insight & judgment, cognition, knowledge, endings - suicidal and homicidal ideation-, reliability).

Pharmacology (most important drugs to know: indications, side-effects, doses)

- SSRIs, antipsychotics (typical and atypical), mood stabilizers, TCAs, benzos
- You will find out that pretty much every drug in psych is used to treat every problem (many psychiatrists use these drugs off-label).

Useful Resources

- Toronto Notes, especially the section with diagnostic criteria
- Year II Notes
- Case Files Psychiatry
- Pre-Test Psychiatry

On-Call Tips

- When you're on call you'll be in emerg and basically EVERY patient will be a risk of suicide assessment! (Learn the SADPERSONS risk factors from Toronto Notes, you'll use it a lot!). Psych assessments are quite thorough. Write notes as you talk to the patient. Consults can take 2-3 hrs depending on the resident.
- WINDSOR: No residents with you on call generally (though this may change as we now have residents training on site), so you will see the patient alone and then present to the attending. Take your time and do a thorough assessment.
- Bring a stethoscope (you are responsible for a very basic physical exam if the patient is admitted) and food. Prepare to be there for a while.
- Get the run-down from the psych-assessment nurse before seeing the patient. Always check past medical records for previous ER/admissions for psych reasons. Glance over the urine tox screen. **Make sure you can defend your risk assessment.**

Family Medicine

General Introduction

- Family is a pretty laid-back rotation. There is an exam, it's 15 MCQ and based upon guidelines of common diagnoses. It is a clicker-style exam done in a group. Its purpose is to stimulate discussion regarding guidelines and common presentations in family practice.
- In London and Windsor, you are responsible for presenting on a topic of your choice during your two-week academic rotation. This is a 20 minute Powerpoint presentation, usually directed towards residents and staff at your centre. This presentation can literally be on any new guidelines or practices that have changed or been updated in family practice.
- On the rural/community portion of the rotation you may spend time in the office, ER, OR, coroner etc. It will show you how varied family can be. Days tend to be longer and busier in the rural portion. There is no call on either rural or core family rotation.
- Every practice will have a different way to write notes. Most practices will have an electronic medical record. These take a while to get used to, and no two types of EMR are the same.
- OWL offers modules on how to use Nightingale (used in the academic teaching centres in London). It will be fairly easy to pick up and write SOAP notes (see internal medicine section if you aren't sure what a SOAP note is).
- Try your best to not only do the history and physical (this is expected of you), but also to come up with an assessment of what you think is going on and a plan. Even if your answer is a bit off base, it helps a lot to learn from your mistakes and it helps the family doctor to teach in areas that you are a bit weaker in.

Topics to Review

- Pharmacology
- Hypertensive and diabetic management & medications
- Antibiotics
- Guidelines (cancer screening, hypertension, diabetes, vaccine schedules).
- Common infections: ear infections, strep throat, pneumonia, STIs, UTI
- Vasculopaths (previous MIs, strokes)
- Asthma
- COPD
- Dementia

Know the Approach to

- Headache, SOB, abdo pain, syncope, weakness/fatigue, backpain, bruising
- URTI – cough, sore throat, ear-ache / popping ear drums
- Smoking (know co-morbidities and how to counsel)
- Vaginal bleeding/discharge/pain
- Addiction (alcoholism, opiates, benzodiazepine dependence/withdrawal)
- Derm: actinic keratosis, seborrheic keratosis, basal & squamous cell carcinoma
- Knee pain/injury (sprains, ligament and meniscal tears)
- Wrist pain
- Back pain (know low back pain red flags and typical management)
- Approach to shoulder injury (Rotator cuff vs. Frozen shoulder vs. Osteoarthritis)

Be aware of the psychosocial component of many illnesses, especially anxiety/depression contributing to pain. If your preceptor does Pediatrics or Obs/Gyn, read up on newborns and know antenatal assessments and labour and delivery.

Useful Resources

- Toronto Notes, especially the family medicine chapter. NOTE: The Toronto Notes take 1-2 years to update guidelines for screening and management, so going to the primary source will ensure you are up to date
- Ottawa Clerkship Manual (frequently updated, google search it on their family medicine website): http://med.uottawa.ca/family/undergraduate-educations/3rd-year
- MSK Medicine (www.mskmedicine.com)
- Mosby's Textbook of Family Medicine
- Sanford's Anti-infective Guidelines for Community-Acquired Infections
- Canadian or Ontario guidelines for screening for/management of specific conditions (CMA Guidelines)
- Choosing Wisely Canada http://www.choosingwiselycanada.org/

Other Tips

Truly, do not sweat about the exam. If you saw a variety of patients and read up on first line treatment of the big topics (HTN, diabetes, COPD, chest pain, etc.) you'll be fine. The exam is 15 MCQ, clicker questions, your whole rotation is in class together and they take up all the answers. This is one of the best rotations to simply learn and appreciate the basics of medicine!