THE MED STUDENT

SURVIVIAL GUIDE

CLERKSHIP's

INs & OUTs

A Student to Student Survival Manual

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Table of Contents

Introduction

Clerkship is one of the most exciting, challenging, and rewarding times of any future physician's career. During this session, the 3rd year clerks who are currently finishing up their clerkship rotations will share some of what they now know from having been in clerkship themselves – things learned from their successes, their failures, and from simply being there. Everything about how to get through clerkship cannot be covered in such a short package, but it does provide the bits of information that may not be so easy to find elsewhere as well as the things that clerks wished they had known from the beginning. The hope today is that this session will help you get the most out of this amazing part of your training that you are about to start….so GOOD LUCK!!!!

Clerkship Necessities

Caitlin Lees, Class of 2013

1. Pager

- You will need to pick up your pager prior to starting your first ward rotation (you won't need it for outpatient rotations like Family Medicine)
- Go to the 1st floor of MUMC at the red elevators. Instead of heading for the cafeteria, go the opposite way
- Turn left down the long green hallway. Walk down it.
- On your right, you'll see a window in the wall with the heading "Telecommunications." Say hello and ask to be let into the office to get your pager.
- Congratulations - after a few months the sound of your pager will be the stuff of nightmares. For now, enjoy choosing different ringtones.

2. Paging

- To page someone within HHS:
    - Dial 87, then the 4 digit pager number
    - WAIT for the dial tone
    - Dial the extension they are to call you back at (handily written on the phone you are calling from)
    - Dial a priority code (1=NOW, 2=urgent but not life threatening, 3=take your sweet time)
    - Hang-up and wait. If someone tries to use your phone say, "Sorry, I'm waiting for a page." Nothing worse than repeatedly paging someone because you don't know if they called while the line was busy.
- To page someone in HHS without knowing their pager number:
    - Dial 76443
    - A friendly person will pick up. Say, "Hi, could you please page [name of person/service resident on call] to [your phone extension]?"
    - Sit and wait.
- To text page within HHS:
    - Login to corpweb
    - Click on "Phone book"
    - Search the persons name

- Fill in the blanks and hit send
- To page within St. Joe's
- Dial 33311
- A friendly person will pick up. Say, "Hi, could you please page [name of person/service resident on call] to [your phone extension]?"
- Sit and wait.
- *Note that at St. Joe's, switchboard will take and leave messages for people. You call switchboard to pick up messages too.

3. Team Pagers

- On rotations like medicine, you might carry the team pager
- This means that any issues with patients under a given team, the nurse will page that pager and assume you have magic answers
- When it goes off, call back and say, "Hi, this is _ , the clinical clerk on team _ returning a page."
- Listen to the problem and write it down
- Ask for additional pertinent information (vitals!!!)
- Explain you are a lowly clerk with no verbal order powers
- If it's a minor over the phone problem, page a resident to call the nurse with a verbal order
- If the patient needs assessment, go see the patient, then call the resident
- If the patient is in trouble, call the resident to let him/her know, then go see the patient and meet the resident there

4. Parking

- Take the Red Elevators in MUMC down to P (P is for Parking!), or drive into the garage and take a regular pay ticket
- Walk towards the Main St. W. Exit
- To the right of the exit, you will see the door to the office
- Go in and say, "Hi, I'm a new clinical clerk. Could I please get my parking pass?"
- Transponders are paid for in two week chunks - from the 1st -15th and the 16th-end of the month. Try to wait until the beginning of the period, otherwise you might pay $50 for 2 days of parking (rip off!)
- Provide credit card or void cheque, as well as your vehicle license plate, make, model, etc.
- Take your transponder - if you have driven in and have a pay ticket, be sure to tell the parking person so that they can let you out for free (only if you've activated your transponder right away)
- **Using your transponder**
- Drive into patient parking
- Look overhead for the grey metal rectangle
- Hold up your transponder and wait for the light to turn red
- The gate will open!
- **Parking at St. Joe's**
- The parking garage is located near the Fontbonne building
- Continue up St. James, past Charlton, and turn into the parking drive

- You park in the garage to the right. Your transponder won't work here until it is activated, so take a ticket.
- Take your transponder with you when you leave your car.
- Walk through the longest tunnel in history. You are on the third floor. Take the elevator (or the stairs near urology) down to the first floor.
- Walk over to the tower (the new part of the hospital, across from Tim Hortons)
- Go up the big staircase to the second floor
- Wander around/ask for help until you find the parking office.
- Show them your ID badge, explain you are a clerk, and ask if your transponder can be activated for St. Joe's
- Give them your transponder, sign their paper, and let them work their magic. If you have parked in the garage, tell them, so that you can be let out with your transponder

5. Swipe Cards

- Your regular ID badge will work for HHS locations
- For St. Joe's, make sure you have the extra chip-disc thing on the back. If not, head to the MD office and ask for one.
- If at St. Joe's you don't have access to things you need (e.g. L&D or the OR), go down to security (down the hall past the information desk) and ask for access.

6. St. Joe's Computer Logins

- You have to get your St. Joe's username (and dictation number) separately - it's not given out along with the HHS package at the beginning of clerkship
- Go up to the 5th floor
- Find room 507
- Knock on the door and say you need a Provider Portal username and password
- He'll check out your ID, have you sign a paper
- The next day, you have your username and password

7. Dictating at HHS

- Dial 5000
- Follow the instructions - you will get your dictation number at clerkship orientation. I suggest writing it on a piece of tape on the back of your ID badge if you have a poor memory like myself
- Remember you have to say the punctuation! This includes periods, new paragraphs, commas, colons, etc.
- At first it might be helpful to make yourself a small pocket sized template to follow.
- **Dictation Template:**
- "This is [your name - and then spell it], clinical clerk, dictating for [doctors name - and then spell it]. Patient's name is [name - and spell it] and patient number is [number under the barcode on a St. Joe's chart, or "U number" at HHS)."
- This is a [discharge summary/consultation/admission note]
- Copies go to: [other docs this would be relevant to - spell the names]
- **Start dictation**

- "- was seen by both myself and the resident on call/attending physician, [name], on [date] for [reason for referral]"
- PMHx (numbered list)
- PSHx (numbered list)
- Meds (numbered list - include doses!!!)
- Allergies (numbered list, include reactions)
- HPI (summarize into paragraph)
- Physical exam (summarize into paragraph)
- Investigations (any significant results, summarized in paragraph)
- Assessment and Plan (summarize in paragraph - mention admission, future investigations/interventions and treatment)
- "Thank you for involving us in this patient's care."
- "End Dictation"
- *Write down the dictation number in the chart!*

8. Dictating at St. Joe's

- At St. Joe's, call 32078 to dictate
- Your dictation ID is your Provider Portal email - without the P
- Unfortunately, this system doesn't give you instructions as you go like HHS (what code to press for dictation type, etc.) - BUT you can get your instruction card from Health Records (get directions from the information desk)

9. Call

- Typically clerks get the same PAIRO guidelines that residents do, meaning that technically you are only to work 24+2 hours - although you will go over on some services.
- Typically you can wear scrubs for the day when you are on call without it being frowned upon.
- Find out which resident you will be on call with. Your team residents will help you make contact with him/her.
- During call, you typically do consults and on some services may deal with ward issues.
- In the morning, you are typically expected to stay for rounds with your team and tie up any loose ends - so don't leave things like discharge summaries thinking someone else will do them for you!

10. Call Rooms

- In MUMC, head down to the information desk mid-afternoon. Ask for a call room key.
- At the Juravinski, head to the area on the 3rd floor between the new (C section) and old (E and F) section of the hospital, with the walkway with the fantastic view. Head down the hall past Internal Medicine offices and swipe yourself into another hallway. On the wall, there is an automated call key dispenser. You can get your key out after 1pm.
- At the General, I have no clue. Someone else please enlighten us.
- At St. Joe's, head down to switchboard (that little window across from the information desk) after 5pm (not 2 minutes earlier - seriously) and ask for your call room key.

Apparently these can sometimes run out, so don't leave it till 11pm when you're ready to cuddle up with a plastic pillow. Make sure to return it by 9 the next morning - they will page you at home.

- St. Joe's call rooms are located in the Martha Wing, a distant and sketch part of the hospital.
- To find these, go up to the second floor to the cafeteria. Follow the signs to the Martha Wing, and then to Human Resources. Notice the disturbing "Staircase to Nowhere."
- Codes for the bathrooms and resident lounge are posted on the back of your call room door.

11. Scrubs

- At HHS hospitals, you have to use the ScrubEx machines. These will automatically dispense scrubs when you swipe your card at it, with a limit of two pairs out at any one time.
- Locations can be difficult to find - best bet is to ask a resident to take you there at each site.
- At St. Joe's, there are no ScrubEx machines and you can get them in change rooms for the service you are on.

12. Keeping track of patients on the ward

- Most inpatient services keep a team list of patients. This information is hugely confidential as it contains names, details of illness, and location. Don't lose it! When you are done, it goes in confidential waste.
- Ask the resident on the team how to access and update the list (if you have one)
- Update it. Seriously. Do it as you go with every new admission. You will make people very sad/angry/frustrated if you don't.
- For services like Internal Medicine where you have your own patients who are quite complicated, consider downloading a "Scutsheet" to keep track of everything. Especially if like me, you are not the best at remembering names or whether someone is on 20mg of lasix or 40mg.

13. Bed Booking at St. Joe's

- This isn't necessary at HHS
- Call switchboard (33311) and ask for bed booking prior to submitting the admission orders for your patient.
- They will ask you a series of questions. They are easy.
- Patient's name and location
- Which doc they will be admitted under
- Male or female
- Do they need contact precautions (and what kind)
- Do they need telemetry
- Can they be located off service (aka off the surgery ward if no beds are available there - usually yes)
- Your pager number for any further questions

14. CaRMS reference letters

- Ask for these early, at the time of your evaluation. When CaRMS finally does roll around, it is good to know that you have these available. Ask anyone you think liked you, whether it's relevant to what you think you will apply for or not. You don't have to actually use these letters later. Consider asking residents on IM and Peds in particular - some programs want senior resident letters.
- Note that reference letters don't have to be from the same kind of specialist as the program you are applying to. Internal Medicine letters, especially, are pretty legit for any program.
- Consider sending in "Early References" - go to the CaRMS website and follow the instructions. Your preceptor may forget you in 6 months (sorry!), and this system essentially means they can write the letter right away (and when they still remember you) and CaRMS will keep it safe until applications open.
- If someone wants to write your reference early, supply them with a copy of your resume and their evaluation of you.
- **Photocopy all your evaluations before handing them in**
- These are useful to send along with CaRMS letter requests later, to jog preceptors' memories about how super-awesome you are.

<u>The Basics</u>

Dressing with Style

- Clerk jackets are only expected on some wards, most notably internal medicine and its subspecialties. These can definitely be left at home for psychiatry and paediatrics. In all other wards, asking the residents or your preceptor will suffice.
- When in clinics, ask your preceptor what they think their patients would prefer
- On the whole, dress professionally since this is what your patients and their caregivers expect
- In general, it's business casual at Mac
- When doing electives at other places, they may be more formal (ex. Medical students in the U.K. and on the U.S. east coast are generally expected to dress formally)
- Some rotations and schools like the men to wear ties (e.g. Medicine, Ophthalmology). If in doubt, over-dress the first day, no one will fault you for being too respectful

What to Have in Your Pockets

The Essentials

- Stethoscope
- Ballpoint pens (and extras you are willing to give up to attendings or residents who ask to "borrow" yours)
- Hospital dictation card

- A copy of your personal password to the computer medical records system and PACS
- Money for food/snacks

Highly Recommended
- Penlight
- Snellen Chart (for visual acuity)
- Pocket reference book (rotation specific)
- A card or piece of paper with the "ADDAVID" mnemonic for admission orders, with examples for each rotation (see below)
- Tea-bags (hot water is far cheaper than tea and you'll go through a lot of tea)

Rotation Specific
- Eg. Stickers/tongue depressors (peds) , Pregnancy wheel (ob/gyn)
- Check out rotation profiles for a more extensive list

Things to Prepare For Your First Day

You won't be lost during your first few days if you…
- Read around "hot topics" for that rotation (refer to "First Aid for the Wards" as a guide for breadth and depth)
- Before psych, practice or review psych interview
- Before medicine, review normal values and the History/Physical (and know all your "failures" (Congestive heart failure, renal failure, liver failure, COPD etc.)
- Before surgery, review knots, sutures, and standard form of a pre-op, OR, post-op and progress notes (see "Current Clinical Strategies in Surgery" pocket book for sample notes, copy and put in your pocket)

The First Day of Any Rotation

The Basics
- Arrive early; give yourself extra time, especially if you are unfamiliar with the hospital site
- Be prepared to be on call the first day
- Introduction to your preceptors, residents
- Make sure the team knows if this is your first clerkship rotation so they'll take extra care to teach you the clerkship basics
- Introduction to the ward/clinic
- Make your best effort to remember everyone's name, especially the names of nurses, ward clerks, allied health staff, etc. – they will always be there and can help you tremendously (having a file on your PDA, or a little note-book with lists of names and roles will come in handy a number of times)
- You will typically start work right away (ex. get assigned patients or start seeing patients)
- Make sure you have personal access to the computer system and PACS
- Find out what the weekly schedule is for rounds/teaching sessions, etc.

Organize call schedule

- Set a time to convene with other students in your rotation - Generally the call schedule is made for you at the start of the rotation. In general surgery, students had to come up with their own schedule which was later sent for approval.
- Internal Medicine places you on their call schedule for you, be sure that you have given your LOA requests submitted at least 5 weeks before the start of your rotation
- Make sure that your residents/chief residents have a copy/access
- Ensure a copy is posted/accessible somewhere on the main ward
- Ensure people within a rotation have each others' home phone numbers in case somebody gets sick, etc.
- If you have any call schedule conflicts, try to tell the rotation coordinator weeks before your rotation. It will save everyone a ton of trouble.

Charting Basics

- Learning how to read a chart thoroughly but quickly is a skill that takes time and practice; it is essential to patient care so take opportunities EARLY on to familiarize yourself with how charts are organized on your rotation (in the end, the hand writing is probably the hardest part)
- Remember that charts are far from perfect: not every important piece of information will be in the chart – it may be on the patient's electronic medical record (on the computer) or on an old chart or not documented anywhere at all
- The types of things that you will write in a chart include:
    - Admission note
    - Progress note (use the SOAP model, though you may need to adapt this per rotation)
    - Procedure note
    - Orders
- After writing any note, always sign your name, followed by "cc" for clinical clerk; then print your name clearly below and include your pager number
- All your notes must be co-signed or you should write under your signature: "d/w Dr. [name of the resident/attending]" for "discussed with" the M.D., as appropriate
- Remember that all chart notes, including yours, become medical legal documents
- Write legibly!!!! (Your patient's health depends on it). If you have poor handwriting, write large and in all-caps, it is universally easier to read.

- Hospitals may have guidelines of abbreviations and words they don't want used in the chart/orders as they may be confusing.

Writing Order and Prescriptions

- Make it a habit to number your orders (to avoid confusion and calls)
- Any orders written in a chart need to have the date and time that they were written
- Any orders that you write must also have your signature, including your printed name, title, pager number, and must be co-signed promptly by a physician

- It’s a good practice to strike out below your orders so others cannot add to your orders
- Chart orders should be written with the following essential information, in order:
    - Generic drug name
    - Dose
    - Route of delivery (PO, IV, IM, SC)
    - Frequency: daily (“od” and “qd” have gone out of fashion, rather write out “daily”), bid, tid, qid, qhs

Examples

- Acetaminophen 650 mg PO q4h prn
- Lorazepam 1-2 mg IM/IV q6h prn

prn = “pro re nata” which is Latin for “as the need arises”

- Any prescriptions need the same as above (except time) in addition to:
    - Patient’s correct name (and preferably address or at least postal code, though a sticker or stamp of the patient card will suffice)
    - Quantity of pills, puffers, etc. to be provided (write “mitte:” or just “m:”)
    - Number of refills
    - If you are writing substances with abuse potential, such as opiates, you will need to write out the number of tabs in explicit letters as well and no refills, and again strike out below your orders (think of it like writing out a financial cheque) and write out the number of pills in word form as well – ie. 50 (fifty).

Examples

Metoprolol 25 mg PO bid x 30 days

mitte: 60 tabs refills: 0

Ramipril 10 mg PO daily x 30 days

mitte: 30 tabs refills: 0

Organizing Patient Information

- You'll be responsible for knowing everything you can about your patients, whose health condition, test results, and ongoing issues will change day to day
- Different people have different preferences for how to organize their patient information
- Options include: regular-sized paper, smaller pieces of paper, note cards (very popular and have transcended the ages), handheld programs
- Pick a system that you think would work best for you and try it out.
- Don't be afraid to change your system – organizing patient information is a skill that will require ongoing development, even into residency
- *Medfools.com* has numerous good templates to try out, feel free to modify them, taking what you like and leaving what you do not need.

Discharge Checklist

- Try to have these things done before you discharge your patient. If you present your attending with a package, they will be very impressed.
- CCAC – Fax the CCAC form (ideally yourself, it's easier) the day before discharge
- See your patient – Write a quick note in the chart, include plan to D/C today and "patient is in stable condition"
- Cover-sheet: Fill out the cover sheet early; it organizes your thoughts for the D/C summary. Remember this is the only thing the family doctor will see (the D/C summary takes weeks to months) so write as if you were writing for the FP.
- Prescriptions: Fill them out as per usual. Mitte: 3 months, no repeats, opioids M: 31(thirty-one)
- Follow-up: Call the family doctors office and any specialists and book follow-up appointments. Record the date and time. Remember most offices are closed from ~11:30-1:30
- Note to patient: Write/type a note to the patient - include:
    - Follow up appointments and numbers of clinics and reason for appointment
    - Instructions to fill prescriptions at pharmacist ASAP
    - Discharge medication list and brief description of what the pill does
    - Any special instructions they need to follow when they go home
    - Notification of any phone-calls / home visits they may receive

- Discharge Summary: follow the guide in which-ever handbook you are using. Keep them short and succinct. Best source is your cover sheet.
- Discharge orders: Include the following discharge orders
    - D/C Foley
    - D/C IV
    - D/C All lines
    - D/C home when able
    - Scripts to Go
    - Follow-up with FP – Arranged
    - Follow-up with Dr._____from_____- Arranged
    - Any instructions for patient to follow at home
- Assemble the entire package and give it to your attending for co-signature.

Dictation Summary Templates

- Dictation summary templates for specific rotations can be found on the internet. A good example which I used frequently is: "http://www.schulich.uwo.ca/medicine/undergraduate/docs/clerkship-london/Dictation_Templates.pdf"
- Several rotations such as Psychiatry and Ob/Gyn have specific requirements and details that are standard - using a template for the first few dictations can help organize your thoughts.

III. THE ROTATIONS

1a) Anesthesia (Hamilton) – *Updated by Adeel Sherazi, Class of 2015. Nick Mendis, Class of 2014. Kan Ma, Class of 2012, and Stephen Lee, Class of 2008* [back]

The Setup

- 2 week (10 day) rotation in one of the four Hamilton hospitals. You will be emailed with your site just before the rotation.
- The first 2 days are at MUMC for teaching:
    - Presentations by staff and residents of core concepts
    - Hands on practical sessions (intubations, IVs etc)
- Days 3-8 are clinical days at the assigned hospitals
- Day 10 is exam day ~ 40 MCQ test and an OSCE practical simulation on the sim-man dummy

The Team

- You and a preceptor anesthetist. Plus a resident when you are on call. Your preceptor is changed every day.

How the Ward Works

- No Ward… no patients to round! =)

The Hospitals

- All sites are equal in quality of learning and teaching.

Typical Day

- Surgeries typically start around 8 am, you should be in the OR no later than 7:45 to help with setup or earlier to do pre-op assessment of the patient. It is a good idea to go see your patient in the pre-OR bay prior to their transport to the OR. Do an airway exam and read their chart.
- Length of surgery varies. You will be sent out for breaks or can ask for it. You will eat lunch/snack in between surgeries or may be given a lunch break… take the breaks when offered, and let your staff buy you coffee if they offer
- The length of your day will vary. You can finish anywhere from 3-5pm.
- You will be assigned to a different doctor everyday by the chief resident. You can check at the end of the day who you work with the next day and the type of procedure.
- Different sites have different rounds scheduled

Call

- You will do 2 calls (either during the week or weekends). Weekday calls start when you finish with your day preceptor and end at 11 pm. Weekend calls are from 7:45 to 4 pm. You can organize amongst yourselves the call schedule.
- During call, you may be in the OR or following a resident to consults, epidurals and deliveries depending on site.

Your Role

- Before the surgery starts or in between cases:
    - You may be asked to go do a pre-op assessment of the patient
    - You can help setup for the case (check anesthesia machine if it's the first case of the day, check suction, laryngoscope, getting proper equipment – ETT, LMA, stylets, airways etc)
    - You can help draw up drugs: unless the anesthetist knows you and you're comfortable, it is better to draw up drugs in their presence and after asking them. Always double check the drug label before drawing up anything AND <u>always label the drug and dose immediately</u>
        - Drugs you can usually safely draw up:
            - 200 mg Propofol (20 cc) in 20 cc syringe. Lidocaine on hand.
            - 50 mg Rocuronium (5 cc) in 5 cc syringe
            - 2 mg Midazolam (2cc) in 3 cc syringe
- When the patient is in the OR:
    - Always introduce yourself if you haven't met
    - Help the nurses put on the ECG leads, BP cuff, O_2 probe, hang IV
- When the patient is to be induced for anesthesia:
    - You may be asked to administer drugs and to bag patient
    - You will and should intubate unless patient has difficult airway
    - Depending on the anesthetist, most will give you one shot at intubation before taking over, others may let you have more tries
- During the surgery:

        - You may be asked to give drugs, change IV bags, draw up drugs, change anesthetic machine settings, put in temp probes, place nerve stimulator
        - You should ask to do the anesthesia chart (recording BP, HR etc)
        - This is your opportunity to ask the anesthetist questions
        - You may be quizzed (excessively by certain select doctors)
    - At the surgery's end:
        - You may be asked to suction pt and to extubate
        - You will help move patient to PACU. You will be at the head of the bed. Remember that when transporting, foot end of the bed travels first

Skills to Develop

- Pre-op assessment – history and physical
- Airway management – especially bagging (with good seal) and intubation
- Basic understanding of anesthetic drugs and their effects
- Basic understanding of using the anesthetic machine

Tools of the Trade

- "Understanding Anesthesia" by Dr. Karen Raymer - this is available as a pdf from the Mac Anesthesia website.
- Optional U of Ottawa 'The Ottawa Anesthesia Primer'. This book is more detailed than the Mac book and easy to read. Anyone interested in doing electives in anesthesia should buy this

What to Have in Your Pockets

- All you need to bring is a stethoscope and a pen for charting
- Find the scrub machines beforehand

The Good and the Bad

- Lots of intubation and airway management opportunities
- You might have the opportunity to put in art lines, do ABG, spinals
- Probably won't get to do IVs unless doing pediatric cases at Mac
- Generally speaking, anesthetists are great teachers
- Long surgeries could be dull and take away intubation opportunities, but good for asking questions. Gyne surgeries usually have fast turnover time so it's good for practicing intubations
- Some anesthetists may leave you alone in the OR with the instruction of "give 1 ml of everything when something happens". This experience could be frightening for the student but also quite fulfilling. Clarify what drug to give, how much and when, if the anesthetist is to leave the room.

Important Points

- At the beginning of the day introduce yourself to the nurses and the surgery team and write your name on the whiteboard
- Only administer drugs if you know what you are doing! Generally speaking, do not administer any drug yourself unless directed
- Ask if you have questions!

- Ask to do things!

Evaluation

- Daily eval cards from preceptor of the day
- 2 call eval cards from either the resident or the staff
- A form of topics to have discussed with staff or residents during your rotation
- Attendance at the teaching sessions in days 1 and 2
- MCQ test on last day (not an NBME)
- OSCE simulation - there is an evaluation card for this. You work in teams of two and a 'situation' happens in the OR which you need to manage.

1b) Anesthesia (Cambridge and Kitchener) - *By M. Kinneret Friedman, McMaster Medicine Class of 2010***,** *Matthew Lipinski, McMaster Medicine Class of 2014, Thiviya Selvanathan, McMaster Medicine Class of 2015, Lili Tong McMaster Medicine Class of 2016*

The Setup

- 2 week rotation in Cambridge at Cambridge Memorial Hospital (CMH) or in Kitchener at St. Mary's General Hospital (SMGH) and Grand River Hospital (GRH)
- The first 2 days involve teaching, most of which is video-conferenced, and some of which may be carried out locally by the anaesthesiologists (schedule will explain in detail where to go).
- Days 3-9 are clinical days at the assigned hospitals
- Day 10 is exam day ~ 40 MCQ test and an OSCE practical simulation on the sim-man dummy -- the sim-man is in Hamilton and for learning purposes only and the exam may be either in Hamilton or in Waterloo

The Team

- You and your assigned preceptor – will be different almost every day although you will spend one day with the REL. There are no residents at this time.

The Hospital

- CMH has 6 OR rooms and is located on the main floor
- SMGH has about 8 OR rooms and is located on the 2nd floor
- GRH has about 10 OR rooms and is located on the 2nd floor (recall that GRH's main floor is 3rd floor. Go down one level for the ORs)
- All sites have several great anesthetists on their team, all of whom are eager to teach and are knowledgeable. Please be aware that they all have different approaches and teaching styles.

Typical Day

- Surgeries typically start around 8 am, you should be in the OR at least 15 minutes early to help with setup or earlier to do pre-op assessment of the patient
- Length of surgery varies. You will be sent out for breaks or can ask for it. You will eat lunch/snack in between surgeries or may be given a lunch break
- The length of your day will vary. You can finish anywhere from 3-5pm.

Call

- You will do 2 calls (either during the week or weekends). Weekday calls start when you finish with your day preceptor and end at 11 pm and no post-

call day. Weekend calls are from 7:45 to 11 pm. You can organize amongst yourselves the call schedule.
- During call, you may be in the OR or following the anesthetist to do consults (very rarely), or epidurals.

Your Role, Skills to Develop, Tools of the trade, What to have in your pockets, important points, evaluation
- As above
- Reading the first few chapters of Understanding Anesthesia or the Ottawa Primer before day 1 is very helpful

The Good and the Bad As above, except:
- Do get to (Try to) put in almost all the IV's. Let the day surgery nurses know if you are keen and they will save some IV starts for you.
- The anesthesia team at all sites is very friendly and loves to teach, and will give you plenty of hands-on opportunities from intubations, IV starts (mostly in pediatric cases), spinals, etc!

1c) Anaesthesia (St. Catharines) – *Updated by Samantha Sigurdson C2015, Alannah Smrke C2014 (By NRC Class of 2011)*

Locations:
St. Catharines General, Welland Hospital, Greater Niagara General

What did you do:
- Lots of opportunity to try intubations (ETT, LMA, bag-mask), secure airways and start Ivs (you are the only student working with the anesthesiologist)
- Generally, you meet up in the OR and prep the equipment and IV drugs for the cases each day.
- You can then go see the patients in the pre-op clinic and try to start their IVs, as well as take a quick history and physical prior to their operation.
- You have to complete two call shifts and they tend to be busy shifts but almost all of the anesthesiologists down here are enthusiastic teachers so you will get to do a lot.

The good and the bad:
- Great rotation!
- If you are enthusiastic and show up ready to work then you will do well in this rotation.
- Try to have the OR room set up and to help prep the patient (put on monitors, start oxygenating them, etc) so you can have more time to ask questions.
- Have a look at what topics you are supposed to cover in your rotation (essential clinical presentation sheet) and ask questions about those topics since you may not see all types of patients that are covered on that sheet.

- Won't see OB anesthesia or peds at Welland or Niagara
- Rank SCS highly if you are interested in anesthesia - broad range of cases.

2a) Emergency Medicine (HHS & St. Joe's) - *By Kan Ma, McMaster Medicine Class of 2012, updated from Jeff Kizis, McMaster Medicine Class of 2008 and Chris Evans, McMaster Medicine Class of 2007* [back]

The Set Up:

The Emergency Medicine rotation is a 4 week block with a full educational week followed by 3 clinical weeks. The first week is a mixture of skills workshops, group tutorials, and lectures. Most of the clerks found this week very helpful and pertinent to what we saw in the ER. Workshops include cardiac arrest protocols, suturing, splinting, and airway management. Lectures and tutorials cover the "bread and butter" Emerg topics such as trauma, sepsis, chest pain, etc.

The clinical part of the rotation involves shift work at the local EDs. Students are matched to either the St. Joe's or Hamilton Health Sciences(HHS) stream. Each stream has its own strengths which are outlined below. Each clerk is given a schedule during the first week of the rotation and switches are allowed between consenting clerks during the first week.

The final day of the rotation involves a day of EBM presentations done by the clerks on a relevant topic of their choosing. These are usually done in groups of two and last less than 10 minutes. They will give you all the info you need about these during the first week. You wrap things up with a short test that is based on the big concepts in emergency medicine. It flies by!

The Team:

In general, clerks are paired with one staff emergency physician (EP) who may be working with a resident. Residents are often from a variety of specialties including EM, surgery, family medicine, psychiatry, and OB/GYN; this reflects the diverse nature of EM and the fact that a basic understanding of EM is key for all medical specialties. You are part of a big inter-professional team including ED nurses, respiratory therapists, consultant residents and staff, clerical aids, and social workers. You will find yourself reviewing cases with the attending or the resident depending on the situation. It is also very helpful to build a working relationship with the nurses on your shift and they can teach you some of the important procedural skills that you are expected to practice in the ED (i.e. IVs, catheters, ECGs, etc.).

How the ED works:

The ED is unlike any other area of the hospital. Patients of all levels of acuity present to the ED and are initially seen by the Triage Nurse, who quickly assesses patients in order to determine the order in which they should be seen. Patients who are brought by ambulance also pass through triage but if they are critically injured or ill the Triage Nurse is generally aware of their impending arrival and these patients are quickly sent to a monitored bed, which may be located in the Resuscitation area. Once patients are admitted to the ED from the waiting room, EPs see the "sickest" patients first and then proceed to the less acute patients.

As there will usually be a number of patients to be seen in the ED, clerks will be assigned patients to see after discussion with the staff EP or resident, in order to ensure they are stable and appropriate for a learner to see. Depending on your comfort level, the acuity of the patient, and the staff EP's preferences you will see the patient together, or alone and then review the case with the staff EP or Resident. It is nice if you can see a mix of patients alone as well as with the staff EP as this makes for a good mix of acuity in the cases you see.

Important Tip: some patients may get triaged as much less seriously ill than they actually are. If you are sent to see a patient alone and feel that they a much worse than expected by the team, play it safe and have the staff or resident see them quickly to confirm or deny your suspicion.

The ER Departments:

Although all of the EDs in Hamilton offer excellent learning opportunities, there are some notable differences between them. The St. Joe's clerks do their shifts at SJH. This stream is unique because St. Joe's is the local referral centre for psychiatric emergencies and has a high volume of these. The HHS stream will work at the Henderson or Hamilton General for their shifts. One advantage is that Hamilton General is the local trauma centre and is the best place to see the most acute cases. There is also excellent exposure to inner city health issues as well as toxicology at this site.

Typical Day*:*

Emergency medicine, unlike most other specialties is a shift-work style of practice. The shifts are usually either 7am-3pm, 3pm-11pm, or 11pm-7am at HHS or 8am-4pm, 4pm-12am or 12am-8am at St. Joe's. Some of the departments will have swings shifts such as 2pm-10pm. The shifts are generally quite busy and keep you on your feet the entire time. At the end of the shift, your team reviews any patients who are still under its care with the oncoming team, outlining the major issues and the patient's disposition (home vs. admitted). Then you are done for the day.

Call:

No call, no pager, no strings attached.

***Your Role**:*

Your job is to squeeze the most you can out of this short rotation and make sure that each shift is a valuable learning experience. You will be seeing patients at your own pace, performing a relevant history and physical exam, then presenting your findings along with a differential diagnosis and a tentative management plan. Some cases you will find easy to handle, others you will have no clue where to start. Do your best! The vast majority of docs and residents are very supportive and happy to teach. You will also have multiple opportunities to hone your procedural skills. Whether it be starting an IV, setting a fracture, or doing a lumbar puncture, ask to be involved. You would be surprised what they will let you do with proper supervision. Charting is another important skill that you will get to practice in the ED. The first week includes a great workshop to help you get started. Remember: This is your medical education, so get in there and get dirty every chance you get.

Skills to Develop:

- Approach to common complaints (i.e. chest pain, abdo pain, etc)
- Assessing if a patient is stable or unstable
- ABC management of acutely ill patients
- ECG interpretation
- Procedures: IVs, casting, suturing, catheters, arterial blood gases, slit lamp, etc.
- Generating differentials and management plans
- Breaking bad news
- Working in a team
- Lab value/Xray/CT interpretation

Tools of the Trade:

A lot of the tools you need are somewhere in the ED, the trick is finding them when you need them. There will not always be a helpful nurse who has time to show you where to find the syringes, needles, gauze, tape, etc. I suggest familiarizing yourself with where the important materials can be found when you start a shift to make things easier on yourself later. You should bring your standard set of tools with you such as stethoscope, reflex hammer, and penlight.

******IMPORTANT******

GOGGLES: You may find yourself in acute situations where bodily fluids are whizzing by you before you know they are coming. It is highly suggested for your own safety that you have goggles with you at all times and use them liberally. You can bring your own or grab a disposable pair for the ED. Don’t wait until you get blood in your eye to start thinking about goggles.

***Resources**:*

There are a number of Emerg texts out there for you too choose from. Tintinalli's "Emergency Medicine: A Comprehensive Study Guide" is the bible of Emergency Medicine, but it would take you 6 months to read it. Check out a couple texts in the library and find one that works for you. The rotation planners also supply electronic copies of multiple useful articles that pertain to the material taught in week one. These are very useful.

***The Good and the Bad**:*

The Good:

1) Variety
2) Acute medicine
3) Procedural Skills
4) Undifferentiated patients
5) No call

The Bad:

- Shift work
- The inevitable drunk/intoxicated/belligerent patient
- ED overcrowding
- Non-acute ED patients.
- Lack of continuity: working with different doctors on each shift makes it hard to build a working rapport with them. They may not have a feel of what you are and aren't capable of and sometimes take the conservative approach.

Evaluations
At the end of each shift, the attending MD who you spent the most time with fills out a Medportal-based form rating you in multiple domains such as knowledge base, professional behaviour, etc. Load this up for them on a computer in the physicians' area and let them know half an hour before your shift is over. You also have to verify you have met all the rotation objectives online, complete a 2 hour triage shift and write a reflection on your triage shift and breaking bad news. Finally, your presentation and test are taken into account in your overall evaluation.

2b) ER (Cambridge or Kitchener) - *By Justin Chopra, MD Class 2010, Updated by Lili Tong Class of 2016*

- Clinical preparation is similar to the section above from Hamilton

Specifics
- Cambridge placements are at CMH and Kitchener placements are at SMGH/GRH
- Similar set-up to Hamilton, as there is one clerk paired with one staff member (preceptor changes from shift to shift).
- There are generally no other learners present (aside from a fellow clerk in your rotation) which gives you the opportunity to do more procedures such as IV starts, suturing and splinting. If interested, you can ask the RT's to show you or supervise you on how to do an ABG. SMGH has more cardiopulmonary cases, while GRH

has more trauma and neurology cases.

- Fewer learners means greater opportunity to pick and choose interesting cases.
- Medium sized ER which makes it easy to find your way around, but like most ERs, it can get busy during the day.
- Preceptors are a friendly group who really go out of their way to make you feel comfortable and a part of the team (they even buy you lunch/dinner, sometimes!).
- There is no call.
- You are expected to do a 2hr triage shift during your rotation.

2c) ER (Guelph General Hospital) - *By Jessica Rollings-Scattergood, MD Class 2010*

Hospital in and outs

- Pay for parking the first day when you get your ID badge – does take a little running around as buildings for each are far apart, if you want there is a limited number of parking spots on the street that you do not have to pay for, just be prepared to walk approximately 10 min to the hospital
- ID badge is picked up on the first day
- Scrubs are located in different spots depending on the construction going on, try and find out where they are located and where to change from the clerk – this might be different by now
- Not the highest volume, but lots of good teaching
- Coffee is tricky to get but necessary!
- Cafeteria has really short and erratic hours so don't count on it, plus you will not have time to stop to pick up lunch/dinner/breakfast so bring your own food with you and snack throughout the day or you will not get a chance to eat

Rotation

- Get to cherry pick – nice to sometimes pick up all abdominal pain one day to see a variety of presentations and then all respiratory the following day
- Lots of good experience with procedural skills – suturing, casting, splinting, IV, EKG some intubations and LP`s depending on how your shifts go
- A large number of the time if blood work is needed it will be drawn when the IV is started, you should ask how this is done as you need to get a certain number of IV starts and it might be tricky if you don`t know how to draw blood at the same time
- You need to get a certain number of IV's and EKGs done during the rotation – in order to get them you have to stalk the nurses to get your numbers
- X-rays and CT scan reading should be a key learning point
- Staff are all great teachers, will allow you to do the majority of the work up on your own and then present your impression and plan as well as propose investigations. As well, if there are any procedures that need to be done, just ask if you can be walked through them and they will often let you do the procedure or at least assist
- There may or may not be a resident there with you - they do try and schedule you on different days so that you are working one and one with a staff member
- Schedule is as in Hamilton, you will have varying shifts throughout the week, different time shifts as well don't expect a set schedule – as well don't make plans

for the few hours after your shift because quite often you end up staying for a few extra hours
- Watch what cases you pick up near the end of the shift – if it is a complicated case you are there until that patient is discharged or transferred to the floor – as is your supervisor who will not be happy to be staying for the extra few hours as they try not to have to transfer care over to the next shift
- Need to do one ride out experience for 12 hours with RCA – arrange on your own
- As well have the opportunity to spend a day with ortho, anesthesia - these are voluntary, not necessary, and depends on your level of comfort in these areas
- As with Hamilton – no call!

2d) ER (St. Catharines) – *Updated by Sam Sigurdson C2015, Alannah Smrke C2014 (By NRC Class of 2011)*

Location: SCGH

Preceptors: Basically everyone teaches

What did you do:
- EVERYTHING: Lots of hx/PE, ordering and interpreting investigations (labs, imaging, ECG), tons of suturing, IV starts, ABG's, foley catheter, consults, reductions, splinting
- 12 eight hour shifts and one two hour triage shift

Cons:
- Bigger traumas, STEMIs go to Hamilton, but may be stabilized at St Catharines
- Have to bug the nurses a bit if you want to do IV, ABG, foleys etc.

Pros:
- Preceptors are all really good. Enthusiastic teachers and want you to have a great Emerg experience.
- ER docs cover the codes with the ICU. Get a fair bit of CODE BLUE experience over your shifts.
- You really do get to do everything.
- Most preceptors want you to learn rather than to just rush through patients.
- Lots of time to look up relevant information/read around cases.
- You're encouraged to practice skills and take on the interesting cases.

3a) Family Medicine (local Hamilton) - *By Adam Puzio, McMaster Medicine Class of 2008, Edited by James Larmer, McMaster Medicine Class of 2009* [back]

The set up –

Each clerk is assigned to one family doctor for the six weeks and will follow that physician in their clinic along with whatever other responsibilities that physician takes on (ex. women's health clinic, nursing home visits, obstetrics, hospital wards, etc.)

Each week will run somewhat similar with variations to be expected. Every Tuesday or Wednesday morning you will meet with a tutorial group for 3 hrs to discuss topics that your group has agreed upon in the previous tutorial. The tutor for this group will be the person who will complete your written evaluation at the end of your rotation. Most academic sessions are held on Thursday; however, the academic sessions only take up the whole day approximately half of the time. Therefore, you will be expected at clinic when you are not completing an academic session. Some of these academic sessions fall at various times throughout the week. You will have to keep an eye on your schedule for these irregular sessions. It can be confusing. Academic sessions throughout the six weeks will cover Early Years, Palliative care, Alternative Medicine, and Global Health. For some of these topics you will be required to write reflections, write short papers, and give brief presentations.

As part of the six weeks there are also mandatory half days and two optional "selective" half days that need to be completed. The mandatory half days include visiting an Early Years Centre, visiting Shalom Village or St. Peter's Residence at Chedoke (nursing homes), palliative care site visit, and alternative medicine half day (you will be each assigned to one of chiropractor, osteopath, Chinese medicine, acupuncture, naturopath, energy medicine etc.). The optional half days (selectives) allow you to broaden the scope of your six weeks and do GP anesthesia, obstetrics, women's health, diabetic foot, homelessness, sports medicine, ER, addiction medicine, etc. This selective experience is optional and you can choose to remain in your family doctor's office if you feel you didn't have enough clinic exposure or you are content with the experience you are currently receiving.

The team –

The team will depend on who is working in your preceptor's clinic. You may be in contact with other physicians who are part of your preceptor's family network, secretaries, nurses, nurse practitioners, pharmacists, and residents (if you are in an academic clinic like Stone Church).

How the ward works –

There is no ward unless your preceptor does rounds at a hospital. The way the wards work will differ depending on location.

The hospitals –

There are none for the most part (unless you're with a hospitalist or with a family doctor who does hospital visits). You will be primarily in the clinic setting.

Typical day –

The typical day is quite variable from preceptor to preceptor as well as depending on the time of day. Your main responsibility is to be in the clinic. Most clinic days will start at 8 or 9am and finish anywhere from 4-6pm (again depending on the day and the preceptors schedule). Some clerks find that their preceptors will have Friday's off or a half day in the middle of the week for which they will have time to read or schedule in selective time.

Call –

There is no formal call during this rotation. You may want to broaden your experience by attending an after-hours or a walk-in clinic. Of course this all depends on your preceptor's schedule. Most choose to enjoy the well deserved time away from call.

Your role –

Your role is to see patients both with and without your preceptor. Most clinics allow you to see the majority of new patient encounters independently. You will be expected to take a history and perform a physical examination. In addition, you will be encouraged to formulate a differential diagnosis. With the differential in mind you will be encouraged to give a most likely diagnosis and will be probed to develop an impression and plan based on your clinical findings.

Skills to develop –

Clerks need to build on their history taking and physical examination skills. They should become comfortable forming differential diagnoses and formulating patient plans. Take some time to become familiar with the commonly prescribed drugs, antibiotics as well as knowing the different coloured puffers patients take. This rotation is a great time to develop an approach to some very common problems as well as improve your communication skills. As you know, family medicine clinics are often extremely busy and it is essential to take a succinct history and relevant physical as well as maintain a healthy patient-physician (medical student) rapport as many of these visits will be time limited.

Tools of the trade –

Stethoscope….most other tools of the trade will be in the clinic setting because your preceptor will need to use them too.

What to have in your pockets –

You may find a pocket dermatology book useful if you haven't had much experience with common skin presentations. I'd also suggest a pocket drug guide. A small pad of

paper will be useful as many new things often arise during the course of a day (you may see 35 – 45 patients) and there is no time to look them up on the spot.

The good and the bad –

GOOD

- No call!!!!
- With one preceptor for the six weeks so you get comfortable with each other
- Schedule is lighter than other rotations which allow for a more of a social life and time to study
- Get a full scope of medicine and you can focus your studying on areas of medicine you don't get in the other rotations
- Tutorials allow you to share and discuss different and interesting patients and ethical scenarios with each other
- Ability to schedule a selective in an area of interest

BAD

- Some clerks feel that there is a lack of clinical experience because there are many mandatory half days, academic days, and tutorials.
- The rotation can get bogged down by extra assignments and having to independently contact preceptors to set up the extra half days.
- Some of the half days (for example the Early Years Centre visit) can feel like a waste of time
- Each preceptor has a different practice and thus each clerk will get a different experience and learn different skills and come into contact with different clinical presentations.

Evaluations

- Final Exam – similar to the Internal Medicine exam; vignette-style, short answer, reasonable difficulty, long (some clerks felt it was harder than the Internal final exam)
- Your preceptor, your tutor and yourself will meet in the final week and have a group discussion about your performance throughout the rotation. Your preceptor's evaluation of you in the clinic, your tutor's evaluation of you in tutorial and on the final exam, and your evaluation of how you think you performed are considered for the final evaluation.
- Family medicine log book (a record of daily encounters) that must be signed by your family physician
- Assignments, reflections, and presentations throughout the six weeks that need to be completed but are not evaluated.
- Palliative Care OSCE (one interview) and Team OSCE (3 stations you complete in a group) – both are done to enhance learning and you will get feedback; these are not taken into account on the formal evaluation.

3b) Family Medicine (Waterloo Region) – *By M. Kinneret Friedman, MD Class of 2010/Matthew Lipinski, MD Class of 2014*

The set up –

- Highly variable, because placement here can vary from being in Cambridge, Waterloo, Kitchener, to Fergus, Drayton, Palmerston and Wellsley…
- Overall, each clerk will be assigned to one family doctor for the six weeks and will follow that physician in their clinic along with whatever other responsibilities that physician takes on (e.g., women's health clinic, nursing home visits, obstetrics, hospital wards, etc). For the most part you will not work solely with your supervisor, but will spend many days working with other physicians in their clinic.
- Some clinics can be quite different / specialized. For example, Dr. Finn in Wellsley works primarily with a Mennonite population.
- Usually each Wednesday you will meet for tutorial – which may or may not be videoconferenced (location varies). Here you will cover topics of your choosing, and will have opportunity to ask questions and debrief. The tutor for this group will be the person who will complete your written evaluation at the end of your rotation.
- Otherwise you will have numerous academic sessions (palliative care, care of the elderly, early years) – approximately one / week. You will also need to book three ½ day site visits to palliative care– you will be given the relevant contact information. You will have the opportunity to book selective days, as well, if interested (in topics of your choosing).
- You will be expected at clinic when you are not completing an academic session (unless you were given a schedule and it says otherwise).
- For some of the academic session you will be required to write reflections, short papers, and give brief presentations. This usually means you have to do the site visit *before* the reflections / projects are due. There are about 6 such 'projects' due near the middle or the end of the rotation – so keep an eye out, and it may get busy!

The team –

- Is highly variable depending on location. In general most physicians in the area work in teams, with access to nurse practitioners and pharmacists (but not always). For the most part (except in Drayton and Palmerston perhaps) you will have residents on your team.

How the ward works –

- There is no ward unless your preceptor does rounds at a hospital. The way the wards work will differ depending on location.

Typical day –

- Highly variable on your clinic, supervisor, and their schedule. May start at 8 or 9am and finish anywhere from 4-6pm (again depending on the day and the preceptors schedule). At some clinics you may have a morning shift, and then do an 'evening' / 'on-call' shift (e.g., 15:00 – 20:00). Some clerks find that their preceptors will have Friday's off or a half day in the middle of the week for which they will have time to read or schedule in selective time.
- You will, for the most part, be using electronic medical record keeping

Call –

- There is no formal call during this rotation. Some clinics will incorporate into your schedule after-hours time, or you may be able to request this

Your role, Skills to develop, Tools of the trade, What to have in your pockets, the good and the bad –

- As above.

Evaluations

- Final Exam –vignette-style, short answer, reasonably difficult. You get to mark it with your tutorial group and the mark is not included in your evaluation.
- Family medicine log book (a record of daily encounters) that must be signed by your family physician
- Assignments, reflections, and presentations throughout the six weeks that need to be completed but are not evaluated, and may still take up a good chunk of time.
- Palliative Care OSCE (one interview) and Team OSCE (station you complete in a group) – both are done to enhance learning and you will get feedback; these are not taken into account on the formal evaluation. This session is carried out in Hamilton, rather than locally.

3c) Family Medicine *Niagara Regional Campus*

- Set up is variable; depends on your preceptor. Most preceptors will not have residents. If they do, you are scheduled at different times, so that you are always one on one with your preceptor.
- You are the only student, so you get to do lots of consults, follow ups, procedures etc, you are very hands on!
- Locations include: St Catharines, Grimsby, Smithville, Niagara on the Lake, Welland, Niagara Falls
- You are assigned to one preceptor for the 6 week rotation. You will participate in all of the components of their practice. Usually if they are part of a team, they will

get you involved in interesting stuff their colleagues do (especially if you have an interest in it!)
- Family doctors here have a huge scope of practice, you can do OR assisting, eating disoder clinic, nursing home visits, palliative care, inpatient hospital work, emergency, obstetrics, sexual health, anesthesia, house calls
- Best to chat with current upper years regarding their experiences in specific regions before you rank
- Tutorials are held once a week. The exam is really for your own learning.

4a) General Surgery (Hamilton - HHS) – *Updated by Adeel Sherazi, C2015, Nikoo Rajaee, McMaster Medicine Class of 2011. Written by El-Nahas and Del Bel, McMaster Medicine Class of 2008* [back]

The setup/team –

- 4 weeks of Gen surg and then 2 weeks of selective (you still do general surgery call during this time).
- Surgery is a team-based rotation (attending, chief resident, senior &/or junior residents, you). Students are assigned to work under a particular team. The patients you will be required to follow are the patients assigned to your team.
- During your rotation, you work with all attendings on your team even though you are only assigned to one as your preceptor. You will be doing the clinics, OR's and short stay procedures with your team based on the schedule of team attendings. However, *your preceptor's schedule is your main schedule.*
- Students generally do call the same day one of their team attendings is on call. That way you can admit patients under your team and continue to follow them on the ward.

How the ward works –

- Various wards/sites operate differently based on your residents' preferences.
- Typically everyone rounds together; you will be expected to round on patients in the ward with your team. Usually starting at 0600 to 0700.
- Sometimes, clerks are asked to come in early, check up on vitals and anything else that has happened overnight. **It is usually the clerk's job to gather the patient's charts and keep track of new blood work, investigation results, & morning vitals.** Bloodwork may not have returned, but make a copy of the list with vitals for everyone.
- Clerks are responsible for writing progress notes during rounds. There are no long notes here… keep it simple. Postoperative day, pain, fluid balance, vitals (usually AVSS: afebrile, vital signs stable), passing gas/ having bowel movements, signs of infection…why are they still here. These are the keys to a surgery ward progress note (admission notes are similar to medicine except more brief).

- Most importantly, when you are new to a ward, always count on nurses to let you know how things work. If you need anything let a nurse know because they're usually glad to help. If you treat them with respect, they make life easy for you.

The HHS Hospitals –

- Juravinski:
    - At the Juravinski, the 4 weeks of Gen Surg are split further into hepatobiliary or colorectal for 2 weeks and acute care service for 2 weeks.
    - Bread and butter cases (see plenty of: appendicitis, cholecystitis, pancreatitis, bowel obstructions)
    - Day cases often have oncology focus (breast, colon, etc..). Also colorectal and hepatobiliary.
    - More consults during the day
    - Fantastic learning environment – lots of teaching from staff and residents
    - Call can average 2-3 consults/night

- General:
    - Hamilton region trauma centre (general surgery team is part of trauma service)
    - Lots of neurosurgery, cardiac surgery, general surgery, trauma, excellent variety
    - Exceptional teaching from staff and residents; all are very passionate about medical education
    - Very busy call

NOTE: For selectives, you can pick things not on the list as most site directors are very flexible. Keep in mind that you need to be back at your site for teachings and call. The last two weeks are heavy for teaching sessions so keep this in mind if you have a later selective.

Typical day – Depends on hospital placement, day of the week, & senior/chief resident schedule

- 6:00 am – Arrive at hospital
- 6:00-6:30 am - Gather patient charts & look up morning vitals, fluid balances, and relevant lab work.
- 6:30-8:00 am - Round on patients with team (staff usually not present)
- 8:00-3:30 pm – Time spent in OR if one of your team attendings has an OR day (usually once a week, sometimes 2)
- 8:00-4:00 pm – Time spent in clinic if one of your team attendings has a clinic day. This is great opportunity to work closely with your staff (for learning or CaRMS reference reasons).
- You usually get to go home around 4:00- 6:00 p.m. if you are not on call.
- If on call, the junior resident will page you to go see consults in the ER or come along to address ward issues. You usually get to leave for home around eight am the next day (after rounds).
- At night you can read around the cases you saw in the OR, ER, clinic, or ward.

TIP: For long days and surgeries, carry sugary snacks.

Call –

- About 10 calls in 6 wks. Shifts may include; scrubbing for emergency surgeries and/or consultations in the emergency department and other wards.
- Call frequency depends on the number of clerks at the site.
- Typically starts at 5pm
- The Call team usually comprises of the senior resident (home call for them), junior resident and you.
- The resident will be paged for consults and he/she will then page you to either see the patient on your own or join them. Consults come from the ER, ICU, Surgical ward and other wards. You will report to your resident when you're done seeing a patient. It is good practice to begin writing orders for the admission without your resident (of course the resident will need to sign off on it). This is a good chance to develop your management skills and learn from your mistakes.
- If a patient requires urgent surgery, you may also be asked to scrub in and assist with the surgery. Although cases are usually rushed because of their urgency, once everything calms down, you will have time to practice some surgical skills (there is less OR time constraint than during the day).
- In some hospitals, you can be a part of the trauma service. If so, you can ask to be paged if there is an incoming trauma. You can decide how much you want to be involved when a trauma patient comes in.
- There is a call room available to you. Ask where to pick up your call room key. Remember to return the call room key before you leave for home.
- Usually you are able to go home after 0800 on your post-call day.

Your role –

Varies but you'll get the hang of it. Be willing to do anything and you'll get to do more.

- The number of patients your team is responsible for will vary greatly.
- Rounds during the morning are fast usually because the senior resident wants to make sure to be on time for the first OR case. So your job is to write down what the resident discusses with the patient (see sample progress note)
- A progress note usually entails any complaints, vitals, fluids, wound/abdomen state, blood work & plan. You should also write down any orders that come up (must get it co-signed)
- You should be the one who knows every patients' relevant blood work, investigations, etc.
- You can also be asked to dictate discharge summaries.
- You can be asked to see patients in the ER or wards during the day. You will then report to your team.
- You are also expected to attend teaching rounds. These sessions are great for learning, but be expected to be able to answer some basic questions. Residents are usually the ones who get grilled.

Skills to develop –

- Will learn to read abdominal x-rays and CTs

- Writing OR procedure notes - you can use a mnemonic like ADDAVID. You can write a template before you scrub in and complete it when the procedure is over and anesthesia is transferring.
- You can get the chance to practice placing NG tubes & Foley catheters
- You can develop your suturing skills, hx/px and assessment

Tools of the trade –

- Pen, Scrubs

What to have in your pockets –

- Basic:
    - *Surgical Recall* (concise and good to read with 5 minutes before surgery, great study tool, the only book you need to survive)
    - *McMaster General Surgery Handbook*
    - Sample admission note and orders, sample progress note, sample OR note, sample discharge note, and sample discharge dictation summaries (at least in the beginning until you get used to it)
    - List of patients on your team with "To-Do" items (i.e. check labs/x-ray results, write orders, etc)
    - Money for lunch/dinner
    - Resident pager numbers

- Additional:
    - *Surgery On Call* (good way to approach common surgical problems you see on call)
    - Lawrence, great for those who want a bit more than the average in explanations
    - Pretest is good for the multiple choice questions but not a necessity.
    - Washington Manual of Surgery –good concise overview of surgical topics. Sufficient as a sole resource for this rotation.

Sample Admission Note:

- Consult the patient's chart/information before seeing the patient.
- DATE & TIME
- **ID**: age, sex, occupation,
- **RFR** (reason for referral or consult): indicate chief complaint or possible diagnosis
- **HPI**: pertinent positives & negatives
- **PMHx**: try to list problems in order of importance
- **Meds**: try to clump meds used to treat specific illnesses together, try to use generic names, and include dosage & frequency
- **Allergies**: always describe the reaction pt has if they suffer from an allergy
- **FHx**: CA, CVS problems (MI, stroke), diabetes
- **SHx**: smoking/alcohol/drug abuse, resources/support at home
- **O/E**: General appearance, VITALS, HEENT, Cardio & Resp exams are important, detailed Abdominal exam, & Neuro exam

- **Investigations**: Blood work including hematology, chemistry, microbiology (gram stain, cultures). Radiology including U/S, X-ray, CT, MRI and others such as ECG, ABG
- **Assessment** (impression):
    - Mr./Ms. [name] is a [xx] year old [gentleman/lady] who has known [relevant PMHx].
    - He/She came to [service] on [date] presenting with [list most relevant HPI].
    - He/She was found to have [list most relevant exam findings (pertinent positives & negatives)].
    - Investigations revealed [list most relevant investigation results (pertinent positives & negatives)].
    - [May describe recent treatments, response to treatments, and present condition, if helpful].
    - This patient's presenting condition is likely the result of [list differential], [although X and Y cannot be ruled out (add this only if appropriate)].
- **Plan**: We will admit Mr./Ms. [name] to the [service ward]. Outline plan, usually in issues-based format.

Sample Admission Order:

- Admit to General Surgery under Dr. X
- Dx: diagnosis or if unknown write down "symptom" not yet diagnosed (e.g. abdo pain NYD)
- Condition: stable/unstable/critical
- Diet: nothing by mouth (NPO), diet as tolerate (DAT), clear fluids (CF), full fluids (FF)
- Activity: usually activity as tolerate (AAT), also bedrest (BR) or nonweight bearing (NWB)
- V/S: q4hr, qshift, q15min x 2 hr then q 1 hr x 4, then q4 hr for post-op
- Call MD for any of the following: temp > 38.5, urine output < 30mL/hr, BP > 180/100 or < 90 systolic, HR > 120 or < 50, Keep O2 sats above 90%, etc
- IV: NS or D5 or Ringer's Lactate @ 100 cc/hr
- Investigations: CBC, lytes, BUN, Cr....AXR, abdo CT (need to fill in requisition sheets)
- Drugs: antibiotics, insulin, home meds, etc…

Sample Progress Note:

- Date & Time
- General Surgery service
- POD (post op day) 3 – cholecystectomy
- Day # of antibiotic
- Pt has no complaints/pt feeling well (always ask about pain [chest/abdo], nausea/vomiting, bowel movements/gas, ambulation, diet toleration)
- V/S: 120/80 76 12 afebrile (Tmax 38)
- I/O: 1000/600
- Drains: JP – 60cc over 24 hours (JP = Jackson pratt drain)
- PE: (quick physical of major systems) - does wound look clean & healthy?

- Assessment: stable POD#3 on IV antibiotics
- Plan:
    - increase PO intake
    - increase ambulation
    - follow cultures
- *(signed)* ***Mr. J. Doe*** *(c.c.)*

The good and the bad –

- You will definitely learn a lot during your surgery rotation.
- Teaching can vary depending on your rotation site so ask your residents and staff questions when things come up. Make sure to attend as much teaching rounds as possible.
- Surgery is very hands on, so you'll get to practice a lot of basic procedures.
- Don't expect to get the chance to be a big player in the OR, your job will mostly be to retract or hold the camera in laproscopic cases. You should be happy if you get the chance to close skin.
- Most of your responsibility will be on the wards. Sometimes it may feel like you're doing a lot of scut work, but your job is very important.
- Patient turnover is much faster in surgery than in medicine, so this can be overwhelming.
- Long days, long nights but great learning for any future speciality; you will need a bit of this.

Evaluations –

- Ask for feedback! You work really closely with residents so they will be able to let you know what you can improve without being intimidating.
- Final multiple choice exam can be variable in terms of what is asked, most people use Toronto Notes as a reference as that helps them prepare for their LMCC.
- Oral exam: you will be asked around 7 questions and be required to present a case that you saw during your 6 wks in from of a staff surgeon (you will be given the name of your examiner by the 2nd wk) Pick a good case that you can present. Present it in full (like an admission note). Pick a case that isn't very complicated (but on the other hand don't pick a routine appendectomy with no complications). Surgical recall is useful for the oral exam cases.
- Surgeons tend to value concise, crisp answers: this goes for OR and for oral exams. Don't bring up issues you don't have background in.
- Encounter cards: different evaluators have different approaches to these. Find out who is collating the final exam, and how they feel about the encounter cards. Some clerks/staff find them valuable; others find them to be make-work.
- Tips that will help you in the rotation:
    - Work hard for your patients, residents and staff: you will be rewarded.
    - Show that you're keen, arrive early for rounds and have things organized for your team.
    - Be concise when you report cases to your seniors.

- Never make things up…saying “I do not know, but I will find out” is a good cop out.
- Never make anyone around you look bad. That includes other students, residents, nurses, etc.
- Always try to practice suturing and knot tying when you have time.
- Read about the OR case the day before. You can see the OR schedule the day before if you want).
- Never argue with anyone, you never know if it will come back and haunt you.
- Don’t worry if you get yelled at while operating the camera during laparoscopy.
- Before entering any OR do a mental check: (hat, mask, scrubs, shoe covers)
- Remember: surgery is a team based specialty

4b) General Surgery (Hamilton - St. Joseph's Site) - *By Rami Elias, McMaster Medicine Class of 2010. Updated by Shawn Dason, McMaster Medicine Class of 2012.*

The set up -

- Six week block of surgery, four weeks of general surgery and two weeks of a chosen selective usually undertaken at the beginning or end of the rotation
- Selective can be in the fields of otolaryngology, plastics, thoracic, urology or vascular surgery.
- Rotation in pediatric surgery at MUMC or a selective in another site than originally placed can be arranged based on availability and approval from site Surgery CTU director and off site preceptor
- A subspecialty selective is optional—students may do 6 weeks of general surgery.

The team -

<u>Staff Surgeons</u>

- Dr. Anvari, Dr. Cadeddu, Dr. Amin & Dr. Hong (CTU Director) are part of the minimally invasive team and are involved in the bariatric surgery program (Dr. Anvari & Hong). Great opportunity to see surgical techniques and anatomy since laparoscopic approach allows viewing from large monitors. Able to assist with camera holding and closure of port holes. Hernia repair, colorectal surgery and other bread and butter cases are also performed.
- Dr. Heller& Dr. Lovrics perform a variety of different core cases. Breast oncology is a particular area of interest for these staff surgeons along with common general surgery cases.

<u>Residents</u>

- Residents will be your main resource throughout this rotation. Each team will have at least one senior +/- junior resident. They can include general surgery residents or off service members. Utilise their knowledge by reviewing how to write orders, informal teaching session or review of surgical techniques. Ask to visit the Center for Minimal Access Surgery teaching unit for introduction to laparoscopy and endoscopic equipment.

Clerks

- Other clerks from your rotation will also be placed at this location and will be your support throughout these next weeks. Remind each other of important events like morning rounds and teaching sessions since they are numerous and sporadic.

How the ward works -

- Patients on the ward include post-operative cases, referrals from the ER and transfers from other wards. Keep the nurses happy as they will help you more this way. The ward often pages the resident during the day if issues are not addressed with in the morning.

The hospitals -

- St. Joseph's hospital is well known for its strong surgical program and great academic staff. The operating rooms, emergency department and call rooms are the main places of interest. The occasional ward consult will be requested so be familiar of where departments are located. The cafeteria is closed during the evenings and weekends so the Second Cup and convenience store are the go to places.
- The Site is well known for minimally invasive surgery (lots of laproscopic procedures). These are mostly bread and butter cases with the occasional interesting/unusual case. Call is typically busy.

Typical day -

- 6:30 - 7:15am: Morning rounds depending on team size and patient load. Assessment and SOAP format notes to be completed on assigned patients. Blood work and investigations to be reviewed and new orders completed. Rounding time is variable—check with the senior resident each day. After rounding, you are usually assigned to what you’re doing for the day. There is some room for preference.
- 8:00am: Operating Room official start. Patient is brought in and prepped for surgery. Aid in placement and preparation for surgery. Staff surgeons will applaud this. Complete OR Note as well as Post-Op Orders. Scrub into surgeries if the option is given.

- 3:30-5:00pm: The OR day ends if no delays. There is usually about 20 minutes between patients in the OR. This is where you can read about the next procedure, complete any outstanding tasks or grab a quick bite to eat. After which afternoons rounds are completed to follow up with any orders or issues. When the OR is done, find the senior resident and inquire about afternoon rounds.
- Clinic days are variable and may last from 2 hours to a whole day. If you are assigned to a clinic, be on time.
- 4:00-5:00pm: Afternoons rounds are preformed (quickly) to ensure orders have been completed and to follow up on investigations. This sometimes lasts from one to two hours.

Call -

- There is a requirement to have one clerk on each night during the six weeks of surgery. Thus, general surgery call is expected during surgical selective period. At St. Joseph's, the option is given to the clerks to devise their own call schedule.
- During call, you are expected to complete in-ward and ER consultations. The consults are usually acute cases and the staff may end up taking them to the OR afterwards. This is the chance for you to see the natural history of a patient's care. Call usually starts at 5:00pm and runs until the next day 7:00am. Although you are officially supposed to work until noon post-call, most residents will let you off shortly after morning rounds (8-9). If you are on call on weekends, you usually have to help round on your team, and get out only after this is done.
- If you are not working, then you should be sleeping. If you are not sleeping you should be eating. If not eating then study. You never know when you have a spare moment so take advantage of a lull.

Your role -

<u>ON WARDS:</u>

- Morning and afternoon rounds are where you will assess and review the patients with your team. The nursing station is the place to go to find the patient's charts. Outside each room, there are charts of the patient's daily vitals which will be useful during rounds. Look at overnight trends in vitals, especially temperature rise (fever), urine output, tachycardia, and blood pressure. Identify the nurse in charge of your patients and ask them if there are any issues to be addressed. If the charted vitals are not current, ask the nurse at the same time for the latest vitals.When rounding with residents or reviewing with staff, take note of any orders to be written. When on the ward, order the necessary items and get it co-signed by the resident. The more efficient you are at writing notes and orders, the better you will be viewed by the team. Surgery notes are brief—it is not necessary to record each detail or write in sentences. Most simple notes consist

of 6-10 lines at a maximum. Postoperative care is an essential part of surgical education so ensure that you understand why each management step is taken.

OR:
As a clerk, your responsibilities will vary depending on staff and the size of your team. The main responsibilities include:

- 1.Writing an in-chart OR Note
    - PPP SAFE DISC (Procedure, preop diagnosis, postop diagnosis, surgeons, anesthesia [GA, spinal, etc], fluids [blood transfusions], estimated blood loss, drains, IV fluids, specimens, complications.
- 2.Writing Post-Operative Orders
    - In the format of admission orders. Rewrite all home meds and previous orders.
- 3.Preparing the patient for surgery (able to insert IVs if you ask the anesthetist)
- 4.Scrubbing in on surgeries - assist during open cases, camera or grasping during laparoscopic cases. Practice your suturing skill and ties since you are often able to close superficial incisions or port holes.
- 5.Transferring the patient to the Post Anesthesia Care Unit (PACU) (make sure you bring along the patient's chart) - if patient is going home, ensure all the necessary prescriptions are filled out (i.e. post-op analgesia)

CLINIC:

- Often you will be given new consultations during clinics in order to boost your learning. Be prepared to conduct a focused history and physical for common non-acute, general surgery referrals. Refer to Toronto Notes for main conditions (i.e. hernia, rectal bleeding, screening colonoscopy, colon CA, etc.). Make sure you are familiar with cases to get a better learning experience. Be prepared to summarize your findings and suggest plans for the patients. Also be prepared to dictate a short note to the referring physician highlighting the history, physical (+ve/-ve), investigations, main issues and plans. Clinics are often hectic and long so be well rested and prepared.

Skills to develop -

- Identify and understand the common disease pathologies presented to general surgeons
- Develop an approach to focused histories and physicals for consultations and the proper identification of an acute patient
- Understand the necessary management steps for common conditions
- Be able to highlight issues with your patients and develop appropriate plans
- Understand the indications for surgery as well as the contra-indications and complications
- Learn and develop surgical skills (scrubbing in, sterile technique, instrument usages and ties)

- Develop professional case summaries and presentation skills to review with staff

Tools of the trade -

- Progress Notes - In SOAP format for morning and afternoon rounds.
- Consultation Report - include all the necessary positive/negatives for history and physical findings as well as completed lab work and investigations. Look in patient's chart or ER note for history summary. Use Provider Portal and Meditech to review old consultations. Clues for a past medical history can often be found here as well as any previous operative report or imaging. Ask patient to show Rx container or even pharmacy print out if possible.
- Admission Orders: Review above and Toronto Notes Pocket Guide General Surgery Section
- Post-Operative orders: Review above
- Patient List - ensure that you list is always up-to-date
- Dictation - make sure you complete all dictations for clinic visits and consultations. Complete them after seeing a patient since the case will be fresh in your mind and the number of dictations grow quickly. Writing a good note will make dictations easier.

What to have in your pockets -

- Drug Reference - whether this is in a form of a pocket reference guide or electronic format on a handheld device. Ensure that the reference includes generic/trade names with dosages. Epocrates and Medscape are available on Blackberry, iPhone, Window Mobile and online formats free of charge.
- Patient List - - each team has a list of patients from the database with all the important information. Make sure you keep a copy to write down pertinent results or orders to write down. Use it as a tool to remember all the necessary issues for each patient. Residents and staff will often request things off topic and you will look like a star if you remember them.
- Stethoscope - you will use it during rounding and consultations to carry out a thorough physical.

The good and the bad -

<u>Good</u>

- Call is busy, there will be some sleepless nights but well worth the exposure, make sure you sleep well the night before call
- Staff/residents will guide you along your way and provide good teaching points

<u>Bad</u>

- Involvement in surgical procedures is highly dependent on the number of learners (fellows/residents/clerks) and there will be times were you take a distant observational role in the OR only.
- Numerous informal teaching sessions and encounter cards to be filled out so make sure you are organized and prepared.

- Hours are long and service requirements are high. Keep your morale up.

TIPS:

- Identify the OR list for the next day and read up on the conditions and surgeries
- Read up on the topic covered on a teaching session before starting
- Have snacks available when you can because you never know when you are able to have lunch
- Know what the issues are for your patient and the plans needed

Evaluations -

- There are evaluations for your staff to fill out at the end of your four week general surgery and two week selective block
- Ask for an informal mid-evaluation to gain feedback for improvement
- Try to get a copy of the evaluation before handing them in since papers often go missing
- Clinical encounters are to be completed along the way by residents and staff, make sure you do not leave them all to the last week
- There is a final MCQ test during the last week of the rotation covering topics included in the lectures and basic knowledge. This is not a big deal.
- A final oral exam will be conducted by a staff from another site asking you to present a case, start to finish, that was encountered. This is not a big deal.
- There will also be scenario type questions that test physical findings, differential diagnosis and management plans after the oral case presentation

4c) General Surgery (Cambridge, Kitchener, Brantford) - *By Jessica Rollings- Scattergood, MD Class 2010, Lili Tong Class of 2016*

Hospital In and Outs

- At CMH
    - Parking paid per month – buy on the first day when you pick up your badge and pager
    - Make sure that dispatch and your supervisor have your pager and cell phone number when you are on call and inform dispatch that you are on for surgery each night that you are on and ask them to page you – they may forget so this is why your supervisor needs your number
    - Medium sized hospital with recently created call rooms in the student wing, with showers, kitchen, computer room and a sunroom.

    - Tim Horton's (closes at 8pm)
    - Caf is in the basement and has short hours, lunch is ok
- At SMGH/GRH
    - Parking is arranged through Kailagh at SMGH for per entry/exit and monthly parking at GRH can be bought from security/parking office but will be a 5-10min walk from the hospital
    - Genera surgeons generally carry their own pagers but some will ask that you leave your number with ED
    - There is a designated space for eating in the OR area and the student space/call rooms is on the 9th floor
- At Brantford
    - Monthly parking can be purchased during business hours from HR/parking office
    - General surgeons carry their own pagers and will call you if there is a patient to be seen
    - You have 24/7 access to the family medicine resident area which contains a kitchen, computer area and call rooms. The video-conference room is also in this area.

Rotation

- Work with a number general surgeon's through your rotation for 4 weeks and then 2 week selective with specialty surgeon – urology, plastics, thoracic, vascular, ENT and ophthalmology are possible options
- Nurses can be great assets to helping you find your way around the OR – they are the ones that supply the stools to us short people
- Day normally starts at 7 or 8am depending on where you are, some attendings will expect you to pre-round, others will not so find out in advance what is expected each day and some attendings will simply ask you to round with them
- OR days finish around 3-4pm unless your preceptor runs over-time. Clinic days tend to run until 3-5pm. Some preceptors have clinic days after their OR days.
- If you need to round on weekends, be prepared to round on all the patients on the floor so get there early if you need to pre-round; not all sites require you to come in during weekends
- Lots of good teaching and hands-on opportunities
- At Cambridge, you need to arrange for your teaching sessions in advance – do this the first week, you need to nail down the surgeons which is less then easy! if you don't get it done in the first few weeks you will regret it! Trust me!
- At Brantford, the main attending physician will give you extra lectures on a variety of relevant general surgery topics.
- If you are scheduled to be one place but another surgeon is doing something interested, then ask to join them for the day -- most will be more than happy to take you especially if your supervisor is doing scopes all day!
- During scope days if you are bored, ask if ENT or urology are in minor procedures and doing something interesting -- then ask to spend the day/half day with them. Most will be happy to have you and are great teachers. Depending on if they have a resident or student of their own, they will let you do a lot if you ask.

Call

- Your choice of home call or in hospital call, based on whether or not you want to drive in
- Don't get post call day unless you can truly explain why and show that you were up all night – which is very unusual
- In Cambridge, call is 24 hours from 8am to 8am depending on how you want to work it you can either be with the doc all day who is on call or just join them at the end of your office day for the remainder of the night
- At all other sites, call is until approximately 11pm – if you are very keen and have an interest, you're welcome to stay but the expectation is you're in clinic the next day.
- For call, you join your designated preceptor during the day and then report for call after your regular day finishes. Often your on-call preceptor is still finishing up their day and you will get a head start on consults in the ER.
- Call is pretty light compared to Hamilton
- Lots of consults in the ER and consults to the floor for central lines, feeding tubes
- Follow all the patients on the weekend for those surgeons not in town – rounds take longer on the weekend
- At Brantford/Kitchener sites, you are not always expected to round on weekends. It is preceptor dependent.
- Great experience! See a lot of things you would otherwise not see during regular hours – acute cases

Pimping

- All great teachers – will ask a lot of the same questions so make sure if you don't know an answer look it up for the next day because someone will ask it again and that way you will have the answer and look like a superstar
- Be prepared to be quizzed during the OR and throughout the day – they don't do it to be malicious but rather because they are surgeons and it's what they do
- Look ahead to the schedule and figure out what will be asked! You can usually make a good guess at what they will be quizzing based on what cases you will have – of course they will always throw in the odd zebra question
- Find the list for the following day which is posted each night
- Be prepared for the anesthetist to ask questions too, especially if you have previously done anesthesia. Be forewarned!

4d) General Surgery (St. Catherines) - *Updated by Sam Sigurdson C2015, Alannah Smrke C2014 (By NRC Class of 2011), updated from Jody Dans, McMaster Medicine Class 2010*

The set up –

- 4 weeks in duration with one academic day (Wednesdays) each week on videoconference from McMaster. The resident usually runs a suturing session at SCS.
- Each student is set up with one preceptor whose OR and office you attend. There is some flexibility to spend time with other preceptors to see different types of surgeries.

- 2 week selective (urology, plastics, vascular, thoracic, ENT, anesthesia – depending on site). Selective is optional; you can choose to spend all 6 wks in general surgery.

The team –

Other physicians, both general surgeons and otherwise (GP's assisting in OR; internists and intensivists on wards). Other learners, such as residents and fellow clerks.

The surgery rotation in Niagara is quite strong. The surgeons are all interested in teaching and let you participate a fair bit in surgeries and minor procedures.

How the ward works –

Rounds early morning (7am) on your own to see how patients are progressing post-operatively as well as patients admitted to general surgery after being admitted from the ER or other services. Review any problems with the resident. Round again with your staff physician later in the day. Ward Nurses will page residents and docs regarding ward issues. Clerks were never paged to handle issues during the day.

The hospitals –

St Catharines General, Niagara General Hospital (if there are 4 clerks in the rotation, 1 will go here)

Typical day –

Rounds at 7am, clinic/OR, home by 5pm- Dr. Kobylecky usually rounds again after OR or clinic so will have longer days, though feedback is she is an amazing teacher. We found the stronger teachers are at SCS though and recommend ranking this site highly.

Call –

Everyone is required to do 9 calls in 6 wks. Shifts may include; scrubbing for emergency surgeries and/or consultations in the emergency department and other wards. Surgeons rarely start cases past 2300 or 0000 unless it is a true emergency. However, clerks are expected so sleep at the hospital.

Your role –

ON WARDS:

- Following patients whose care you have been involved with and writing progress notes

- Writing orders which have been discussed with resident or staff

- Learning (ex. Natural post-op progression before patient can be sent home)

OR: assisting with surgeries (some preceptors are better about letting you do other things besides retracting). Helping set up patients for cases and bringing patients to the

recovery room. Writing post-op orders.

CLINIC: seeing patients, assessing them and then review your assessment and plan with preceptor. Minor procedures.

Skills to develop –

- Surgical skills (suturing)
- Understanding the indications and complications of surgery
- Pertinent history and physical to rule out or rule in need for surgical intervention
- Presentation skills of cases including assessment and plan

Tools of the trade –

- Progress notes: SOAP format is useful (**S**ubjective complaints of patients, **O**bjective findings such as wound healing, P/E findings, lab investigations, **A**ssessment of patient's overall well being and **P**lan based on assessment.
- Admission orders: use AD DAVID or something along those lines
- Post- op orders: same as admission orders (Residents are great tools to teach you how to write the first few)
- Consultation: I find it useful to go through charts first and gather all history possible for HPI and PMHx. Even use Meditech to look up previous visits. I also look up investigations that have been done up until the consultation. I make a consultation note template with all the information down under appropriate headings along with headings of things I need to do during consultation (i.e. P/E), then interview patient to confirm details that are important.
- Dictation: If consultation notes are organized, dictation is much easier. There should be a template at each site to help organize your dictation.

What to have in your pockets –

I didn't find that I needed much other than a pen and occasionally a pharmacopoeia or PDA/phone for drug references.

Surgical Recall for times when you play the waiting game

The good and the bad –

About St. Catharines: a great place to do a surgical rotation because there is a lot of opportunity to do hands on learning. Being in a smaller center, I felt like we were able to interact with staff more consistently as opposed to the larger centers. Videoconferenceing academic days can sometimes pose technical problems, and the afternoon small sessions would be better if run here. Staff members, including administrative staff, are all very friendly and helpful. The OR attendings are, for the most part, very funny, NICE people. You're encouraged to work hard, participate as much as you wish, and to get lots of exposure to various aspects of gen surg.

About the rotation: the rumours are true, surgery is one of the more demanding clinical rotations you will face, not only intellectually but also physically. Lots of encounter cards and forms to fill out which I found to be very cumbersome, so stay on top of them. Tips: Check the case log for the next day, and read up on the medicine/anatomy surrounding the case.

Evaluations –

- Evaluations for both general surgery (4wks) component and selective (2wks) need to be filled out by your preceptor. How this is done is dependent on the

style of your preceptor. These evaluations are then sent to the site co-ordinator who completes the evaluation for your transcript.
- Written exam, multiple choice (60 questions).

4e) Urology Selective (Hamilton-St. Joseph's site) - *By Rami Elias, Class of 2010. Updated by Shawn Dason, Class of 2012.*

The set up –

- Two weeks of urology that can be done at any time within your surgical block
- You are placed with the entire team of urologists and may follow one or several staff members

The team –

- The staff cover a variety of different subspecialties that may interest you including oncology, transplantology and endourology. The residents are very personable, relaxed and approachable. When you are placed in a urology rotation, you work with the entire team and you may have multiple supervisors since there are no formal teams.
- The program is a small group of highly motivated people who enjoy a keen student. There are often many visiting clerks that perform electives at St. Joseph's hospital since the program director practices there. Fall and winter months are the main dates were these students visit.

How the ward works –

- Patients on the ward include mostly post-operative cases and referrals from the ER. The nurses have urological training and are extremely helpful.

The hospitals –

- McMaster's Institute of Urology at St. Joseph's Hospital is the center of urological care in Hamilton. The staff cover areas of oncology, endourology, stone disease and minimally invasive surgery.

Typical day –

- 7:00am: Morning rounds depending on team size and patient load. Assessment and SOAP format notes to be completed patient by patient by the entire team. Blood work and investigations to be reviewed quickly before rounding. Patient plans and new order are completed as patients are seen. Throughout the day, between OR cases the results are reviewed. Wednesday rounding is at 6:30AM and Friday rounding is at 6:00AM.

- 8:00am: Operating Room official start. Patient is brought in and prepped for surgery. Aid in placement and preparation for surgery. Staff surgeons will applaud this. Complete OR Note as well as Post-Op Orders. Scrub into surgeries if the option is given.
- 3:30-5:00pm: The OR day ends if no delays. There is usually about 20 minutes between patients in the OR. This is where you can read about the next procedure, complete any outstanding tasks or grab a quick bite to eat. After which afternoons rounds are completed to follow up with any outstanding issues.
- 9:00am: Clinic days start later and end roughly at 5:00pm with some time for lunch in-between.
- 4:00-5:00pm: Afternoons rounds are preformed (quickly) to ensure orders have been completed and to follow up on investigations. Occasionally, the junior resident completes this task in the afternoon if they are not participating in clinic or OR.

Call –

- Call is optional for the most part. If you are interested, you may ask the resident on for that night to call you for interesting cases or procedures. After hour cases usually include stone cases as well as kidney transplants. Call is home call. Weekend coverage is city-wide.

Your role –

ON WARDS:

- During morning and afternoon rounds, this is where you will assess and review the patients as a team. The nursing station is the place to go to find the patient's charts. Outside each room, there are charts of the patient's daily vitals which will be useful during rounding. Look at overnight trends in vitals, especially temperature rise (fever), tachycardia, urine output and blood pressure. The nurses are a valuable resource and they will tell the team the outstanding issues for each patient. When rounding with residents or reviewing with staff, take note of any orders to be written. When on the ward, order the necessary items and get it co-signed by the resident.

OR:

- As a clerk, your responsibilities will vary depending on staff and the size of your team. The main responsibilities include:
    - Writing an in-chart OR Note
        - PPP SAFE DISC (Procedure, preop diagnosis, postop diagnosis, surgeons, anesthesia [GA, spinal, etc], fluids [blood transfusions], estimated blood loss, drains, IV fluids, specimens, complications.
    - Writing Post-Operative Orders
    - Preparing the patient for surgery.

- In certain surgeries, you may be able to assist.
- Transferring the patient to the Post Anesthesia Care Unit (PACU) (make sure you bring along the patient's chart) – if patient is going home, ensure all the necessary prescriptions are filled out (i.e. post-op analgesia)

CLINIC:

Often you will be given new consultations during clinics in order to boost your learning. Be prepared to conduct a focused history and physical for common non-acute, urology referrals. Ask the residents that day before which staff you will be following during clinic the next day. Identify their specialty and read up on common cases. Refer to Toronto Notes for main conditions (i.e.renal/prostate/bladder/testicular oncologies, stone disease, etc.). Smith's General Urology and Campbell's Urology are the go to resources. These are available on AccessMedicine or MDConsult respectively. Make sure you are familiar with cases to get a better learning experience. Be prepared to summarize your findings and suggest plans for the patients. Also be prepared to dictate a short note to the referring physician highlighting the history, physical (+ve/-ve), investigations, main issues and plans. Dictation is staff dependant—so clarify if staff will dictate the note themselves.

Skills to develop –

- Identify and understanding the common disease pathologies presented to urologists
- Develop an approach to focused histories and physicals for consultations and the proper identification of an acute patient
- Understand the necessary management steps for common conditions (i.e. prostate CA, stone disease)
- Be able to highlight issues with your patients and develop appropriate plans
- Understand the indications for surgery as well as the contra-indications and complications
- Learn and develop surgical skills (scrubbing in, sterile technique, instrument usages and ties, laparoscopic assistance and cystoscopy manipulation)
- Develop professional case summaries and presentation skills to review with staff

Tools of the trade –

- Progress Notes – In SOAP format for morning and afternoon rounds.
- Consultation Report – include all the necessary positive/negatives for history and physical findings as well as completed lab work and investigations. Look in patient's chart or ER note for history summary. Use Provider Portal or Meditech to review old consultations. Clues for a past medical history can often be found here as well as any previous operative report or imaging. Ask patient to show Rx container or even pharmacy print out if possible.
- Admission Orders: Review above and Toronto Notes Pocket Guide General Surgery Section

- Post-Operative orders: Review above
- Patient List – ensure that you list is always up-to-date
- Dictation – make sure you complete all dictations for clinic visits and consultations. Complete them after seeing a patient since the case will be fresh in your mind and the number of dictations grow quickly. Writing a good note will make dictations easier.

What to have in your pockets –

- Drug Reference – whether this is in a form of a pocket reference guide or electronic format on a handheld device. Ensure that the reference includes generic/trade names with dosages. Epocrates and Medscape are available on Blackberry, iPhone, Windows Mobile and online formats free of charge.
- Patient List – each team has a list of patients from the database with all the important information. Make sure you keep a copy to write down pertinent results or orders to write down. Use it as a tool to remember all the necessary issues for each patient. Residents and staff will often discuss inpatients you will look like a star if you remember them.
- Urology Handbook – If you are keen on urology, carry a quick reference book with you. If you have time before a case, read up on the necessary background information.

The good and the bad –

<u>Good</u>

- St. Joseph's Healthcare is recognized as one of the busiest minimally invasive surgical centers in Canada, therefore, there is the opportunity to see many cases.
- Staff and residents are very relaxed and laid back, with a no pressure mentality.
- Often able to assist on major cases and able to participated avidly during minor surgical day procedures
- Staff teachers take a one on one role with students to teach them on a daily basis

<u>Bad</u>

- It's only two-weeks long!

TIPS:

- Identify the OR list for the next day and read up on the conditions and surgeries including the relevant anatomy
- Read up on the topic covered during grand round sessions before starting
- Have snacks available when you can because you never know when you are able to have lunch

- Know what the issues are for your patient and the plans needed
- Read up on common conditions in urology and their relevant anatomy
- Be keen and helpful to all members of the urology team

Evaluations –

- There are evaluations for your staff to fill out at the end of your two week urology block. Try to figure out who you intend to have filling out your evaluation at the end and let the residents know early on—this ensures that you can have enough time to work with them for an appropriate evaluation.
- Ask for an informal mid-evaluation to gain feedback for improvement
- Try to get a copy of the evaluation before handing them in since papers often go missing.
- Clinical encounters are to be completed along the way by residents and staff, make sure you do not leave them all to the last week. You can complete all of your encounter cards on your selective if you wish.
- The final general surgery test may include questions about urology.

4f) Plastic Surgery Selective - *By Jessica Rollings-Scattergood, MD Class 2010*

- Lots of questions!
- Great teachers
- Be prepared to write on the white board know your stuff
- "suboptimal" is his way of saying do it again
- Will let you do things on the non-cosmetic patients
- Works in hospital once/month – great experience see if you can coordinate for this day
- Experience in a pay for service clinic
- Lots of photographs to learn from, great base to learn from
- Staff are all great to work with
- Spend some time with the nurse watching injections
- Call is extremely light, worth doing in case something does come in

4g) Pediatric Surgery Selective (MUMC) - *By Nikoo Rajaee, McMaster Medicine Class of 2011*

The set Up –

- Two weeks that can be done any time during your general surgery rotation. I recommend that you do it during either your first or last two weeks. Your team includes five pediatric surgeons, two pediatric surgery fellows, two senior gen surgery residents (3rd yr), an off service peds junior resident (may include another off service junior resident) and one or two clerks

The team –

- The staff cover a all aspects of pediatric surgery and any pediatric trauma (ie. MVA). Pediatric surgery includes everything from thoracic to colorectal. You will

see a wide variety of procedures. Keep in mind that much of pediatric surgery is congenital anomalies so you'll be exposed to very interesting cases. The residents are very personable, relaxed and approachable. You will work with all the pediatric surgeons although you'll be assigned to one as your preceptor
- The program is a small group of highly motivated people who enjoy a keen student.

How the ward works –

- Patients on the ward include mostly post-operative cases
- There are also many NICU patients but the fellows are usually responsible for seeing them

Typical day –

- 6:00am: Morning rounds. You should arrive 5-10min before and print the patient list for everyone, look up the patients vitals, INCLUDING ins/outs/ Assessment and SOAP format notes to be completed patient by patient by the entire team. Blood work and investigationsshould be reviewed quickly before rounding. Patient plans and new orders are completed as patients are seen. The results are reviewed between OR cases throughout the day.
- It is YOUR job as the clerk to write the notes. It helps when there are two clerks as you can switch because rounds are very fast on this team. Write RELEVANT information (if the vitals are stable, write AVSS). DATE AND TIME YOUR NOTES!!!
- 8:00am: Operating Room official start. Patient is brought in and prepped for surgery. Aid in placement and preparation for surgery. Staff surgeons will applaud this. Complete OR Note as well as Post-Op Orders. Ask if you can scrub in, the staff are very amendable to students scrubing (you may not get to aid in the procedure, but children are very small and it helps to get a closer look)
- 4:30-5:00pm: The OR day ends if no delays. There is usually about 20 minutes between patients in the OR. This is where you can read about the next procedure, complete any outstanding tasks or grab a quick bite to eat. After which afternoons rounds are completed to follow up with any outstanding issues.
- 9:00am: Clinic days start later and end roughly at 5:00pm with some time for lunch in-between.
- You will be expected to see patients on your own and give an oral report of the case to your staff before you go see the patient together. Take initiative.
- 4:00-5:00pm: Afternoon rounds are preformed (quickly) to ensure orders have been completed and to follow up on investigations. Occasionally, the junior resident completes this task in the afternoon if they are not participating in clinic or OR.

Call –

- Call is optional but highly recommended. If you are interested, you may ask the resident on for that night to call you for interesting cases or procedures.

Your role –

ON WARDS:

- During morning and afternoon rounds, this is where you will assess and review the patients as a team. The nursing station is the place to go to find the patient's charts. Vitals are on Meditech. Look at overnight trends in vitals, especially temperature rise (fever), urine output and blood pressure. The nurses are a valuable resource and they will tell the team the outstanding issues for each patient. When rounding with residents or reviewing with staff, take note of any orders to be written. When on the ward, order the necessary items and get it co-signed by the resident.

OR:

- As a clerk, your responsibilities will vary depending on staff and the size of your team. The main responsibilities include:
    - Writing an in-chart OR Note
        - Include: date, procedure, staff surgeons, assistants (residents/clerks), type of anesthetic, estimated blood loss and any intra-operative complications. Also include if any drains were placed or specimens sent to pathology.
    - Writing Post-Operative Orders
    - Preparing the patient for surgery (able to insert IVs if you ask the anesthetist)
    - Scrubbing in on surgeries – first or second assist during open cases, camera or grasping during laparoscopic cases. Practice your suturing skill and ties since you are often able to close superficial incisions or port holes.
    - Transferring the patient to the Post Anesthesia Care Unit (PACU) (make sure you bring along the patient's chart) – if patient is going home, ensure all the necessary prescriptions are filled out (i.e. post-op analgesia)
    - Ask to close if you will the case has gone well and you're on time as the staff are very open to students suturing

CLINIC:

Often you will be given new consultations during clinics in order to boost your learning. Be prepared to conduct a focused history and physical for common pediatric surgery cases. Read up on GI cases as many referrals are for abdo pain. Ask the residents that day before which staff you will be following during clinic the next day. Identify their specialty and read up on common cases. Refer to Toronto Notes for main conditions (i.e.Hirschsprungs, CF, pectus excavatum, etc.). Surgical Recall is the go to resource. Make sure you are familiar with cases to get a better learning experience. Be prepared to summarize your findings and suggest plans for the patients. Usually the staff dictate themselves but ask on your first day what they would prefer. Clinics are often hectic and long so be well rested and prepared.

Skills to develop –

- Identify and understanding the common disease pathologies presented to pediatric surgery
- Develop an approach to focused histories and physicals for consultations and the proper identification of an acute patient
- Understand the necessary management steps for common conditions (i.e. umbilical hernias, inguinal hernias)
- Be able to highlight issues with your patients and develop appropriate plans
- Understand the indications for surgery as well as the contra-indications and complications
- Learn and develop surgical skills (this will be a great rotation for suturing)
- Develop professional case summaries and presentation skills to review with staff

Tools of the trade –

- Progress Notes – In SOAP format for morning and afternoon rounds.
- Consultation Report – include all the necessary positive/negatives for history and physical findings as well as completed lab work and investigations. Look in patient's chart or ER note for history summary. Use Meditech to review old consultations. Pediatric patients are usually easy because they don't have much of a PMHx. REMEMBER TO ASK ABOUT MOM'S PREGNANCY!
- Admission Orders: Review above and Toronto Notes Pocket Guide General Surgery Section
- Post-Operative orders: Review above
- Patient List – ensure that your list is always up-to-date
- Dictation – make sure you complete all dictations for clinic visits and consultations. Complete them after seeing a patient since the case will be fresh in your mind and the number of dictations grow quickly. Writing a good note will make dictations easier.

What to have in your pockets –

- Drug Reference – whether this is in a form of a pocket reference guide or electronic format on a handheld device. Ensure that the reference includes generic/trade names with dosages. Epocrates is available on Blackberry, iPhone, Windows Mobile and online formats free of charge.
- Patient List – each team has a list of patients from the database with all the important information. Make sure you keep a copy to write down pertinent results or orders to write down. Use it as a tool to remember all the necessary issues for each patient. Residents and staff will often request things off topic and you will look like a star if you remember them.
- Stethoscope – you will use it occasionally during rounding and consultations to carry out a thorough physical. Most residents do not carry one.
- Surgical recall – has a good pediatric surgery section, will help before OR cases

The good and the bad –

Good

- Staff and residents are very relaxed and laid back, with a no pressure mentality
- Often able to assist on major cases and able to participated avidly during minor surgical day procedures
- Staff take a one on one role with students to teach them on a daily basis

Bad

- Some staff are more hands on than others
- Some staff like to pimp more than others but mainly they're looking for someone who is willing to work hard and keen to learn

TIPS:

- Identify the OR list for the next day and read up on the conditions and surgeries including the relevant anatomy
- Read up on the topic covered during grand round sessions before starting
- Have snacks available when you can because you never know when you are able to have lunch
- Know what the issues are for your patient and the plans needed
- Read up on common conditions in urology and their relevant anatomy
- Be keen and helpful to all members of the team

Evaluations –

- There are evaluations for your staff to fill out at the end of your two week pediatric surgery selective
- Ask for an informal mid-evaluation to gain feedback for improvement
- Try to get a copy of the evaluation before handing them in since papers often go missing
- Clinical encounters are to be completed along the way by residents and staff, make sure you do not leave them all to the last week
- There is a final MCQ test during the last week of the rotation covers topics in pediatric surgery so understand the main conditions

4h) Pediatric Urology Selective (MUMC) - *By Nikoo Rajaee, McMaster Medicine Class of 2011*

The set up –

- Two wks that can be done any time during your general surgery rotation: recommended that you do it either the first two wks or last two wks
- Your team includes two pediatric urologists +/- a senior urology resident and you.

The team –

- The staff cover all aspects of pediatric urology (ie. fetal hydronephrosis). Much of their scope of practise is congenital malformation so go back to MF3 and read about hypospadias!
- The residents are very personable, relaxed and approachable. You will work with both pediatric urologists although you'll be assigned to one as your preceptor
- The program is a small group of highly motivated people who enjoy a keen student.

How the ward works –

- Patients on the ward include mostly post-operative cases

Typical day –

- 7:00am: Morning rounds. Depends on your patients list (somedays you may have no patients to round on!). You should arrive 5-10min before and print the patient list for everyone, look up the patients vitals, **INCLUDING ins/outs.** Assessment and SOAP format notes to be completed patient by patient by the entire team. Blood work and investigations to be reviewed quickly before rounding. Patient plans and new order are completed as patients are seen. Throughout the day, between OR cases the results are reviewed.
- It is YOUR job as the clerk to write the notes. Write RELEVANT information (if the vitals are stable, write AVSS). DATE AND TIME YOUR NOTES!!!
- 8:00am: Operating Room official start. Patient is brought in and prepped for surgery. Aid in placement and preparation for surgery. Staff surgeons will applaud this. Complete OR Note as well as Post-Op Orders. Ask if you can scrub in, the staff are very amendable to students scrubing (you may not get to aid in the procedure, but children are very small and it helps to get a closer look)
- 4:30-5:00pm: The OR day ends if no delays. There is usually about 20 minutes between patients in the OR. This is where you can read about the next procedure, complete any outstanding tasks or grab a quick bite to eat. After which afternoons rounds are completed to follow up with any outstanding issues.
- 9:00am: Clinic days start later and end roughly at 5:00pm with some time for lunch in-between.
- You will be expected to see patients on your own and give an oral report of the case to your staff before you go see the patient together. Take initiative.
- 4:00-5:00pm: Afternoons rounds are preformed (quickly) to ensure orders have been completed and to follow up on investigations. Occasionally, the junior resident completes this task in the afternoon if they are not participating in clinic or OR.

Call –

- Call is optional. If you are interested, you may ask the resident on for that night to call you for interesting cases or procedures. There are not typically any pediatric urology emergencies.

Your role –

ON WARDS:

- During morning and afternoon rounds, this is where you will assess and review the patients as a team. The nursing station is the place to go to find the patient's charts. Vitals are on Meditech. Look at overnight trends in vitals, especially temperature rise (fever), urine output and blood pressure. The nurses are a valuable resource and they will tell the team the outstanding issues for each patient. When rounding with residents or reviewing with staff, take note of any orders to be written. When on the ward, order the necessary items and get it co-signed by the resident.

OR:

- As a clerk, your responsibilities will vary depending on staff and the size of your team. The main responsibilities include:
    - Writing an in-chart OR Note
        - Include: date, procedure, staff surgeons, assistants (residents/clerks), type of anesthetic, estimated blood loss and any intra-operative complications. Also include if any drains were placed or specimens sent to pathology.
    - Writing Post-Operative Orders
    - Preparing the patient for surgery (able to insert IVs if you ask the anesthetist)
    - Scrubbing in on surgeries – first or second assist during open cases, camera or grasping during laparoscopic cases. Practice your suturing skill and ties since you are often able to close superficial incisions or port holes.
    - Transferring the patient to the Post Anesthesia Care Unit (PACU) (make sure you bring along the patient's chart) – if patient is going home, ensure all the necessary prescriptions are filled out (i.e. post-op analgesia)
    - Ask to close if you will the case has gone well and you're on time as the staff are very open to students suturing

CLINIC:

Often you will be given new consultations during clinics in order to boost your learning. Be prepared to conduct a focused history and physical for common pediatric urology cases. In the orientation package there is a handout on pediatric urology prepared by Dr. Braga. It is extremely useful for this selective and highly recommended that you read it before beginning your selective. Ask the residents that day before which staff you will be following during clinic the next day. Identify their specialty and read up on common cases. Make sure you are familiar with cases to get a better learning experience. Be prepared to summarize your findings and suggest plans for the patients. The staff will expect you to dictate and you should do so right after you see a patient in clinic. Clinics are often hectic and long so be well rested and prepared.

Skills to develop –

- Identify and understanding the common disease pathologies presented to pediatric urology
- Develop an approach to focused histories and physicals for consultations and the proper identification of an acute patient
- Understand the necessary management steps for common conditions (i.e. chronic UTI's, hydronephrosis)
- Be able to highlight issues with your patients and develop appropriate plans
- Understand the indications for surgery as well as the contra-indications and complications
- Learn and develop surgical skills (this will be a great rotation for suturing)
- Develop professional case summaries and presentation skills to review with staff
- Develop skills in reviewing radiological imaging (ie. U/S of the kidneys for grade of hydronephrosis)

Tools of the trade –

- Progress Notes – In SOAP format for morning and afternoon rounds.
- Consultation Report – include all the necessary positive/negatives for history and physical findings as well as completed lab work and investigations. Look in patient's chart or ER note for history summary. Use meditech to review old consultations. Pediatric pts are usually easy because they don't have much of a PMHx. REMEMBER TO ASK ABOUT MOM'S PREGNANCY!
- Admission Orders: Review above and Toronto Notes Pocket Guide General Surgery Section
- Post-Operative orders: Review above
- Patient List – ensure that you list is always up-to-date
- Dictation – make sure you complete all dictations for clinic visits and consultations. Complete them after seeing a patient since the case will be fresh in your mind and the number of dictations grow quickly. Writing a good note will make dictations easier.

What to have in your pockets –

- Drug Reference – whether this is in a form of a pocket reference guide or electronic format on a handheld device. Ensure that the reference includes generic/trade names with dosages. Epocrates is available on Blackberry, iPhone, Windows Mobile and online formats free of charge.
- Patient List – each team has a list of patients from the database with all the important information. Make sure you keep a copy to write down pertinent results or orders to write down. Use it as a tool to remember all the necessary issues for each patient. Residents and staff will often request things off topic and you will look like a star if you remember them.
- Stethoscope – you will use it occasionally during rounding and consultations to carry out a thorough physical. Most residents do not carry one.
- Surgical recall – has a good urology section, will help before for anatomy in the OR

The good and the bad –
Good

- Staff and residents are very relaxed and laid back, with a no pressure mentality
- Often able to assist on major cases and able to participated avidly during minor surgical day procedures
- Staff take a one on one role with students to teach them on a daily basis
- Can come in later in the morning as not many inpatients

Bad

- Pimping oriented staff. Know your anatomy very well.

TIPS:

- Identify the OR list for the next day and read up on the conditions and surgeries including the relevant anatomy
- Read up on the topic covered during grand round sessions before starting
- Have snacks available when you can because you never know when you are able to have lunch
- Know what the issues are for your patient and the plans needed
- Read up on common conditions in urology and their relevant anatomy
- Be keen and helpful to all members of the urology team

Evaluations –

- There are evaluations for your staff to fill out at the end of your two week pediatric urology selective
- Ask for an informal mid-evaluation to gain feedback for improvement
- Try to get a copy of the evaluation before handing them in since papers often go missing
- Clinical encounters are to be completed along the way by residents and staff, make sure you do not leave them all to the last week

4i) Plastic Surgery Selective (Hamilton) - *Updated by Adeel Sherazi C2015. By Yu Kit Li, McMaster Medicine Class of 2011*

The set up –

- Two weeks of plastic surgery any time within your surgical block
- You are part of the on-site plastic surgery team.
- Many of the clinics are held in MUMC - this meant that I was seeing a lot of pediatrics patients. The general cases included burns in the NICU, skin grafts following BCC or SCC excision, cleft lip and cleft palate repair and orhopedics/fractures at the hand.

- The clinic bread and butter cases were hand pathologies like trigger finger, congenital deformities and fractures. For adult clinics, it was generally BCC or SCC and carpal tunnel.
- Half my days were in the ambulatory care day surgery, and I had two days in the OR (variable based on preceptor). The rest of the days were in clinic or consults by the senior resident.
- Great teachers
- Lots of questions - do your reading before if you want to impress. The preceptors are willing to teach if you do not know what is happening.
- Will let you do things on the non-cosmetic patients. I put on a skin graft and stitched it into place, but I had to ask for this.
- Call is extremely light, worth doing in case something does come in

The team –

- For the most part, you will spend some time with each of the on-site plastic surgery staff surgeons although you may have been assigned to a particular staff supervisor
- You will also work with most of the on-site plastic surgery residents (PGY-1, 3-5)
- The residents are very approachable, like teaching, and are a great resource to learn from
- There are often visiting clinical clerks, especially at MUMC and St. Joseph's Charlton Campus
- Team size is smaller than general surgery

How the ward works –

- Patients on the ward include mostly post-operative patients and referrals from the ER

The hospitals –

- Available at MUMC, St. Joseph's Charlton and King campus, Hamilton General Hospital
- Sub-specialities available at specific sites:
    - MUMC – Pediatric (e.g. cleft lip/palate, craniomaxillofacial abnormalities)
    - Hamilton General Hospital – Burns

Typical day –

- 7:15am: Morning patient rounds with plastic surgery residents ± staff
- 8:00am: Days consist of 3 general activities: OR, minor procedures, or clinic
- A) Operative Room
    - Clerks are usually given the option to scrub in

        - There is usually 20 minutes between OR cases – use this time wisely to eat, read up on the next case, see consultations from the emergency/ward, or ask questions
        - In general, most postoperative patients are not admitted
        - OR ends around 4-5; after, quick patient rounds are done on postoperative patients with residents ± staff
- B) Clinic
    - Usually tightly scheduled
    - Assessment and case review totals ~15 minutes per patient on average
- C) Minor Procedures
    - Clerks are usually given the option to scrub in
    - Variable procedures are performed, and may include operative treatment of skin and soft tissue lesions, common hand conditions, and saline injections into breast implants
    - Best opportunity to practice basic surgical skills
- Weekly grand rounds are held every Wednesday from 7:00-8:00am in MDCL
    - Rounds are geared towards residents

Call –

- Call is optional for clerks
- If you are interested, call the operator and find out which junior plastic surgery resident is on call and let them you would be interested in seeing consultations or participating in procedures
- Typical night: 2-3 consultations from emergency/ward, ward issues (residents usually will not call you about this), and 0-2 emergency OR cases
- Examples of emergency OR cases: hand/digit replantations, necrotizing fasciitis, bite injuries, etc.
- Coverage for call is the entire city and is home call

Your role –

ON WARDS:

- Assess patients as a team (residents ± nurses), review vitals and previous investigations, document findings, and write orders
- All orders must to be co-signed by the resident/staff

OR:

- Responsibilities vary depending on the staff and size of your team
- Responsibilities are similar to those of a general surgery clerk and include:
    - Participating in pre operative care
    - Completing post-op orders, the OR note, prescriptions, ± face sheet
        - See Toronto Notes for instructions on how to write post-op orders and OR notes

    - Helping with clean-up and patient transfer after case completion
    - Transferring the patient to the Post Anesthesia Care Unit (PACU)
    - Participating in post operative care
- Clerks are usually given the option to scrub in during cases, but this varies with the size of your team and the complexity of the case
- If scrubbed in, observe procedures carefully and anticipate when your assistance can improve overall efficiency (e.g. cutting sutures in a timely fashion, holding hand/digits in a position to facilitate suturing/dressings/casting, wiping blood away to improve view of surgical field, etc.)

CLINIC:

- Clerks will often be given new consultations during clinics
- Be ready to conduct a focused history and physical examination
- Be able to summarize your findings and suggest plans for patients
- Your assessment and case review with staff should generally take ~15 minutes altogether
- Dictations are encouraged by staff
    - See Clerkship Handbook for instructions on how to perform a dictation

MINOR PROCEDURES:

- Opportunity to practice basic surgical skills varies based on team size
- For the most part, clerks will be first assist for resident/staff
- Observe procedures carefully and anticipate when your assistance can improve overall efficiency (e.g. cutting sutures in a timely fashion, holding hand/digits in a position to facilitate suturing/dressings/casting, wiping blood away to improve view of surgical field, etc.)

Skills to develop –

- Learn how to perform a history + physical examination for basic hand conditions/trauma
- Learn how to perform a history + physical examination for skin and soft tissue lesions
- Gain an introductory understanding of management principles for craniomaxillofacial trauma and peripheral nerve lesions
- Learn how to manage an acute wound from start to finish
- Understand the role of local anaesthetics, antibiotics, and tetanus prophylaxis
- Learn principles of wound healing and the reconstructive ladder
- Gain proficiency in basic surgical skills, including sterile draping, suturing, instrument and hand tying, wound dressing, and casting
    - See Plastic Surgery Interest Group Basic Surgical Skills Learning Module for video-based instruction of the surgical skills listed above and information on local anaesthetics, antibiotics, and tetanus prophylaxis (only medportal users can access it)

        - http://sites.google.com/a/medportal.ca/basic-suturing-learning-module/
- Learn how to summarize findings, present cases concisely, and perform dictations
- Read up on anatomy, including:
    - Brachial plexus, peripheral nerves, hand & wrist, craniomaxillofacial, and breast etc.

Tools of the trade –

- Progress Notes – usually in SOAP format
- Consultation Report – same as general surgery
- Admission Orders – same as other disciplines, but remember:
    - Does the patient require antibiotics? Investigations (x-rays)? Tetanus prophylaxis? NPO?
- Post operative orders – same as general surgery
- Patient List – ensure that your list is always up-to-date
- Dictations – dictate seen consultations and clinic follow-up ± discharge summaries
    - Do these dictations ASAP

What to have in your pockets –

- Drug Reference – may be electronic or paper-based, useful for looking up antibiotic dosages
- Patient List with list of to-dos for each patient
- Stethoscope – keep it inside your bag in case you need it, mostly it is not required
- Recommended introductory plastic surgery handbooks:
    - Plastic and Reconstructive Surgery Essentials for Students by ASPS (free online)
        - http://www.plasticsurgery.org/d.xml?comp=x1512
    - Practical Plastic Surgery for Nonsurgeons by Dr. Semer (free online)
        - http://www.practicalplasticsurgery.org/book.html

The good and the bad –

<u>Good</u>

- Quite simply, the most amazing field (in my opinion)
- In general, there are more opportunities to practice basic surgical skills than in general surgery
- Staff and residents welcome keen clerks and enjoy teaching
- Lower volume compared to general surgery = more time to read
- No formal evaluation measures, thus onus is on you and you alone to learn as much as you can

Bad

- No formal teaching scheduled for medical students
- Sometimes there may be too many clerks
- Specialized field requiring specialized knowledge
- Material not as extensively tested on LMCC

Tips

- Read up on cases on the OR list and if possible the clinic list; read up on grand round topics
- Have food in your pocket in case the clinic/OR gets busy
- Be keen, helpful, and respectful to all members of the plastic surgery team
- Keep a ruler, multiple pens, a drug reference, and the patient list in your pocket
- Wear a white coat during clinics
- The more proficient you are, the more opportunities you will get
    - Practice suturing at home if possible
    - Use the Plastic Surgery Interest Group Basic Surgical Skills Learning Module to improve your skills and reduce unnecessary manoeuvres

Evaluations –

- There are evaluations for your staff to fill out upon conclusion of your elective/selective
- Ask for an informal mid-evaluation for feedback
- Obtain a copy of your evaluation before handing them in to avoid lost paperwork

4j) Cardiac Surgery Selective (Hamilton General) - *By Amy Montour, McMaster Medicine Class of 2011*

The set up –

- Two weeks that can be done any time during your general surgery rotation. It is recommended that you do it during your first or last two weeks.
- Your team includes the cardiac surgeon +/- a surgical resident and you.

The team –

- The staff cover all aspects of surgical cardiac disease including coronary artery bypass grafts, valve replacement and repair of aortic dissections.
- You may not have a resident working with you so be prepared to spend a lot of time alone with your surgeon.
- The program is a small group of driven, highly skilled physicians who expect an enthusiastic student.

How the ward works –

- Patients on the ward include mostly post-operative cases

Typical day –

- 7:30am: Morning rounds. Depends on your patients list (some days you may have no patients to round on!). It is super important to be on time. As the clerk you will likely just follow the surgeon but it's a good time to ask questions.
- 8:00am Operating Room official start. These surgeries are approximately 3-5 hours so make sure you eat and use the washroom before entering the OR. The clerk should go to the patient holding area, meet the patient and read the chart before going to the OR. The cardiac OR is a more complicated place than a normal OR. There is often a second surgeon for saphenous vein harvest, an advanced practice nurse setting up the bypass machine and an anesthiologist placing a central line. As a clerk you should aid in placement and preparation for surgery but only with the explicit instructions of the nursing staff/surgeons/ anaesthesiologist in the room. You will be scrubbing in and standing on stools to the left of the surgeon, wait to take your place until the surgeon directs you.
- 4:30-5:00pm: The OR day ends if no delays. There is usually about 20 minutes between patients in the OR. This is where you can read about the next procedure or grab a quick bite to eat. You may end the day in the echo viewing area of the heart investigation unit reviewing new patients.
- 9:00am: Clinic days start later and end roughly at 12:00pm in the heart investigation unit or private offices. You will not be expected to see patients on your own. Take advantage of opportunities to do the physical examination as pre-op patients often have impressive findings.

Call –

- You will not be expected to take call.

Your role –

ON WARDS:

- During morning rounds you will accompany your surgeon.

OR:

- As a clerk, your responsibilities are first and foremost to learn. Preparation for the OR should include reviewing anatomy, common surgical procedures, complications of cardiac surgery and cardiac medications.
- During the surgery you may have the opportunity to assist with opening, suctioning, and positioning of the heart during suturing of the bypass grafts.

CLINIC:

You will likely attend appointments with your preceptor. During consultations you will have the opportunity to perform physical exams.

Skills to develop –

- Identify and understanding the common cardiac disease pathologies
- Understand anatomy and physiology related to the heart – lung bypass machine
- Understand the necessary management steps for conditions common to this service (i.e. CABG, aortic valve replacement, aortic dissection)
- Understand the indications for surgery as well as the contra-indications and complications
- Develop skills in reviewing radiological imaging (ie. Echocardiography, angiography)

Tools of the trade –

Any text on cardiac surgery – ask your preceptor what reference they suggest.

What to have in your pockets –

- Stethoscope – you will use it occasionally during rounding and consultations to carry out a thorough physical. Most residents do not carry one.
- Surgical recall – has a good cardiac section, will help for the many questions you will be asked in the OR!

The good and the bad –

<u>Good</u>

- Staff are excellent teachers with world class surgical skills.
- Few residents mean that you will spend a lot of one-on-one time with the surgeon
- Often able to participate on major cases Staff take a one on one role with students to teach them on a daily basis
- Limited time in clinic and on wards – focus is on OR time

<u>Bad</u>

- Pimping oriented staff. Know your anatomy and physiology very well.
- Few residents means you have to figure out a lot of things for your self and take the brunt of the pimping!

TIPS:

- Identify the OR list for the next day and read up on the conditions and surgeries including the relevant anatomy
- If a staff asks you a question you don't know – make sure you find out because you will be asked again.
- Have snacks available when you can because you never know when you are able to have lunch
- REVIEW ANATOMY!

- Be enthusiastic and prepared – this is not a rotation where you can be too relaxed!

Evaluations –

- There are evaluations for your staff to fill out at the end of your two week selective
- Try to get a copy of the evaluation before handing them in since papers often go missing

4k) Otolaryngology Selective (St. Joseph's and HHS Sites) - *By Jeyla Chen, McMaster Medicine Class 2011*

The set up

- 1 week of ENT (HHS) and 1 week of Head and Neck (St. Joe's)

The team

- H&N team at St. Joe's has about 4-5 staff, 1 chief resident, and 3-4 residents (including off service residents)
- St. Joe's team primarily specializes in head and neck – e.g. H&N malignancies, thyroid diseases
- MUMC/General team sees primarily common ENT conditions – MUMC also has a large pediatric patient population
- Chief residents arrange weekly schedules for each student/resident on the team, you usually end up working with multiple supervisors, and get a good mix of both OR and clinic days

How the ward works

- Mainly post-op cases. Rounds at St. Joe's are at 0700h.

The hospitals

- St. Joe's, MUMC, Hamilton General, and Henderson

Typical day

- 0700 – morning rounds
- 0800 – OR starts
- 0900 – clinic starts
- 1600 – most clinics end around this time
- 1700 – most ORs end around this time

Call –

- There are no ENT-specific calls as you will be covering general surgery call

Your role –

OR:

- Most ENT/HN surgeries are quite tight in space, so unless you are scrubbed in you are unlikely to see much (unless there's a scope hooked up to a camera)
- Role in OR varies depending on how many residents are in the room with you, and what the surgery is
- Typical OR jobs for clerk as in any other surgical rotation: writing post-op orders, OR note

CLINIC:

- All the staff/residents are extremely supportive of your learning and you will mostly see patients on your own (unless there is a room limitation).
- During your week at St. Joe's, you may also get a chance to go to JCC for a day in H&N oncology – it's a great learning experience as you will work as part of a multidisciplinary team including rad onc and med onc

Skills to develop –

- Focused H&N Hx and PE, focused ENT Hx and PE
- Anatomy
- Surgical assist skills

The good and the bad –

- This is a great opportunity to see a wide range of H&N and ENT conditions and to become familiar with the corresponding anatomy
- MUMC site has large number of pediatric patients so it's nice to get a mix of both peds and adults during your ENT week at HHS
- You will get a schedule for the week from the chief resident the Sunday before you start the selective (they usually make sure you get a fair combination of both OR and clinic)
- There are no formal teaching sessions scheduled into the week (at least not during the two weeks I had my selective), so you should definitely read up on cases on your own and ask residents/staff questions during the day in order to get more informal teaching

TIPS:

- Read up on common conditions specific for your site – e.g. H&N malignancies for St. Joe's, general ENT for HHS – surgical recall and Toronto Notes are good tools to use

- Read up on OR cases for next day – the list is usually up by mid afternoon of the previous day
- ASK QUESTIONS! The residents and staff are great resources for your learning!

Evaluations –

- Selective evaluation to be filled out at each site you are at – i.e. one at St. Joe's, and one at HHS
- Unless you are under a specific supervisor, you typically ask the staff that you worked most with to do the evaluation

5a) Internal Medicine- (Hamilton) - *Updated by Adeel Sherazi C2015 and Melanie Zimmermann, Class of 2013, Kan Ma McMaster Medicine Class of 2012, from Callum Dargavel, McMaster Medicine Class of 2010* [back]

The Hospitals

- All 3 sites have similar patient volumes and diverse patient populaitons.
- All sites have 3-4 CTU teams (varies depending on the month) with an attending, SMR, and 2-3 JMRs. Usually one of the 3 teams also has a Junior Attending (PGY 3 or 4)
- All sites have dedicated MD-based teams (attending alone with a Nurse Practioner or Physician Assistant) that are not CTU teams and these manage the bulk of the ALC patients.
- The 3 sites are: St. Joe's , Hamilton General, and the Juravinski Hospital

How the ward works

- 3-4 Internal Medicine teams
- Other people on wards include: nurses, allied health (OT/PT, social work, RT, dietician, pharmacist) - a good place to complete your IPE credits.
- Consultants and their respective entourages

- Weekly clerkship tutorial with a Faculty and usually a Chief Medical Resident

The Team

- All sites have 3-4 SMR-based CTU teams:
    - SMR teams – Attending, possibly a Junior Attending, SMR, 2-3 JMRs, maximum 3 clerks (includes elective students and PA students)
    - There is a maximum of 18 junior learners (JMRs, clerks (including elective students, and PA students) on 3 teams

- An SMR = PGY-2, the JA = PGY-3 or PGY-4. Thus on non-SMR teams your head resident will have more experience & is focused on providing teaching, but you will invariably see your attending less.

Typical Day

- Before 0800 – You could pre-round if you would like or have a heavy patient load. Often, bloodwork is not reported this early.
- 0800-0900 – Morning Report (@ HGH and JH)– the CMR reviews interesting cases. Excellent teaching.
- 0800-0900 @ SJH – AM sign over from the on call team
- Grand Rounds are 0800-0900 Wed @ SJH and Thurs @ HGH & JH
- 0900 – 1200 – Ward Work – meet with your team, discuss new issues, round on your patients
- 1200-1300 – CTU noon rounds (except Wed) – depending on the site, usually subspecialty presentations. Usually valuable.
- Afternoon – finish rounding on your patients. Check up on bloodwork/tests ordered in the AM. +/- team rounds (walk/bedside vs sit-down rounds)
- 1600-1700 @ SJH –Daily Report (similar to Morning Report)
- 1700 – sign over with the on call team
- Depending on site/patient volume, typically leave somewhere from 1700-1800
- **Read around your patients.**
- Note: Wednesday = Internal Medicine resident teaching half-day. Usually a great afternoon to spend some one-on-one time with attending, and be the point man dealing with team issues.

Call

- Constantly evolving depending on PAIRO guidelines. There are detailed call guidelines on the Medportal IM Clerkship site. Usually ~1 in 4.
- Role = consults, ward issues, CODEs
- Generally, sleep is limited. The SMR balances consults, so if you have already done a few you may have to wait before getting another - napping during this time is recommended.
- All sites are now a non-team based call. Like the name implies, you are not on call with your team; instead, one member from the team is on each night.
    - Advantages: Teaching around new cases occurs each day with new admissions – excellent learning for clerks/JMRs. As a clerk, you represent your team: you receive the team pager and are first call on team issues on the wards = prepares you well for residency. Your whole team doesn't have to hand off its patients to the team on call = continuity of care
    - Disadvantages: limited flexibility in switching calls.
- **Important! If you know you need a day off for call, you ideally need to let the site administrative assistant/CMR know at least 4 weeks before the next resident block starts (they are on a 13 x 4 week schedule starting July 1 each year).**

- **MAKE SURE you let your attending know that you are post-call… and ASK that you leave. The expectation is that you work "24+2 hrs" like the residents so you should be able to leave around 10 AM. Post-call days should be respected and sometimes the attending does not remember that you are post-call…**

- **You must see your patients post-call before you leave and hand over any outstanding issues to your team before leaving.**

Your role

- Admitting, following and discharging patients (goal is 4-7 patients, usually maintained, varies from site-to-site)
- Good admission order sets exist and you should fill these out before you present your case.
- What do you mean by "having a patient"
    - Ideally you admitted the patient, and came up with a DDx/Dx and plan. You will follow the patients you admitted to your team - act like you are responsible for their helath and advocate appropriately.
    - Daily Hx and P/E – SOAP note format
        - Patient ID
            - Age, sex, from home vs retirement home vs nursing home
            - When was the patient admitted
            - What is the working diagnosis/issues
            - Briefly mention relevant PMHx
        - Subjective – note any new patient complaints. Note relevant present/absent symptoms
        - Objective
            - Vitals, including O_2 requirements. Ins & Outs.
            - Focused P/E
            - Labs, imaging, procedure findings, etc.
        - Assessment/Plan
            - Give a 2-liner assessment if uncomplicated; make a list by affected systems if complicated. List plans with assessment in this format.
    - Check all test results
    - Get orders signed by residents
    - Report to team – *know all important variables, have a plan, discuss issues with team*
    - Communicate with consultants, patient, family, etc.
    - Dictate discharge summaries – stay on top of these
- Deal with a wide variety of patient issues including complex medical diagnoses (ie. peripheral vertigo, cryptococcal meningitis in an AIDS patient) & multifactorial issues in complex patients (ie. patients with a stroke resulting in severe disability)

The Admission

- Expect to take anywhere from 1-2hrs, takes a while to begin with
- Remember to check MEDITECH/Provider Portal for PMHx & previous, objective, test findings. Very important in your presentation (ie. previous stress tests/angiography results in an ACS patient).
- Have your photocopied admission notes in hand and your thoughts gathered for 0700 after a night on call to hand-over to your attending. See *oral presentatio*n tips below. (Remember to remove any patient identifying data on any photocopied notes that you are carrying around with you.)
- Getting feedback helps. All attendings were happy to give this.

The Oral Presentation

- A key skill in medicine that you will learn during this rotation.
- Be able to present the comprehensive 5-10 minute case, as well as the 1-minute or infamous “2-liner” summary. Always present information in an organized manner, and in the context of your differential.
- People seem to stress not looking at your notes for uncomplicated cases. Just be sure to know the key details of your case and make eye contact more often than not and you’ll be fine.

Skills to develop

- Expect to practice: IV starts, place leads/run ECGs, ABGs
- Try to practice: NG/Dobhoff placements, Foley placement
- Observe and hopefully try: thoracentesis, paracentesis, arthrocentesis, art-line placements, central line placements, LP, CODE-related procedures. You will definitely be active with compressions during the codes - for other procedures, help the resident as much as possible.

What to have in your pockets

- Technically, can get by with just up-to-date, just find a computer.
- The little red McMaster Survival Guide is useful (+ given to you at the start of the rotation)
- Pocket Medicine (small little purple binder-bound book) is extremely useful and cheap, your most used pocket resource. A lot of people have switched over to "Approach to Internal Medicine" by Hui which, in my opinion, was a life saver compared to Pocket Medicine.
- Pharmacopoeia pocket-book (a quick guide to meds + dosing), cheap & valuable
- Additional:
    - Reflex hammers and penlights are useful but are usually found around the ward

- Handbook of Emergency Cardiovascular Care is an excellent, pocket-sized with algorithms for CODEs (asystole, PEA, VT/VF), tachy/brady-arrhythmias, ACS, etc. Around $35.

The good and the bad

- The ultimate rotation for learning. The most day-to-day teaching you will receive in any rotation. You will receive the most autonomy and responsibility in Medicine vs all other rotations. Extremely gratifying.
- Most sites are extremely busy, some feel overwhelmed by workload.
- Call is often busy, especially when you have the team ward pager. Both good – great learning opportunity, see/deal with acuity – and bad – tiring.
- There are a lot of details to deal with on a day-to-day basis and some patients have long hospsital stays with few acute issues.

Evaluations

- Tests: The American National Board of Medical Examiners Internal Medicine standardized clerkship exam which is MCQ
- Attending evaluations (minmum of 2 during the rotation)
- Encounter cards & ECE Log.
- Online SIMPLE cases (15 are mandatory)
- See the IM Clerkship Medportal site and manual for details

5b) Internal Medicine (St. Catharine's) - *Updated by Samantha Sigurdson C2015 and Alannah Smrke C2014 (By NRC Class of 2011, updated from Maria Bagovich, McMaster Medicine Class of 2008)*

The team

- Attending, +/- junior resident (family medicine), 2 clerks (including you)
- Current program, 6 different preceptors (1 preceptor/week, each doctor starts on a Wednesday). There is more direct contact with your preceptor as you report directly back to him/her and follow their day-time schedule. At SCS there is now a "CTU" so all your patients are on one floor.
- Longitudinal tutor for afternoon teaching

The hospitals

- St. Catharine's General
- Welland Hospital

How the ward works

- St. Catharine's

    - CTU set up, just means you have a set preceptor for one week and all of your patients are on the same floor. Rounds with the team (PT, OT, RN, Social Work, Discharge Planner) are daily at 10:30.
    - Mostly consult-based service with daily follow-up of patients on ward as needed and until patients are of educational benefit
    - Hospitalist service in place for continuing care issues
    - Less routine day-to-day work; no writing of D/C summaries, rather you dictate all admission notes (really good practice in dictating and able to understand management and disposition)
    - One week on PCU, which is a great time for learning.
    - Some exposure to out-patient clinics (maybe one or two altogether)
- Welland
    - Consult-based service with inpatient follow-up
    - Good quota of ICU patients - community internists follow such patients, no "intensivists". However, this ends up being a mix of patients, i.e. ICU/CCU/step-down unit. There is also a telemetry section separate from the ICU.
    - Exposure to out-patient clinics
    - You're on call with your weekly preceptor or at least one of them that you have worked with before
    - 2 weeks ICU, 2 weeks emerg consults, 2 weeks hospitalist

Typical day

- Highly variable based on your site and preceptor
- Typically pre-round between 07:30-09:00 (find out first day what time consults will start and when your preceptor likes to round)
- St. Catharine's there is a large turnover of consults; get used to letting go of patients (will not have to set up D/C planning, CCAC etc., this is done by the hospitalist and d/c planner services)
- Welland, more follow-up with patients (for the most part)
- Morning = rounds, new consults or clinic
- 12:00-13:00: lunch (variable)
- Afternoon: rounds, new consults or clinic
- Between 1-3 times per week in late afternoon = teaching usually by Dr. Rabin (~4-5 pm) - expect some late afternoons (topics include approach to various topics) ("tutorial")
- Read around your patients

Call

- Around 6-7 calls and its only until midnight so no post-call (Welland you usually get sent home earlier, very busy at SCS)
- In current system, in St. Catharine's you will do no f/u from call patients
- In Welland, you follow the patients you admit if it's with your weekly preceptor

- However, need to understand that every day is like being “on-call” as you continue to get new consults.

Your role

- Taking patients (average 4-6)
- Patient load actually varies, but there will always be a high turnover of new patients

The Admission

- See above
- In the St. Catharine’s program, you will get quite good at this, as it is the primary focus. There is ample opportunity for learning physical exam skills.
- This is a great opportunity to get feedback on presentation style (the blank and impatient stare of your preceptor will let you know if your dissertation has gone overboard).

The Oral Presentation

- See above

Skills to develop

- Ample opportunity if you are persistent
- RTs are wonderful to students. Physicians especially in ICU are great! Opportunities for ABG, art lines, central lines, PFT bedside monitoring, lumbar punctures, paracentesis, thoracentesis, NG tube and foley placements. Opportunities are highly variable and will depend on what staff you have and your own time availability (it gets busy with multiple consults).
- Express enthusiasm and motivation to get opportunities

What to have in your pockets

- Little red McMaster Survival Guide (excellent)
- Penlight and straight edge/ruler for JVP
- More so in need of aids, as there is no Up to Date

The good and the bad

- Preceptors do not know when you are call with them or your hours, you have to use your own initiative to find the preceptor and let them know that you have to leave by midnight since you are working the next day.

- There are weekly Medicine Rounds held at the St Catharines site (with catered lunch) which cover general medicine topics.
- There are multiple teaching sessions throughout the week (CXR approach, excellent ECG teaching by Dr. Pallie, approach to asthma, approach to pre-op assessments etc.) as well as your core teaching sessions with Dr. Rabin. However there is no structured teaching on a day to day basis, compared to a CTU in Hamilton many students feel the teaching is extremely lacking.
- Opportunity to be part of the IPE Ward which involves participating in a specific IPE curriculum with nursing students and other allied health.
- Negatives include the high preceptor turnover rate. At times, may feel a bit choppy. This means that you will not have continuity of care with patients during your rotation. Some preceptors are unwilling to teach, preceptors are highly variable.
- Sometimes, you may have issues with patients and not being able to reach your preceptor in the time-line you would prefer; you will need to learn to manage stress and responsibility at your level of training independently. Don't take on more than you can chew.
- For the most part no residents (which can be a good/bad thing); we had several weeks with the junior family medicine resident (no internal medicine residents)
- You always have access to the attending, even if there is a resident on with you.
- Lots of opportunities to do consults, with time to read up on cases on the fly.
- Presenting at rounds is a great learning experience.

Evaluations

- Tests: The American National Board of Medical Examiners Internal Medicine standardized clerkship exam which is MCQ
- Attending evaluations (minmum of 2 during the rotation – one from every person you work with is ideal)
- Encounter cards & ECE Log.
- Online SIMPLE cases (15 are mandatory)
- Pre Test is a great resource for the exam.

5c) Internal Medicine (Waterloo and Kitchener) - *Updated by Lili Tong Class of 2016, Thiviya Selvanathan C2015. By M. Kinneret Friedman, McMaster Medicine Class of 2010/Matthew Lipinski, MD Class 2014*

The team

- On hospitalist, your team consists of the attending, resident(s) – typically family medicine
- On CTU, your team consists of the attending (changes week to week), resident(s) – typically family medicine and/or internal medicine but may be PGY1s who are off-service as well, and fellow clerk(s); this is a very inter-disciplinary rotation and a great chance to fill your IPE cards
- You will have several preceptors spending at least 1-2 weeks with each one. Off CTU, there is more direct contact with your preceptor as you report directly back to him/her and follow preceptor's day-time schedule. On CTU, you may report to a senior resident if there is one present. Preceptors are both general internists or hospitalists.

- If you're placed in Kitchener, the schedule involves 3 weeks on hospitalist (which over the stroke unit and stroke prevention clinic) and 3 weeks on CTU at Grand River Hospital.
- If you're placed in Guelph, you may spend time on internal medicine wards, ICU and the step-down unit. Details can be arranged depending on your interest.
- The CTU was established in 2015 so the exact organization of your rotation may vary.

The hospitals

- Grand River Hospital
- St. Mary's Hospital

- Guelph General Hospital

How the ward works

- Grand River Hospital – General IM
    - You will carry out consults on patients admitted to ER the night before on an almost daily basis. You will follow your patients on the general IM wards, or on the stroke unit (5A) (a nice perk – you learn a lot about stroke management!)
    - You will usually be on call when your supervisor is on call, and be expected to stay till 20:00 or 22:00 (max till 00:00). Clerks generally do not get called during the night (house call) as they are expected to be present for the next day.
    - You will be expected to write follow up notes, and dictate admission and discharge notes where appropriate (good practice).
    - Some supervisors may be open to having you at their out-patient clinics (if they have one).

- Grand River Hospital – CTU
    - Start at 0800: you may wish to get there earlier to print lists for the team and pre-round.
    - 0800-0900: Teaching with your attending. The style/topic will vary depending on your preceptor. You may also be asked to prepare a small topic to teach as well.
    - 0900-1100: Nursing rounds. You will round with the team and nursing on all your patients. Patients who will be D/C will have priority and you may be asked to leave rounds to finish paperwork for D/C during rounds. If there are consults to be seen, you may be asked to see the consults while the rest of the team rounds.
    - 1100-1200: Multi-disciplinary rounds. You round on your patients with the entire multi-disciplinary team including OT, PT, spiritual care, SLP, CCAC and any other relevant members
    - 1200-1300: You may have mandatory teaching sessions but you are welcome to eat lunch during this time.
    - 1300-1700: See your assigned patients and manage their problems.

Your attending or senior resident will be available to review/change management
- You are expected to see patients, speak with allied health professionals if needed, write notes and plan management for your patients; if they need consults to other services, you will do the consult
- KNOW YOUR PATIENTS because you will take a lot of responsibility for them and nursing staff will come to you with questions
- When patients are ready to be discharged, you will prepare paperwork for discharge (including follow-up, medications, cover sheet, etc) and dictate the D/C summary
- CTU has 22 patient beds and there are typically 4 learners on the team so your patient load is typically 4-5 patients of varying levels of acuity.
- This is a phenomenal learning experience and you will see some very neat clinical presentations
- On call is until 1300pm although if the beds are full, then you can leave early. Weekend call starts at 0900 with rounds and typically finish by 1200-1300; you write progress notes as you round. You can do home or in house call for the remainder of the day if there are any beds available.

Guelph General Hospital: Rotation is divided usually into two weeks of different subspecialties and four weeks of hospitalist. Various subspecialities include ICU, Step Down, Nephrology.

- Days usually 8:00-4:00
- Primarily will be working on the wards with the hospitalists. Often you will be placed on "intake" with a preceptor for a week. This involves managing all of the ED consults/admissions. Lots of opportunities to interview patients.
- Staff give lots of opportunity to manage patients independently, while still providing supervision.
- There is a great interdisciplinary team eager to teach learners.
- Intensivists/Internalists are fantastic teachers, eager to have students.
- Most of the day revolves around rounding on patients in the morning, creating a treatment plan and then addressing issues that occur during the day.
- Call: typically a weekend call (Sat-Sun) and one weeknight when you're on the hospitalist service
- Subspecialty weeks:
    - Nephro: Clinic (8-5) + consults in hospital
    - ICU: manage patients in ICU + consults

Typical day – general IM (schedules for subspecialties highly variable)

- Typically meet at 08:00 at Grand River Hospital where consults from the night before will be delegated to different teams. You will usually then go to ER to do your consult.
- 10:30 – Meet with supervisor (may be earlier or later in the day) to discuss consult(s) and plan management. Dictate admission note.
- Rest of day involves following previous inpatients. There are not always 'official' rounds – you usually round on them yourself and then meet with your supervisor to catch them up and management plan. (Usually new consults during the day are only taken by you if your team is on call).

- 12:00-13:00: usually noon teaching rounds (sorry, but you usually won't get lunch!). Currently these occur daily, held by a variety of specialists on a variety of topics (e.g., venous thrombosis, GI bleeding, GI cancers, etc.). It is useful to do some reading ahead for these.

- Afternoon: inpatient follow up, outpatient clinic if applicable

- Read around your patients
- You will have tutorial with a longitudinal tutor once a week (usually Wednesday afternoon). It is useful to do some reading ahead for these tutorials.

Call

- Though you will often go home earlier, call usually ends at 2300, as you are expected to be present for the next day starting 08:00 (i.e., there is no 'post call'). If you do stay after midnight, or need to return to the hospital overnight, you are excused the next day.
- You will not necessarily follow patients you admit, but if the patient is interesting you will usually be able to request this.
- Unlike other hospitals, you receive new consults on an almost daily basis so essentially you are 'on call' almost every day (technically speaking).
- You're expected to do one day call a week and one weekend call over the 6 weeks.

Your role

- Taking patients (average 4-6)
- What it means to "have a patient" see above

The Admission

- See above
- You will discuss your admission with your supervisor (or the junior resident on your team if you have one), rather than at handover.

The Oral Presentation

- See above

Skills to develop

- As above - ample opportunity if you are persistent, but opportunities are highly variable and will depend on what staff you have, your own time availability (it gets busy with multiple consults), and what procedures your patients require.

What to have in your pockets

- Little Red McMaster Survival Guide – will be provided for you
- Penlight, reflex hammer (it's always hard to find one on the floor!)
- There is access to Up to Date and other resources

The good and the bad

- You don't have a lot of exposure to sub-specialties but those can be pursued during your selective block instead. On CTU, you will consult a number of specialists for your patients and they are often more than happy to do some teaching around a case. The number of specialties you're exposed to is very patient dependent though.
- There are no official morning or bed-side teaching rounds on general IM but lots of structured teaching session on CTU.
- Sometimes, you may have urgent issues with patients and are unable to reach your preceptor at the time you would prefer; you will need to learn to manage stress and responsibility at your level of training independently. Don't take on more than you can chew.
- For the most part, no residents (which can be a good/bad thing). They can help a great deal with teaching and can be resourceful, but if there is a procedure, they are usually first in line.
- There is a great opportunity for autonomy. In my opinion, you work at a junior resident level, as you speak directly to the attending and are expected to give concrete suggestions regarding management.
- Doing IM at Grand River will almost certainly mean you will follow at least some patients on the stroke unit. This is an opportunity you cannot always get otherwise , and will definitely reinforce your knowledge of presentation, etiologies, and management – very useful!
- It feels rushed on CTU to manage all your patients in the afternoon and do new consults and contact relevant specialists but you will learn to be very time efficient and there is a lot of support from your senior residents/attendings.

Evaluations

- Tests: The American National Board of Medical Examiners Internal Medicine standardized clerkship exam which is MCQ
- Attending evaluations (minmum of 2 during the rotation)
- Encounter cards & ECE Log.
- Online SIMPLE cases (15 are mandatory)
- See the IM Clerkship Medportal site and manual for details

5d) Geriatrics Selective (Hamilton)

How the ward works –

Depending on the hospital, you will work primarily as a consultant service for inpatients or as part of hte team on the geriatric rehab ward. You see the patients, write up a consult note, include your recommendations (remember since you are not MRP, all orders must start "geriatrics suggests") and follow up with the primary team as well as with allied health.

The hospitals –

- St. Joe's
- Juravinski

Typical day –

Consult Team:

Start the day at around 9:00. See your consult patients and follow-up on patients you've already seen. Have numerous interspersed informal teaching sessions. You may have clinic with your attending which is like an out-patient version of your ward assessment. You may even have home visits, which are a very interesting experience.

Rehab Ward

Start the day at 8:30. Round on your patients, write up progress notes. Numerous teaching sessions throughout the day. Can take the opportunity to observe and participate in allied health assessments.

Call – No call, HURRAY!

Your role –

Do a thorough and full assessment. Draft the report and your orders. Follow-up with your patients and any services you enrolled. D/C planning.

Skills to develop – Drugs, Drugs, Drugs. Know which medications make you muddled up-top and which don't. Know how to take a very thorough history and do a complete head-to-toe exam (particularly neuro and cognitive, MMSE and MOCA). Develop your medical writing and learn to draft a clear, concise and detailed consult note.

Tools of the trade –

- MOCA and MMSE forms
- RxFiles – Gives great drug profiles and recommendations for switching meds

What to have in your pockets –

- Stethoscope
- Reflex Hammer
- Lots of Pens
- Scrap paper

The good and the bad –

- You really develop your history and physical skills

- It is medicine “light”; similar skills and patient population without the pressure and call.
- Some of the patients you meet have great life stories, it’s worthwhile to listen.
- Cases can get kind of repetitive, you basically are dealing with preventing delirium and coping with dementia but the first couple are lots of fun.
- The tutorial is very long and a little dry

Evaluations –

- You must do a presentation on a geriatric topic on the second Thursday of the rotation.

- You must fill out numerous encounter cards.

- There is a final evaluation form from your preceptor that is sent to your tutor.

5e) Infectious Disease Selective (Grand River/SMH) - *By Jessica Rollings-Scattergood, MD Class 2010*

Hospital in and outs

- Cafeteria is pretty good, Tim Horton’s line is always long but there is also coffee in the caf which is pretty good
- Pay for parking on your first day
- ID badge has to be picked up from security on the first day – ask for the same access as your supervisor – ID badge is the same for SMH and GRH make sure to get access to both hospitals if you are at both sites

How this rotation works

- 2 weeks on ICU, each intensivist is on-service for one week
- Each morning starts around 9 AM with interdisciplinary rounds with pharmacisists, dieticians, nurses, RTs, opportunities to lead discussions if interested
- Help your supervisor with consults, and occasionally to their (subspecialty) clinic if they have the odd patient coming in
- No residents on-service so far. You have the opportunity to do most if not all procedures for lines, tubes and intubations. Most intensivists will get you involved whether you like it or not. They love to teach; be sure to read up on critical care topics for meaningful discussions.
- Ask the RTs for tips on how to insert art-lines and how to manage ventilator settings.
- Pharmacists and dieticians are also great sources of knowledge, e.g. how to pick the appropriate antibiotics

Infectious disease

- Lots of consult, act as a consultant not MRP on any patients, nice variety
- Work in two hospitals
- Get to see how the infection control office at the hospitals works
- Nice introduction into internal medicine
- Learn your antibiotics (well start to at least)
- Great preceptor
- Lots of good learning opportunities throughout the rotation
- Learn how to read laboratory results for bacterial cultures
- Day starts at 9am and finishes by 5 or 6pm each night
- No call!
- Lots of teaching!!!!!

5f) Intensive Care Selective (Hamilton) – *By Eugenia Poon, McMaster Medicine Class of 2011*

How the ward works –
You work in the ICU ward looking after the inpatients. At the General there are two areas of the ICU you may be assigned to. All patients are rounded on everyday and sometimes there are discharges and admissions. You are on a team with the Intensivist, possibly an ICU fellow, residents from a variety of specialties and a pharmacist. Other members of the team include the nurses who are a valuable asset, respiratory therapist, and physiotherapist.

The hospitals –

- Hamilton General Hospital
- MUMC

Typical day –

Start the day at around 7:15. There is a teaching session until 8:00. You split up the patients with the residents in the morning, do your individual rounds on your patients, do complete rounds with the attending and then write all notes in the afterwards. Orders are written with the attending rounds. You also need to follow up with any consultant services as patients also tend to have other services involved (neurosurgery, general surgery, etc.).

Call – No call, HURRAY!

Your role –

Do a thorough and full assessment. Draft the report and your orders. Follow-up with your patients and any services you enrolled. D/C planning.

Skills to develop – How to assess patients who are comatose or ventilated and intubated. Learn to speak to families about difficult issues and also understanding complex patient issues. You are able to get an understanding of ventilators and

procedures such as central lines, arterial lines and NG tubes. Get a good understanding of shock/sepsis and trauma/head injuries at HGH especially.

Tools of the trade –

- Drug book to understand the variety of drugs that patients are on and what interactions can occur
- Talking to an RT to understand the ventilator settings and types of ventilation available

What to have in your pockets –

- Stethoscope
- Penlight
- Lots of Pens
- Scrap paper

The good and the bad –

- You really develop your physical skills and understanding of lines
- Some of the patients you have will have complex medical histories that brought them to the ICU
- You may be involved with family meetings or difficult decision making
- There is a presentation you must present to the attending and other students at the end of the rotation on a topic of your choice
- Tutorial once a week can be quite interesting and can be adapted to your interests

Evaluations –

- There is an internal medicine list of encounters that you keep track of
- Each week you have a different preceptor as intensivists work for one week durations
- Each week you need your preceptor to fill out an evaluation for you
- There is a final evaluation form from the site tutor who sees you three times if he or she is not your preceptor so it is nice not to have a complete stranger fill it out

5g) Cardiology Selective (Hamilton) – *By Kim Zhou, McMaster Medicine Class of 2011*

How the ward works –

The General has two cardiology wards – the CCU for more critical patients, and the inpatient ward where you will be working. Typical patients would be those with UA/NSTEMI, valvular disease, and CAD. The team consists of the staff, fellow, an off-service resident, and you. Walking rounds take place in the morning, and the remainder of the day is for consults, admissions, and clerical work. There is usually a pharmacist who rounds with you, as well as nurses.

The hospitals –

- Hamilton General Hospital

Typical day –

Variable starting time to the day depending on the patient load, but usually between 7:00-8:00. Everyone (minus staff) arrives to divide patients and pre-round on them. Something I noticed that was different in cardio was that staff like to have your notes *completed* by the time you round as a team so they can sign it, so be very efficient! Orders are written during walking rounds with the team.

Call – No call!!!

Your role –

Know your patients extremely well! Check their meds daily. Examine them and write clear, concise notes – longer is *not* better. Take the initiative to write orders. Follow-up with your patients and any services you enrolled. Always think about D/C planning – does the patient need Social Work, OT/PT, homecare, follow-up appointments?

Skills to develop – Thorough understanding of the cardio-respiratory exam and the physiology behind your findings. Important to pay attention to volume status.

Tools of the trade –

- Drug book
- Internal med handbook

What to have in your pockets –

- Stethoscope!
- Internal med pocket book of your choice

- Drug reference

- Something to organize your patients – have a master sheet with their key points on HPI, PMHx, Meds so you don't have to re-copy it every day and you'll have it handy on rounds.

- Lots of Pens to "lend"

The good and the bad –

- You will become a superstar at cardiology! These patients are hospitalized because they have significant pathologies – you will hear all sorts of murmurs, extra heart sounds, adventitious lung sounds, bruits.
- There is not a lot of formal teaching – varies with your staff, resident, and fellow. On the other hand, there are no presentations to do, no tutorials.
- Be fiercely independent! There is not a lot of hand-holding in this selective so take the initiative to read around your patients and construct their management plans on your own.

Evaluations –

- There is an internal medicine list of encounters that you keep track of

- Your final evaluation is from the site preceptor – this is very bizarre as you may not spend a single day with him, but he uses the evaluations that your preceptors complete

5h) Nephrology Selective (Hamilton) – *Updated by Adeel Sherazi C2015. Written by Diana Khalil, McMaster Medicine, Class of 2011*

How the ward works –
You are assigned to either the Nephrology Team or the Transplant Team - both teams do consults for each other while on call, and the teams are great at getting both clerks on Nephrology for interesting cases, therefore you get good exposure to both aspects. The transplant team generally admits patients pre-op for transplant or patients who are coming in down the road with issues like arrhythmias, infection etc. You work out of St. Joseph's on the Nephrology or Transplant ward looking after inpatients. You are assigned anywhere between 2-5 patients which you independently round on, and report back to the fellow or a senior resident. Staff comes in PM to review patients and treatment plans.

The hospitals –
St. Joseph's Healthcare

Typical day –

Handover from overnight call, is at 0800. Teams then divide their own patients, you will typically be assigned 2-5 patients. You will round on your patients independently, review labs, write progress notes, and review orders with your fellow or senior resident. The staff nephrologist will come at around 1100 to review patients and treatment plans. Many patients admitted to nephrology, do not present with primary renal problem, therefore in many cases you will need to refer for consults and follow-up.

Call – No Call, HURRAY!!!

Your role –
Do a thorough and full assessment, reviewing laboratory results. Write progress notes and review your orders with the fellow. Follow-up with your patients and any services you have consulted. When your team is on day-call you will do consults from Emerg, admit orders, dialysis orders. D/C planning.

Skills to develop –
How to do a full & thorough fluid assessment. Which drugs affect the kidney's and how. Dialysis planning and orders.

Tools of the trade –
- There is a handbook for the doctors which is around 50 pages in length. It is on the nephrology drive and really helped me succeed in this rotation. Alternatively, you can aske the elective coordinator about it.
- Drug book to understand the variety of drugs that patients are on and what interactions can occur with their renal disease.
- Internal Medicine pocket book.

What to have in *your* pockets –
- Stethoscope
- Lots of pens
- Scrap paper

The good and the bad –
- Lots of variety as in some cases, primary concern is NOT renal, therefore you cover a lot of general internal medicine
- Able to see interesting cases in both nephrology and transplant
- Lots of afternoon teaching by the staff and fellows
- Really hone your understanding of the kidneys, acid/base and electrolyte balances
- Really develop physical skills

Evaluations –
- Case Presentation you present to the assigned staff and the other clinical clerk(s)
- Internal Medicine encounter cards you fill out as you go
- Dictated D/C summary is evaluated by your staff…great feedback!
- There is a final evaluation form from the site preceptor/tutor.

5i) Rheumatology Selective (Hamilton) – *By Joshua Wald, McMaster Medicine Class of 2011*

How the ward works –

You spend some days on the ward and some days going to clinics with different rheumatologists (almost all have offices within walking distance of St. Joe's). When on the ward you are predominantly a consult service which means most of the time the patients are admitted under a service such as internal medicine but rheumatology has been asked to help manage the patient. There are also usually a small number of patients admitted directly under rheumatology. In addition to seeing patients you also see consults both in emerg and from the wards.

Clinics –

You will do a number of half day clinics with different rheumatologists. This is pretty variable depending on the physician and the day. Some clinics might be mostly RA, others more vasculitis and others focus more on MSK complaints like rotator cuff tears, OA, and carpal tunnel.

The hospitals –

- St. Joe's

Typical day –

Start at 9:00 for clinics 8:00 when on the wards. For wards you meet with the team to go over the list and any consults that haven't been seen yet and usually do some teaching then you see your patients and meet in the morning or early afternoon with the attending and the rest of the team to go over the plan for everyone. In the afternoon there can be more teaching or seeing consults depending on how busy it gets. For clinics usually one clinic from 9:00-12:00 with you the staff and sometimes a resident then a different clinic often with a different staff from 1:00-4:00 or 5:00.

Call – No call, HURRAY!

Your role –

Do a thourough assessment of consults and new patients in clinic focusing on chief complaint/reason for referal and MSK and neuro exams. See consult patients on the wards and write progress notes/ communicate to the admitting service your investigations/managment and plan.

Skills to develop – MSK and neuro exam! Joint counts, palpating for effusions, joint injections are the primary focus. Lots of chance to practice each exam

Tools of the trade –

- Reflex hammer

What to have in your pockets –

- Stethoscope
- Penlight
- Reflex hammer
- Scrap paper

The good and the bad –

- The format allows you to explore lots of different aspects of rheumatolgy from emergency room to ward consults to office visits.
- Don't spend much time in any one place so can be hard to start feeling comfortable.
- Lots of opportunities to practice those tricky MSK and neuro exams and good teaching around physical exam skills and tricks.
- Complex in patients often with multiple services involved, can be good or bad depending on your preferences

Evaluations –

- There is an internal medicine list of encounters that you keep track of
- Different preceptor almost every day so final eval is a bit tough but the coordinator does talk to all the docs you work with.
- There is a final evaluation form from the site preceptor/tutor

6a) Obstetrics/Gynaecology (Hamilton) - *By Julie Francis, McMaster Medicine Class of 2008, updated by Jacquie Filteau C2015 and Barbara Kuziora McMaster Medicine Class of 2007* [back]

The Set Up

Six weeks split into three blocks:

- The first week is teaching with all clerks together at McMaster

    - Lectures on introductory topics in OB/GYNE
    - Hands-on sessions in the clinical skills lab
    - Opportunity to practice speculum and bimanual exams on standardized patients
- 4 weeks on L&D at SJH, MUMC or in a community setting

    - During this time you will be expected to do at least 8 half-days with a community preceptor in their clinic
    - All time not in clinic is spent on L&D
    - Call at SJH or MUMC is usually 1 in 4 or 1 in 5 depending on how many clerks there are
- The last week is a teaching week again

    - Everyone comes back to Hamilton for lectures on more advanced topics in OB/GYNE
    - Clinical skills lab sessions on obstetrical emergencies
    - Final exam

The Team

- L&D: staff (always in-house), Ob/Gyn residents, interns, clerks and nurses. It is very important to make friends with the nurses early as they are your key to getting called for cervical checks, deliveries, etc.
- Community Preceptor Clinic: You and your community preceptor. Some preceptors were only able to commit to the minimum 8 half days, however some students who found the experience enjoyable were able to do more time with their preceptors. This can also be done as 4 full days, etc. Coordinate clinic times with your fellow clerks so that there is always a clerk on L&D and to try and limit all of you being there at once to optimize exposure.

How the Ward Works

- Most of your time will be on the Labour and Delivery floor and the postpartum ward during your L&D rotation, however you may be asked by a resident to assess a patient in the ER and then present the case to them. If you go to the ER, take a complete history and physical but delay any internal examinations until you have the resident present!
- Post-partum patients are discharged 24-48 hrs after vaginal births and a minimum of three days after C-sections. Post-partum rounds are done in the morning after teaching (7am) and hand-over (7:30am). You will usually see the uncomplicated cases and review with the intern or resident after.
- On L&D you will be assigned patients to follow, make sure to introduce yourself to them early as it is more comfortable for the patient and the nurses if you have met them prior to assisting in their delivery.

- Post-call you are able to leave after teaching and hand-over, so usually around 8am. You are still expected to help out with post-partum rounds, so usually the on-call team does half of the post-partum patients before 7am teaching rounds!
- Try and round quickly in the morning and meet all patients that may deliver that morning- this will ensure you won't miss any opportunities!

The Hospitals

- SJH: This is the 'low risk' maternity centre in Hamilton and as such has a very large volume. You will have an opportunity to participate in a lot of uncomplicated deliveries and most will feel very comfortable doing deliveries by themselves at the end of the rotation. Get your cervical checks done as early as possible. The residents here are PGY-2's and are very eager to let you get involved if you show enthusiasm right from the start.
- MUMC: This is the 'high-risk' centre for Hamilton and surrounding area. Low risk deliveries do occur at MUMC but not in the same volume as SJH. This unfortunately means that although seeing interesting high-risk cases, hands on experience may be limited due to low risk volume.

Typical Day

- Community placement clinic: Most start their clinics between 8 and 9am. You will go to teaching and hand-over on L&D prior to this if you are at MUMC or SJH! Also, if your clinic doesn't start until 9am, then you are expected to help with post-partum rounds before running over to clinic. At the clinic you will have the opportunity to participate in antenatal visits, take histories on Gyne patients, perform speculum and bimanual exams, do PAP tests, etc.
- L&D:

    - 0700- Teaching from the Chief Resident, this is one of the best features of doing your OB/GYNE rotation in a teaching hospital, an excellent resource
    - 0730- Handover in the morning from the team on call (after handover and rounds on-call team is free to go home). MEET AND LEARN ABOUT YOUR PATIENTS!!!
    - 0800-0900- Post-partum rounds
    - 0900-1730- Most of the day is spent monitoring labouring patients (cervical checks) and performing assessments on women who believe they may be in labour (in Triage). Introduce yourself to the ward clerk and nurses and let them know you want to be called for all assessments. Write your name and pager on the board. Check your patient's progress often and make friends with their nurse in order to decrease the chance that they will forget to call you in for a delivery. It is also possible to attend clinics in the hospital if they are going on, or go down to the operating room to see some Gynaecological Surgery.

Call

- All clerks do one or two calls at SJH or MUMC during the teaching weeks (week 1 and 6)
- Call during the 4 week L&D time is traditionally heavy. It will either be 1 in 4 or 1 in 5. This is only for 4 weeks, but can be a very busy time. Sleep on call is minimal and unfortunately sometimes if you go to sleep you will miss out on deliveries, if they forget to call you. Since the call rooms for clerks are not on the labour and delivery floor, it is often better to just catch a nap on the couch in the conference room to ensure you are not missed for deliveries! Also, befriend the resident on call and let them know you want to be called in the middle of the night. Post call you are off after morning handover (approximately 8 am), but don't forget post-partum rounds!

Your Role

- See new assessments and admissions from Triage on L&D – if you have done the admission, nurses and residents are far more likely to let you participate in the delivery!
- Perform and chart assessments of patients on post-partum rounds
- You may also chart progress of your patients who are admitted for delivery; cervical checks, etc.
- Assist/perform the vaginal delivery and repair: let the resident know you want to get hands-on exposure. It is often better to go in the room early on while the patient is pushing, and establish rapport with the patient and nurse, rather than to run in at the end just for the delivery itself
- 2nd Assist in c-sections

Skills to develop

There are many skills you should attempt to develop during your Ob/Gyn rotation.

- Speculum exams (you should be able to develop a great deal of comfort in performing pap smears and taking swabs/samples during this rotation)
- Bimanual exams (you should be able to get a good feel of what a normal uterus and adnexa feel like)
- Cervical Checks – dilation and percent effacement (you are required to get 10 cervical checks signed off on during your rotation, however you should have the opportunity to perform at least 5 times this amount!! Some students did not complete their 10 checks due to low volume at some community sites, and the staff is generally very understanding). For a bonus, try to assess position and station as well, this is much harder.
- Hands on delivery skills (including delivering the head, shoulders, body, umbilical cord clamping and umbilical cord gas sampling) At many sites, you should be able to perform these skills independently by the end of your rotation.
- Repair of perineal tears (Ask the resident for the opportunity to attempt this, it takes practice so don't be upset if you don't get it your first time. Read around the different degrees of lacerations and how you repair them.)

- Surgical skills including holding the laparoscope or retractors, cutting sutures (key: whenever you see someone suturing something, ask the scrub nurse for the scissors and don't let them go! This may be the most hands-on they will let you get) and basic knot-tying.
- Detailed assessments to determine "Is this patient in labour?" and "Have the membranes ruptured?"
- Interpretation of Fetal heart rate monitoring strips. Make sure you read up on this since you will have to do a lot of these!

Tools of the Trade

The Quick and Dirty MUSTS on your admission/progress notes:

POSTPARTUM PROGRESS NOTES:

The 7 B's to a postpartum assessment:

- Bleeding – any per vaginal bleeding, quantify. Also ask about foul-smelling discharge.
- Breastfeeding – is the patient doing it, any issues
- Bladder and bowel function
- Baby – is the baby healthy, is Pediatrics involved
- Blues – ask about their mood, 80% of women have post-partum 'blues', need to pick up those with post-partum depression
- Belly pain – uterine tenderness + fever and foul-smelling discharge is post-partum endometritis until proven otherwise
- Breathing - Ask about SOB, calf pain, and chest pain to screen for DVT/PE

OBSTETRICAL:

- Gestation in weeks, GTPALM, EDC, LMP, Blood group (RH factor and antibodies), VDRL/Hep B/Rubella/HIV status.
- Hx of present pregnancy: Last U/S, Placenta clear of os? Any complications with this pregnancy so far? (Prenatal visits, bleeding, DM, HTN, fetal anomalies).
- Past OB Hx (year/sex/location/gestational age/duration of labour/complications/mode of delivery of previous pregnancies)
- Current condition: 4 questions you ALWAYS ask
    - Contractions (start time, frequency, duration, intensity
    - Membranes (are they intact? If not: time of suspected rupture, history, colour, odour)
    - Fetal movement
    - Bleeding – per vagina

GYNECOLOGICAL:

- 1st day of Normal LMP
- Menses Hx: cycle frequency, length, nature of bleeding (amount, presence of clots or painful cramps, presence of bleeding between menses)
- Past Gyne Hx: STI's? Last PAP smear? Hx of abnormal PAP smear? Gyne Surgeries? Contraception? Menarche? Menopause?
- Full Obstetrical History: GTPALM
- Past Medical Hx- especially urinary, sexual, and surgical history
- Family history of Gyne Cancers or Breast/prostate/bowel

What to Have in Your Pockets

- Pregnancy wheel (to determine EDC)
- Lubricant for cervical checks
- Tape measure (for symphysis-fundal height)
- Any small pocket book for reference

The Good and the Bad

- The four weeks of call can be difficult however the most learning takes place on these shifts, try to stay up and experience it!
- Nurses can be your best friend or your worst enemy. Nurses are very protective of their patients, you need to respect the nurses and help them out! Learn how to set-up for a delivery and ALWAYS help clean up!!!)
- Be around. You may lose a lot of wonderful opportunities if you are not easily accessible to the nurses and residents.
- It is a wonderful specialty, lots to see and do (office, L&D, surgery!)….seek out opportunities for learning to get the most out of your experience.

Resources

- Hacker and Moore: Essentials of Obstetrics and Gynaecology
    - The bible for clerkship level
    - OB/GYNE keeners may want something more advanced though
- Obstetrics and Gynaecology On-call book
    - Just the basics for on-call emergencies
- Obstetrics and Gynaecology Pre-test
    - Part of the "pre-test series"

- Essential for scoring well on the final exam

Evaluations

- Cervical checks- Once you get 10 correct you no longer need your cervical checks double checked, so try to get these done as early as possible
- L&D Encounter Cards- Get these completed early! Residents, interns and staff can all fill them out. All ten of them must be filled out and there are specific situations for you to encounter listed on them.
- Community Preceptor Clinic Encounter Cards- these are larger than the standard clerkship encounter cards and list ten topics they want you to experience with your community preceptor, you must have at least 7 filled out. There are also questions for you preceptor to ask you on these. Be sure to read around the topic before asking for a card to be filled out.
- Two full evaluations while on L&D (MUMC/SJH only)- these need to be filled out by staff or by the chief resident
- Community Preceptor evaluation- at the end of your rotation, all the above documents are handed in to your community preceptor who uses them in conjunction with your OSCE and written exam marks to write your final transcript submission
- Written exam- the American standardized clerkship exam. This is a very hard exam; best resource to study from is the Obstetrics & Gynaecology Pre-test book.

6b) OB/GYN (Fergus) - *By Jessica Rollings-Scattergood, MD Class 2010*

Hospital In and Outs

- Tiny hospital
- Free parking
- Rural hospital – run by family physicians, get to truly experience rural medicine
- Very small caf with short hours
- Located downtown so can walk for lunch – Hooligan's has good coffee!
- Everyone is accommodating to students, they are used to having a large number of students and are all very nice

Rotation

- Day starts between 6:30 and 7:30 ends at varying times depending on whether or not there is a delivery to attend or a c-section or how late clinic runs but generally done by 6ish at the latest
- Lots of gyne experience
- First assist in most cases with front row view of the surgery
- If you are interested in anesthesia – tell the anaesthetist (all are GP anaesthetists) and are all great teachers and happy to teach and let you try procedures

- C-sections – first assist
- Get to take cord blood samples
- Vaginal deliveries – lots of hands on experience – but need to do call in order to get this experience
- Colposcopy experience in Palmerston – 45 min drive from Fergus will often carpool with doc
- Palmerston is a smaller hospital then Fergus – all very good nurses to work with
    - Get to do lots of consults in Palmerston
- Rounds are quick because there are not that many inpatients
- Lots of experience with dictations, in office get to review and edit your dictations, in the hospital they are gone so learn where the rewind/pause buttons are
- IUD insertions
- Lots of pap smears
- Hysterosalpingograms (that's some nice obs/gyn imaging – but that's OK you'll learn that later!)
- Infertility consults
- Lots of pessary insertions and fittings (it's a treatment for urinary incontinence)
- Occasional ER consult – rare
- Pre-natal clinic once per week for 2 hours – see a lot of pre-natal patients in a short amount of time get to know them prior to their delivery – more likely to allow you to attend if they know you
- OB rounds each Friday morning at 7am during the year and 7:30am in summer, during the year each week they have a presentation on OB for rounds for 30 min, each week is a different topic, be prepared to present at least once on the topic of your choice (but there's free food!)
    - Rounds are designed to introduce all of the docs to the patients expected to deliver in the next month so that you have an idea of who is expected to walk through the door

Call

- Be prepared to be on call a lot – there are not that many births and if you want to see as many as you can you need to be prepared to be on (home) call practically 24/7 – you can travel to Guelph when on call
- Home call – call in each change of nurse shift around 30 min (7:30) after changeover to find out if there is anything brewing and if you can run errands or if you should be close to the hospital, same goes if you are planning on going into Guelph or 30 min away from the hospital just call before you leave to make sure there is nothing that you need to be prepared for
- Provided with a pager but also give your phone number
- Work with family physicians who attend the majority of the vaginal births – all great teachers
- MAKE SURE THE NURSES KNOW YOUR FACE!!!! They are the ones that will be calling you, if they don't know you are around they will not call you and you will not get to attend enough deliveries. Food is always a good idea, nurses

appreciate anything baked, Pillsbury is acceptable, but homemade gets you bonus points!
- Have fun!

6bi) OB/GYN (Cambridge) - *Matthew Lipinski, MD C2014)*
Hospital:
- Relatively small birthing unit. 6 bed OB floor
- Two dollar parking close to hospital
- Limited after hours food options
- A medical student wing dedicated to learners. Includes on call rooms (basically converted hospital rooms).

Rotation:
- Great mix of OB, OR, and clinic. There are approximately 6 Obs/Gyns in the area, 3 whom take students regularly and a couple who will also take you on call.
- On-call are on the OB floor, 24 hour shifts, in house.
- Clinic days are usually 8am-5pm, seem many prenatals, as well as gyn consults.
- OR days vary depending on the preceptor. Scheduled OR days are not C-sections, more gynecological surgeries.
- Often will have to round on patients post-partum/post-op the morning before clinic.

Call:
- Variable level of business. Deliveries range between 0 and 4 babies per shift.
- 24 hours in house call, post call day the next morning.
- Limited after hours food options, Tim Hortons closes at 6:30pm (aka. Pack lunch and dinner, or pack dinner and buy lunch).
- Lots of free time if not busy. Spend time with the nurses on the floor (at least in the beginning). They will be your best friends so get on their good side. Tag along for checks with them and they will call you more when women are actually delivering.
- Use the free time to practice hand tying or reading up on OB.
- Be available and they will call you.
- You will consult emerg for any OBS/GYN concerns, sometimes they are a direct admit to the floor.

Overall: Amazing site for learning. Lots of hands on experience with OR and deliveries. Staff are willing to teach and will definitely let you do a lot if you express an interest.

6c) OB/GYN (St. Catherines) – *Updated by Alannah Smrke C2014 (By NRC Class of 2011, updated from Justin Chopra & Laura Eustace, MD Class 2010)*

With the new hospital opening, deliveries only occur in St Catharines. Welland and Niagara Falls have community OB/GYN and do minor GYN procedures, but major GYN OR and all deliveries happen in St Catharines.

Call occurs in the St Catharines General Hosptial and is shifts (usually 12 hours). You may be with your preceptor, or one of the other OBs.

Hospital Ins and Outs:

- This hospital has a mix of low and medium risk deliveries. The volume of births you can expect depends entirely on luck, and how much you are allowed to do depends on your preceptor.
- There are can be family medicine residents on service during call only generally.
- Teaching is one-on-one with your preceptor, so be keen and make a good impression, and you will likely get to do more (cervical checks, delivering newborns, drawing cord blood, removing placenta, suturing episiotomies)
- Because it isn't an academic center, there aren't teaching sessions or rounds as there are in Hamilton, but call is home-call and is usually fairly quiet.
- Assigned to one preceptor for your 4 weeks in St. Catherines or Welland

Rotation:

- Expected to assist in clinic with preceptor from approximately 8:30-14:30.
- If your preceptor has patients who are expected to deliver that morning/afternoon, then you are to follow your preceptor to L&D and assist with their deliveries.
- Deliveries after 6 PM generally handled by the on-call physician
- 4-6 call-shifts scheduled over the course of 4 weeks; students are not required to stay in-house and can go home provided they can return within 5-10 minutes of being paged.
- Call shifts may or may not be scheduled with your preceptor.
- Accommodations within 2 minutes driving distance are provided free of charge, as well as a gym membership to the local YMCA
- Administration is flexible when it comes to organizing call-schedules

What did you do:

- Preceptor dependent
- Will get lots of exposure to community OB/GYN. We get lots of clinic exposure. This means lots of Paps!
- Depending on your precptor may get exposure to colposcopy, terminations
- Will round in in-patients when on call and with your preceptor
- On call, cervical checks, assessment of pregnant women from emerg, emerg consults, deliveries

The good and the bad:

- You get to do a lot!
- Can be challenging to get in your assessments on the floor- be proactive!
- Great exposure to common obstetrical and gynecological problems, with lots of hands-on teaching and instruction.
- Some preceptors may provide less informal teaching but let you do a lot (or vice versa)

7a) Orthopedic Surgery (McMaster Site) – *Updatd by Jacquie Filteau C2015 and Kan Ma, McMaster Medicine Class of 2012. By Stephen Petis and Raman Mundi, McMaster Medicine Class of 2011* [back]

What is Orthopedic Surgery?

Orthopedic Surgery is a broad surgical specialty that focuses on the diagnosis and management of pathologies of the musculoskeletal system. Although often associated solely with the surgical management of fractures, the specialty manages a breadth of pathologies that affect patients of all age groups and all functional levels. Accordingly, this rotation consistently proves to be a valuable learning experience for all students, regardless of their specific career aspirations. The primary goal in Orthopedic Surgery is often to restore patient's function and quality of life. Sub-specialties include:

- Pediatric orthopedics
- Upper and lower limb arthroplasty (joint reconstruction)
- Foot and Ankle
- Arthroscopy
- Spine surgery (both adult and pediatrics)
- Orthopedic trauma
- Sports medicine
- Orthopedic oncology

With a change in pace from other clerkship rotations, there are ample learning opportunities in orthopedic surgery as it is one of the more labour intensive specialties. On-call experiences can be busy, especially with a significant elderly population and the high incidence of hip and distal radius fractures associated with this age group. Fracture clinics often include a roster upwards of 70 patients, providing ample opportunity for students to improve proficiency in history taking and MSK physical exams. A highlight for many students is time spent in the operating room. The OR allows students to directly observe orthopedic interventions first hand while assisting both staff and residents. Although these procedures can be physical demanding (holding limbs, retracting), students often prefer the opportunity to be directly involved. Embracing the learning opportunities offered throughout this rotation will make for an enjoyable and rewarding orthopedic experience.

Highlights of Orthopedics at McMaster

Headed by an enthusiastic program director, Dr. Brad Petrisor, orthopedic surgery at McMaster is a program that takes pride in its commitment to teaching, professionalism, and the cohesiveness between staff, residents, and medical students. The residents that comprise the program are committed to providing a worthwhile and non-threatening learning experience for clinical clerks.

With such a diverse population, the city of Hamilton offers a tremendous patient volume that inevitably creates ample opportunities to gain exposure to a variety of orthopedic pathologies.

A highlight of McMaster Orthopedics is its orthopedic oncology service situated at the Juravinski Cancer Centre. Dr. Michelle Ghert, McMaster's orthopedic oncologist and renowned research scientist, delivers weekly oncology rounds to the orthopedic residents every Wednesday morning. These lectures come highly recommended as part of your clerkship learning experience.

Finally, McMaster University is a global leader in orthopaedic research. Touted by many as the foremost authority in evidence-based orthopedics, Canada Research Chair, Dr. Mohit Bhandari, has led several multi-national orthopaedic clinical trials. His innovative efforts, as well as those of the Joint Arthroplasty Group, continue to change the face of orthopedic practice worldwide. Dr. Bhandari is committed to mentoring students with an interest in research and to date, has provided several students with opportunities to lead high-impact projects and author papers in peer-reviewed journals.

The set up –

At all the sites except the McMaster site, clerks are assigned to an Orthopedic surgeon and their team of residents for the two week duration of the rotation. At McMaster, Dr. Missiuna, who is the site director at Mac, feels that clerks get a better experience if they aren't assigned to just one preceptor, so you will get to know all the orthopedic surgeons at MUMC.

During the two week rotation, you are expected to attend fracture clinics, see new consults in the ER and on the Orthopedic wards, scrub in and assist in the surgeries, and attend outpatient clinics with your preceptor.

The academic day for this rotation is Wednesday morning. You are expected to attend the Orthopedic rounds in the morning followed by one 3hr lecture on each Wednesday morning with the material that will be important for you to study for the final exam. The slide shows are long and the presenters usually don't get through all the material, but you are still required to know it. Take note that these 2 3-hour sessions attempt to cover most areas of orthopedics, so it is a good idea to go over the slides prior to the lectures.

Site-specific teaching will vary. Generally, each site will have fracture/radiology rounds at around 7am on varying days of the week. Templating rounds (how to plan a joint replacement using a radiograph) occur usually once weekly at the Juravinski centre.

Resident teaching involves speaking with the resident on service with you about covering topics you have either seen or wish to know more about; many of the residents will have pre-prepared slides of various topics that they can deliver to you.

The hospitals –

Site	Type of Call	Specialties Offered
McMaster University Medical Centre (MUMC)	Home call until 11. No post-call days.	Sports Medicine Pediatric Orthopedics Pediatric Spine Arthroscopy
St. Joseph's Hospital	Home call	Upper extremity arthroplasty/arthroscopy Lower extremity arthroplasty/reconstruction Foot and Ankle
Hamilton General Hospital	In-House call (due to trauma service)	Orthopedic Trauma Adult Spine Sports Medicine Foot and Ankle
Juravinski Hospital	Home call	Lower extremity arthroplasty/reconstruction Foot and Ankle Orthopedic Oncology

The team –

Similar to the General Surgery rotation, the team consists of the Staff Orthopedic surgeon, the Chief Ortho Resident, the specific Residents assigned to that preceptor, and you the clinical clerk. As part of any surgical rotation, the team in O.R. is also going to include the Anesthesiologist, the Anesthesiology resident/clerk, and the nursing staff.

How the ward works –

At McMaster there was not a lot of ward exposure. At the other site where there are specific Orthopedic wards with inpatients, then the wards work similarly to the general surgery wards. As such, please see the general surgery section of this Survival Guide.

Typical day –

There is no typical day in Orthopedics. Your day will depend on your preceptor's schedule or the schedule you make amongst yourselves if you are at McMaster. Throughout your rotation you will spend time in the ER, on the wards, in the fracture clinic, in the outpatient clinic, and like any surgical rotation in the OR.

- Fracture Clinic
    - Fracture clinic can be an overwhelming experience due to the tremendous patient load. Understand that concise (and brief) histories and physical exams come recommended, but the staff and residents will do their best to ensure adequate learning opportunities. There are up to 200 patients per day.
    - Emphasis is on radiographic interpretation of fractures and fracture healing, quick and concise histories and physicals, casting opportunities, and small procedures such as wound management and joint injections.
    - Learn to: interpret x-rays, understand fracture healing, take a concise history revolving around acute complaints, perform an appropriate physical, learn to do a closed reduction of a fracture, devise a treatment plan for acute presentations, and dictate.

- Operating Room
    - Emphasis is on anatomic approaches (how to actually get to what you want to fix through the skin), surgical indications/contra-indications, surgical procedures, post-operative orders, and wound management.
    - Learn to: scrub into the OR, execute proper sterile technique, describe relevant anatomy pertinent to the pathology/procedure, write post-op orders and an operative note, gain hands-on technical skills such as drilling or suturing.

- Outpatient Orthopedic Clinics
    - Some surgeons may hold "office" clinics in order to spend more time with more developmental or chronic musculoskeletal complaints, such as osteoarthritis.
    - Emphasis is on concise histories and physicals (more time than fracture clinic), imaging interpretation, non-operative/conservative management of orthopedic complaints, surgical indications/contra-indications, and small procedures such as joint injections.
    - Learn to: take a concise history and apply physical exam skills in order to narrow differential diagnoses, interpret various imaging modalities such as plain radiographs, MRI, and CT scans, learn the conservative, pharmacotherapeutic, and surgical management of various conditions, and dictate.

- Emergency Room
    - Emphasis is on concise history and physicals, management of acute traumas (ATLS), imaging interpretation, orthopedic emergencies, casting and reduction opportunities, admitting and discharge planning, and small procedures such as wound debridement or joint aspirations.

- Learn to: diagnose acute orthopedic complaints using a history, physical and imaging, assist in closed reduction/splinting/casting of fractures, assist in closed reduction of dislocated joints, manage orthopedic emergencies (septic joint, cauda equina syndrome, etc.), admit a patient for management (usually surgical), discharge patients to follow-up in fracture clinic.

Call –

Call schedule (begins at 5PM weekdays, and usually 8AM weekends): approximately 1 in 4, which usually translates into 2 weekdays and one weekend day (site specific details are found below). At McMaster, Juravinski, and St. Joe's it is home call. At the General the call is in house because of the trauma service. At all sites, during call you will be in the O.R. usually as the 2nd assist (1st assist is the resident) when there are Ortho cases on the surgery board and otherwise seeing new consults in the ER. If it is home call and there is nothing going on you can go home but be prepared to step one foot in the door and be paged back to the hospital!!!

Day call: this includes answering pages for the ER prior to 5PM on weekdays. It is recommended that clerks at each site speak with the residents each day to assign themselves to day call, optimizing the learning experience. Assignment to day call usually happens at fracture/radiology rounds each morning.

Your role –

As a clerk your role is to learn about orthopedics. You will be expected to attend lectures and rounds. You will be expected to scrub in and assist in the OR. You will be expected to attend fracture clinic and outpatient clinics. During your call you will also be expected to see new consults in the ER.

Skills to develop –

Reading X-rays; resetting bones; casting; suturing; scrubbing and assisting in the OR; taking Orthopedic histories and performing physical exams; learning anatomy and nerve distribution.

Many of the qualities to be an effective clerk are intuitive and would promote success in any specialty. They are especially warranted in orthopedics, owing to the high volume of patients and breadth of clinical practice.

- Professionalism – punctual, respect patient confidentiality, dress appropriately (where scrubs to clinic only if your staff does)
- Offer a helping hand – see consults in the ER (especially during the day, the residents will appreciate it), attend to acute patient issues on the ward, write admission/post-op orders and the operative note before your resident does, pull up any relevant imaging in the OR before your staff/resident (XRs, MRI, etc.)

- A surgeon once said, " The key to the OR is a resident's attendance at clinic"; if you are assigned to one preceptor, attend all of their clinics even if you think it would be cooler to go to the OR
- Do your best to remain sterile in the OR, and DO NOT complain when you get asked to retract; again, embrace each opportunity
- Enthusiasm! It is a short rotation, and you would be surprised with how much more willing staff and residents are to teach/let you get involved if you appear enthusiastic

Tools of the trade –

In the fracture clinic, you will use plaster for casting and scissors for removing the casts.

What to have in your pockets – Nothing really required.

The good and the bad –

GOOD

- Only a two week rotation!!!
- Home Call

BAD

- Clinics can be very rushed with minimal time for teaching

Evaluations –

- Final Exam – combination of multiple choice and short answer; *definitely speak to upper years about available resources for exam prep!!*
- 5 Encounter cards – must be filled out and signed by your staff physician or residents

- Formal evaluation – must be filled out by your preceptor or the clerkship director at your site

Recommended Resources –

- McRae, R. Pocketbook of Orthopaedics and Fractures. 2nd Edition.
- Thompson, J. Netter's Concise Atlas of Orthopaedic Anatomy.
- Hoppenfeld, S and deBoer, P. Surgical Exposures in Orthopedics: The Anatomic Approach. 3rd Edition.
- Blackbourne, L. Surgical Recall. 5th Edition.
- Canale, T. Campbell's Operative Orthopedics. 10th Edition. – note: very detailed, but available online through MD Consult
- Baxter, S. and McSheffrey, G. Toronto Notes. 2010 Edition.

- http://www.uptodate.com - need to be onsite for access
- http://www.wheelessonline.com/ortho

7b) Orthopedic Surgery (Cambridge and Kitchener) - *By M. Kinneret Friedman, MD Class of 2010, Updated by Lili Tong Class of 2016*

The set up –

- If you're in Cambridge, you will either be at the hospital or the orthopedic clinic. You will have one preceptor, but will work with almost all the orthopedic surgeons there. There are no residents on this rotation.
- If at GRH, you will have 2-3 preceptors and spend about equal proportions of your time with them. Schedule is given ahead of time.
- All preceptors who accept students have been excellent teachers. They're fun to work with and ask lots of relevant questions.
- Preceptors appreciate students rounding on their patients on the ward.
- At Cambridge you will be given a schedule at the beginning of your rotation.
- In general, you will attend a couple fracture clinics, may see new consults in the ER when you are on call, follow up on the patients on the Orthopedic wards if requested (generally you will be requested to do this after your first on call shift), scrub in and assist in the surgeries when scheduled for OR, and attend outpatient clinics with one of the several surgeons or your assigned preceptor.
- If you are in the Kitchener site, your preceptors are all in the same building for their outpatient work.
- If you are in the OR, the day starts around 0800 and ends around 1500
- If you are in a clinic, the day starts around 0900 and ends around 1700.

Call –

- You will be expected to do 2-3 on call shifts. Call generally goes until 2300 as there is no 'post call'. Call will involve carrying out consults, as well as scrubbing in for operations on the board. In general when you are in the OR you will be 2nd assist.
- There is now a "Hot Room" during the day for emergency cases. As such, call is generally for emergencies which cannot wait until the next morning. You may still be asked to do ER consults though.

For more information see above (McMaster site).

7c) Orthopedic Surgery (St. Catharines) – *Updated by Samantha Sigurdson C2015 (By NRC Class of 2011)*

Location: St Catharines General Hospital

Preceptors: Dr Josefchak/ Dr C and P Robert
Dr Martin / Dr Masnyk

What did you do:

- Work in a variety of settings including office, the fracture clinic and the OR.
- See new consults, scrub on surgeries, perform reductions

The good and the bad:

- Variety of patients/cases

- Call is reasonable
- Preceptors do pimp, and may give readings to discuss the next day

- Some let you do a lot (reductions, close etc) especially Dr Robert
- Interested in making the rotation relevant for your future career (jf possible)

7d) Orthopedic Surgery (Niagara Falls) – *By NRC Class of 2011*

Location: GNGH (Niagara Falls)

Preceptors: Dr. Flores & Dr. LeRoux

What did you do:
- Mainly OR assist and fracture clinic, both preceptors are very encouraging that you spend your time in this rotation doing what you will find beneficial for your future career and they will ask other orthos if you can tag along with them if there is a neat surgery going on.

The good and the bad:
- Dr. LeRoux doesn't take students in his office, so office time can be limited
- You don't get a lot of hands out experience (suturing) in the OR, just lots of observation and holding of retractors
- Both preceptors are very relaxed and teach a lot!

8a) Pediatrics (Hamilton) – *Updatd by Jacquie Filteau C2015. By Hamilton Class of 2011.*

Organization of the Rotation:

Track 1 and 3:
4 weeks in a community Pediatrician's Office outside of Hamilton
2 weeks on the General Pediatric Ward at McMaster Children's Hospital

Track 2:
2 weeks on the General Pediatric Ward at McMaster Children's Hospital
2 weeks in a pediatric subspeciality service at McMaster Children's Hospital
2 weeks in the pediatric ER at MUMC

Teaching and tutorials occupy every Friday afternoon.

The team:

McMaster
Three teams on the wards at McMaster Children's Hospital:
- Two teams care for in-patient pediatric patients, and consist of:
    - Staff attending pediatrician
    - One PGY-4 in pediatrics

    - Two or three PGY-1s that may be pediatric residents or off service residents
    - Two or three clinical clerks
- The third team cares for the level II nursery and the chronic care pediatric patients and consists of:
    - Staff attending pediatrician
    - One PGY-1 in pediatrics
    - Two or three elective clinical clerks. No core clerks.

How the ward works

General Pediatrics Wards:
There are three ward teams each lead by 1 staff physician. Team three takes care of the chronic cases and neonatal cases. The other two teams alternate in taking new patients to their team (team one odd days, team two even days). Clerks from any team will see consults in the ER during the day, but patients will only be admitted to one team each day. Morning handover occurs at 7:15 am, which is generally followed by teaching. Then, you'll see your patients, find out what occurred overnight, and round with your staff or senior resident. There is a teaching session at lunch, then following up on paperwork or tests in the afternoon. On the wards, it is absolutely essential to get to know your patients' nurses, particularly if you're in the level two nursery. They know your patients really well, and with infants, would like you to check with them before examining. Finally, handover occurs at around 4:30pm. Extra teaching during the day may take place depending on the week.

The hospitals –
General Peds Ward work occurs at McMaster Children's Hospital or hospitals in the surrounding area.

Subspecialty services are at MUMC except for St. Joe's NICU and a few take place at St. Joe's. If you're in track 2, you'll be assigned to two specialties, though you may have to travel back and forth once in a while

St. Joe's Neonatology - mostly feeding and growing issues, many infants are premature. The ER has the Pediatric Short Stay Unit, but the children seen here are only supposed to be treated for 24 hours. If there are more complex issues going on, then the child is transferred to McMaster. Complicated newborn cases are often diverted to McMaster, because there isn't the capability to ventilate infants at St. Joe's.

Call –

- Consults will come in throughout the day at both McMaster and St. Joes
- Call during your community rotation is mandatory if your preceptor does call shifts
- McMaster

        - At McMaster, there is a senior pediatric resident specifically assigned to seeing consults during the day, but he or she is usually very open to clerks seeing these consults if they have time after rounds are completed on the floor
        - Let that individual know your name and pager number and you can help out with daytime consults
        - You do not have to be “on call” to see these patients
        - Night float has been established for the clerks – you will have one week of days on CTU and one week of nights.
- St Joe’s
    - Call starts in the morning and ends the next morning after handover

Your role –

You are expected to take 2-6 patients. The patient load actually varies, but there will always be a high turnover of new patients.

- What it means to “have a patient”…. (same as Internal Medicine)
    - In the morning, you’ll visit your patients and chat with their nurses to find out how their night has been and if there are any new issues.
    - You will present your patient to the staff or senior resident during morning rounds.
    - Write daily Hx & P/E; progress note (ID, SOAP format, include lab values and vitals which includes weights, ins+outs)
    - Write orders
    - Check all test results
    - Report to team
    - Communicate with consultants, patient, family
    - Dictate discharge summaries

Skills to develop –

- Developing rapport with children of all ages – including screaming, crying ones!
- History taking from parents who may or may not be able to explain what their child is experiencing
    - HEADDSS history for adolescents
- Physical exam across the ages from neonate to adolescent
    - Including the “opportunistic” exam for when children are less than keen on being examined
- Neonatal Resuscitation protocol
- Growth charts
- Immunization records and schedules
- Recognition of the sick and not sick child

Tools of the trade –

- AAP/Peds in Review (from www.aap.org): In my opinion, this is the best source for our level. Any common presentation will likely have a Peds in Review article. This is great for approaches (for example, “approach to a child with a limp”) as well as common illnesses. It will generally cover pathophysiology, clinical signs and symptoms, investigations as well as management.
- HSC handbook of Pediatrics: This book has a basic overview of many childhood illnesses, and some details like diagnostic criteria and management. However, it’s not the best book for “approaches to”. It is handy to carry around.
- Nelson Pediatric textbook (condensed version)
- Eating/Drinking/Voiding/Stooling parameters in different ages, Developmental Milestones, Growth Charts

What to have in your pockets –

- Pediatrics Survival Guide (Green; given in your package at the start of the rotation)
- Drug book or access to Uptodate for drug information
- Pen light
- Tape measure
- Stickers on your nametag or in your pocket to distract the toddlers, a fun dangly toy on your stethoscope
- Have on the tip of your tongue some fun distracters for kids
    - “Do you have any elephants in those ears?”
    - “Any monkeys jumping around in this belly?”
    - Good knowledge of Dora, the Wiggles and recent Disney characters (Aladdin and Bambi are passé)

The good and the bad

- There are many opportunities for learning, not just details of pediatric conditions, but basic approaches to many different common presentations
- A chance to practice your skills as a ward clerk – taking care of all of the details of a patient’s care
- People tend to be very nice – they’re pediatricians!
- Especially if you’re in Track 2, just when you’re starting to get used to things you move on – this can have positives, in that you get a variety of exposures, but it can also make it hard for you to feel confident
- Practice communication skills – not just with kids, who may or may not be able to fully communicate with you, but also with parents and family members
- Most peds wards really work as a team, so this is a great opportunity to get to know the way an interdisciplinary team can function and who is involved
- Peds forces you to think about why you’re ordering tests! You really have to think twice about ordering blood work and CTs because the potential for harm is higher

Evaluations –

- 8 encounter cards (Mini-CEX) to be completed across your two or three placements (only two can be filled out by residents)
- One evaluation from your community preceptor, ward preceptor and selective preceptor (as applicable)
- Participation in tutorial
- Online CLIPP cases (complete 20/31)
- Multiple Choice exam at the end of the rotation – heavily based on CLIPP cases!
- Final evaluation written by your tutor based on all of the above information

8b) Pediatrics (Kitchener) - *By Jessica Rollings-Scattergood, MD Class 2010/Matthew Lipinski MD Class 2014, Updated by Lili Tong Class of 2016*

Hospital in and outs

- Cafeteria is pretty good, Tim Horton's line is always long but there is also coffee in the caf which is pretty good
- All clerks will be placed on the CTU at Grand River Hospital and will attend nearby pediatrician clinics
- Pay for parking on your first day – you have access to the main on-site garage
- ID badge has to be picked up from security on the first day
  - You will have access to NICU, ORs, L&D and the C-section rooms
- Note: you can get scrubs from L&D as opposed to the main ORs
- There is an on-call room just outside NICU – you sign out the key from NICU.
  - It's hard to find so ask a resident to show you on the first day.

Call

- Before call or at the beginning, go to L&D to leave your pager number on their clipboard (and make some indication on the sheet that they should call you too for deliveries)
- Call room key can be picked up from the NICU clerk at the beginning of the shift, call room has a tv, computer, shower, bathroom
- Call is 12 hours shifts either 12pm to 8pm or 8pm to 8am if on night get following day as post call day off after CTU in the morning.
- On call approximately ¼ through this rotation (i.e., 1 in 4)
- In hospital call – lots of experience on call
- Attend high risk deliveries, consults in ED, round on floor patients
- At high risk deliveries - immediate neonatal resuscitation and evaluation
- Procedures are done mostly on call including umbilical lines, intubation, neonatal assessments

General Day

- Assigned to one preceptor each week for the 6 weeks (CTU) and a variety of preceptors during afternoon clinics
- General day begins at 8am for rounds on inpatients ; you will go see patients on both the pediatric floor and the NICU. You will divide the patients up within your group, see patients solo for approx. 1.5 hours, then round on all patients as a team.
- Afternoons are in an outpatient clinic at hospital or in an out-patient office
- Office generally runs until 5-6pm

- Office is a lot of general pediatric presentations (ie ADHD, autism, developmental delays etc). You will see more acute cases and interesting things while on call.
- Spend one day a week in Guelph at KidsAbility which is community care assess programs including FAS, autism, developmental delay assessments – helpful to learn what is out there for support.
- If you are on day call, you will have an opportunity to eat lunch before meeting with your preceptor.

Things to remember

- Pediatric differentials are totally different from adult
- Have fun with the kids, start with the minimally invasive physical skills first before moving on to the more invasive stuff
- No white coat – want to avoid scaring the kids
- The majority of the information will be gathered from the parents
- CTU is a great learning experience, but can provide obstacles if there are issues within the group. Ensure that the team gets along and you will have a great rotation.

8c) Pediatrics (Niagara Falls and Welland) – *Updated by Samantha Sigurdson C2015 (NRC Class of 2011)*

Inpatient pediatrics is ONLY in St Catharines. Community pediatrics still occurs in Niagara Falls and Welland. These are where you will be assigned preceptors.

Call will be assigned at the St Catharine's Site. You may be with your preceptor or other pediatricians. Occurs once a week, however we have been told this is changing for next year and it may be 3 weeks of "CTU"/hospital and 3 weeks clinic.

What did you do:
- Full clinic days back at Dr. Shaikh's or Bonsu/Visbal's office, where he lets you do full visits on your own (well child checks, problem/acute visits and consultations) and then present to him my findings and ideas for treatment and management.
- Dr. Al-Darazi gives direction for high-yield peds topics, he's a good teacher.
- Generally you can be as independent as you want- great experience!!

The good and the bad:
- Be upfront about your level of experience as a clerk and your level of comfort -- they will tailor his expectations/teaching to your level.
- Good rotation with lots of exposures to the bread and butter of peds.

Although it's variable, generally have some exposure to more acute inpatient pediatrics too.

9a) Psychiatry – *Updated by Lili Tong Class of 2016, Adeel Sherazi C2015 and Katie Sheehan, Class of 2010; written By Kelly Luu, Louise Sun, and Nadine Gebara McMaster Medicine Class of 2008* [back]

The Rotation

Psychiatry is a six-week core clerkship rotation. Clerks are assigned to one or more preceptors who work in outpatient clinics, on inpatient wards, do home visits, or as part of the consultation-liaison team to medical and surgery wards. Depending on your assignment, you will have exposure to adult, child-adolescent, geriatric and/or forensic psychiatry. Clerks are generally based out of the Hamilton hospitals, Grand River Hospital in Kitchener, Homewood in Guelph, or various community placements.

The Basics

- Orientation
  - The first day of the rotation is an orientation day at St. Joe's.

B. Academic/Teaching Days
  - Every Wednesday is an academic/teaching day at St. Joe's. This starts at 8am with Chief Resident teaching, followed by Grand Rounds at 9am, and then by several teaching sessions on different topics in psychiatry. Tutorials are held on Wednesday afternoons. Each tutorial group can decide which topics they would like to cover. The teaching sessions are videoconferenced for students at sites outside of Hamilton.

- ECT Morning
  - Each clerk may have the option to attend electroconvulsive therapy on one morning at St. Joseph's Hospital. This session usually begins at 7:15 am and lasts approximately 45 minutes to an hour. You will observe the treatment routine and discuss ECT with the physician. There is an optional opportunity to attend a second session of follow up with the patients you observed, where you have the chance to speak to them about their experience with ECT.

D. Call
  - Each clerk based in Hamilton does two or three overnight call shifts at the EPT/EPAU at St. Joe's. This is a great opportunity to learn more about acute psychiatry and crisis management.
  - Weeknight call starts at 5pm when you meet the EPT team for handover and usually lasts until the next morning 8am. If you have an academic day the next day, you can leave at midnight and are expected to attend the full academic day.
  - Saturday, Sunday and holiday call: Starts at 9 am and goes till 9am the next day (24 hours).
  - The team generally consists of a senior resident, a junior resident, and several clinicians who are nurses or social workers. Patients who are seen in EPT are first 'medically-cleared' by the ER doctors. You will see patients by yourself or with another person on the team. Your role is to gather the history of presenting illness, develop a provisional diagnosis and disposition for the patient. Most patients will either be admitted to a psychiatric ward or have outpatient follow-up arranged. There is a specific note writing system in the EPT and a resident will show you how to fill this out for the patients you see. Call goes until 8am where you handover to the day team. You then go to your service. There is no set

expectation for the next day. If it was a slow night and you got lots of sleep, maybe you'll want to stay the next day as usual. If you did not get any sleep, maybe you'll want to go home after handover. Maybe you can stay half the day, etc. Just make sure you let your supervisor know what your plans are.

E. Typical Day

- It is difficult to summarize a typical day in psychiatry, as this will vary greatly depending on your placement and preceptor. For the most part, psychiatrists will work 9am-5pm in either inpatient or outpatient settings.

- The composition of your team will also vary based on your placement. You will likely work closely with your assigned psychiatrist and other health professions such as social workers and nurses. On the inpatient wards, there may be psychiatry or off-service residents on the team as well.

- On inpatient wards, you will likely start your day by talking with the nurses and reviewing the overnight notes to see how your patients are doing. You can then round on your patients and write notes in their charts. You may also talk with your patients with your preceptor later in the day. If there are new patients, you will likely do an intake interview with your preceptor. Remember to do physical examinations on new patients and write an admission note. Family meetings may also be scheduled during the day. Multidisciplinary team rounds are usually held once a week.

- In outpatient clinics and home visits, you may be working with a team of physicians, nurses, social workers, psychologists. The day will consist of a mixture of watching/doing follow-up visit assessments (short, assessing the updates since last visit) or full consults which can last 2 hours. Full consults are referred from family physician or other psychiatrists who have referred the patient for a second opinion or to receive a specific therapy. If you do a consult, you will be supervised by the physician or another health care professional and will then write up your consult note and dictate it.

- On consultation-liaison psychiatry, you will see medicine and surgery patients who have been referred to psychiatry. Your job is to answer the question asked by the referring team. This may involve reviewing the medical/surgical records, previous notes and discharge summaries, gathering collateral information and interviewing the patient. Do a full psych consult and make recommendations for treatment. Discuss with your staff before you dictate this consult and write "psych recommends" in the order sheets.

How the ward works

St. Joes

- The wards at St Joes are in the Juravinski tower 9th and 10th floor (Acute Mental Health)

- Patients get admitted from the EPT (emergency psychiatric team)
- There are 3 psychiatrists on each floor, each with about 9 patients
- There is an isolation area for patients who cannot wander around the ward by themselves

Grand River Hospital:

- The adult psych ward is mostly for acute mental health issues and is on the 1st floor (basement). There are usually 4-5 psychiatrists on the inpatient ward at a time
- Patients usually get admitted from EPT (ER), but sometimes get transferred from ICU, medicine, or surgery, after their medical problems are cleared.
- Patients younger than the age of 18 are usually get admitted to CAIP (child and adolescent inpatient psychiatry) on the 1st floor (basement).
- Isolation rooms are available for both child and adult inpatient wards.
- Your day usually starts at 9am, where there are brief multidisciplinary rounds in the staff room for handover.

- Note – if you are in the Waterloo Regional Campus rotation, you will do two weeks on the Child and Adolescent Psychiatry Unit at Grand River Hospital, and then four weeks in adult psychiatry.

Homewood Health Centre:

- You will be assigned to the unit in which your preceptor works (e.g., geriatrics, Comprehensive Psychiatric Care unit, Trillium [i.e., acute psychiatric care]).
- Therefore, schedule is highly variable.
- You will usually have the opportunity to arrange for a day at a different service (e.g., addictions, eating disorders, PTSD, etc.).
- You do not do call at Homewood; your call shifts will be at EMHU in Guelph General Hospital. Calls done at Grand River Hospital are arranged separately (discussed below).
- Note – if you are in the Waterloo Regional Campus rotation, you will do two weeks on the Child and Adolescent Psychiatry Unit at CMHA in Guelph or Kitchener, and then four weeks in adult psychiatry in Homewood or EMHU.

The Hospitals

a) St. Joe's/West 5th:

- The psych wards are in the new West 5th site and they're nice!
- There is a typical hospital cafeteria on the 2nd floor Mary Grace Wing only open till 6pm
- There is parking in the lot across from the Fontbonne building off of James St with a parking pass. When you leave, you need to show your parking pass (not transponder) and write your permit number on the parking ticket.

- The call rooms are really far from the EPT but they're not bad. There's a bed, desk, dresser, public showers and washrooms.

b) Grand River Hospital, Kitchener:

- If you are interested in psych, or just want to learn more by seeing and doing lots, this is the place for you. If you are interested in acute psychiatric presentations, Homewood is great. You may be placed at Freeport which is a long-term psych facility and has a slower turn-over rate compared to other placements.
- You will work with about 3 supervisors here, so you'll get to do a variety of inpatients and outpatients. You may also do some consults in nursing homes and rehab.
- You'll have call in Kitchener to be arranged after you start the rotation. Expecation is you do one weekend and two day calls.
- Your ID card is also your parking pass here. There's a parking garage as well as outdoor parking.
- Cafeteria and Tim Horton's are on the main floor.

c) Homewood

- Homewood is a 312 bed hospital entirely dedicated to mental health and addiction.
- There are various treatment programs for addiction, eating disorders, depression/anxiety, post-traumatic stress, geriatrics, crisis care and comprehensive psychiatric care.
- As a student you will receive a parking pass (once you provide a $20 deposit) in the lot behind the hospital.
- You can use the gym facility on the lower level of the hospital.
- Three mandatory call shifts at EMHU. For week day calls, you will join the on-call physician after your day. For weekend calls, ask your assigned preceptor. You will likely have the opportunity to meet them at the weekly Tuesday meetings (where you get free food too!) If not, our admin or your preceptor can facilitate communication.

Your Role

- Your primary role is to learn! Don't just follow your preceptor around; ask questions and learn more about pharmacology and psychotherapy.
- Interviewing: Psychiatry interviews are difficult and take a lot of practice. Try to be very organized and keep the interview on track. Getting as much practice as you can and observing others doing interviews can lead to great learning.
- Note writing: Psychiatry notes are also different. Ask your preceptor or resident to review your notes with you so that you have a chance to improve.
- Presentation: You should learn how to recognize common psychiatric presentations and how to differentiate between the similar ones. The DSM-V criteria are used loosely by some physicians but you should know them and use them strictly.
- Management: You should learn how to manage the common psychiatric presentations, e.g. what therapy is effective, which medications to use, the side effects of medication, values you need to monitor on certain meds.

Tools of the trade

- DSM-V

- DSM-V Mental Disorders: Diagnosis, Etiology, and Treatment – this has the DMS-V criteria plus the current guidelines and literature review, flow-charts for diagnosis, other helpful tables
- If you're worried about the exam, American-based multiple choice review books are helpful
- American Psychiatric Association Clinical Practice Guidelines can be found online
- There are several good psychiatry pocketbooks available at the bookstore. I really liked the Massachusetts General Hospital/McLean Hospital Residency Handbook of Psychiatry.
- The Psychiatric Interview by Carlat is also a good resource

What to have in your pocket

- Pens
- Notebook/paper/system to keep track of your patients
- Dictation codes
- Encounter cards - don't forget to get these filled out as you interview new patients!

The good and the bad

The Good

- The pathology is generally very interesting and there are a lot of useful skills that you will develop during this rotation that will be helpful throughout your career (i.e. in regards to communication with patients and note-writing)
- The rotation is well-organized. You know your schedule before the rotation starts.
- Great teaching on Wednesdays
- Relatively light call schedule

The Bad

- Sometimes, students assigned to one place for 6 weeks so what you will see will depend on your site and there might not be as much variety as you'd like.

- Other students work with preceptors who do purely outpatient work, which typically means less opportunity to do new assessments.

Evaluation

- Encounter cards: You are expected to complete 12 encounter cards.
- Preceptor evaluation: Your preceptor will complete this at the end of your rotation regarding your performance.

- Staff evaluation: You will complete an evaluation of your tutor and your supervisor
- Transcript: Your tutor will write a summary based on your performance in tutorial and your preceptor's evaluation. This is what will go on your transcript
- Exam: The psych exam is an American Board Shelf Exam. It's over 100 multiple choice questions. It will not influence your evaluation at all. It seems to be more for the department to track how well students are learning. It is a long exam and many of the students felt rushed.

9b) Psychiatry (Waterloo) – *By Katie Gregory, McMaster Medicine Class of 2011*

Above information from Hamilton with regards to Homewood and Grand River Hospital applies to the Waterloo campus rotation.

9c) Psychiatry (St. Catharine's) – *Updated by Samantha Sigurdson C2015 (By NRC Class of 2011)*

What did you do:

- Round on inpatients, interview new outpatients.
- Attend afternoons with child psychiatrist, Niagara Child and Youth Services, and eating disorder patients.
- Attend day hospital and interview day patients with Dr. Perez at SCS
- Rotate days with various psychiatrists at SCS and Dr. Boyd in the community.

The good and the bad:

- Call shifts are now in St. Catharine's (newly) unsure of how slow/busy they will be
- Each doctor has a different comfort level with what you are allowed to do independently with their patients, so it's important to advocate for what you want out of the experience.
- You are exposed to very different styles of practice and approaches to psychiatry.
- You will become very good at the psychiatric interview.

9d) Brantford General Hospital – By Sameer Shaikh, McMaster Medicine c/o 2012.

- Community psychiatry offers ample opportunities to learn and regularly practice the essential skills of psychiatry. Although there are 5 psychiatrists in the hospital, you will be primarily working under Dr. Prayaga but have the opportunity to see other patients if you're interested.
- You will have the chance to routinely conduct your own in-patient and outpatient consults, follow-up and manage your own patients daily, and watch

ECTs on a regular basis. You will also have the opportunity to practice your dictating skills, and occasionally will get practice in writing up consultation notes for outpatients.

- The University will give you the option of driving to and from Hamilton daily (a 25 minute ride on most days) or enjoying free accommodation at a residence in downtown Brantford (The Bodega Inn). If you choose to stay in Brantford, the University will still subsidize your weekly mandatory visits to Hamilton for teaching (nearly $35 per trip). The University will not subsidize hospital parking which is $45 for a monthly pass or $6 daily. You will also have to pay a $20 deposit to obtain a hospital ID badge on your first day.
- Your preceptor will be on call occasionally at BGH, but these calls are usually not very busy and are good opportunities to witness acute psychiatric presentations. You will still have to do 2-3 EPT calls in Hamilton.
- The cons: Without residents around you will not have as much teaching, but you are always welcome to ask the staff questions. Also, you will not have much exposure to CBT or child psychiatry.

9e) Forensic Psychiatry (West 5th) - By Nick Mendis, McMaster Medicine Class of 2014

- One of the hidden gems in clerkship! To get this 3 week placement, you need to rank forensic psych when you're ranking clerkship tracks in May.
- Forensic psych is based out of West 5th Hospital which is literally just up the street from St. Joe's
- You will get to interview in-patients on the forensics floor, go to the Hamilton jail, and accompany forensic psychiatrists to court for trial. It's really cool, and one of the things that definitely makes you appreciate the many ways to use a degree in medicine
- Guaranteed you will leave with some unique patient stories
- You get your own private office. With a direct line to the mayor. Okay fine, just the first part.
- Downside is they don't get a ton of students, so the schedule is not really designed with you in mind. However, everyone is eager to get you involved, so as long as you are around and ask if there is anything you can tag along to, you'll get to see a lot

IV. PERSPECTIVES [back]

Communicating with Patients and Families

As a clerk, you will often find yourself in the position of being the primary care provider for your patients. You will often be the person who knows your patient the best and your role will include being the main communication link between the team and the patient and their family. This is both a privilege and a responsibility….

- Always be as honest and direct as you can when talking to the patient and their families; introduce yourself as a “senior medical student” (as “clinical clerk” is often not understood) and explain what your role will be up front.
- Always respect the privacy and wishes of the patient
- Never discuss patients in public places or in front of other patients – this seems like a simple rule but you will be surprised how easy it is to forget where you are or who else is around
- Minimize technical jargon when talking to patients and families and explain any medical terminology you use (you’ll notice that some attendings/residents are much better at this than others)
- Immediately inform the patient of any upcoming investigation and events
- Always finish by asking the patient if he/she has any questions
- Never fudge an answer – if you are unsure, remind the family that you are in training and tell them that you will consult with the team or the appropriate persons and get back to them promptly
- Getting consent or breaking bad news are very important skills to learn but are things that you are not expected to do on your own and there are many situations where you should never be in this position; when in doubt, ask you resident or politely decline (remember: anything that makes you feel uncomfortable is something that you probably shouldn’t do)
- When you are on a service where you are assigned your own patients, you will often be the person who is most familiar with your patient’s condition and needs
- There may be situations where you need to be an especially strong and active advocate on behalf of your patient to your team., to consultants, etc. in terms of needing to draw more attention to a particular issue or to get something done regarding patient care (this is often where you, as a clinical clerk, can make the biggest difference and potentially even save a life).
- Remember that as the junior member of the team, you are in the unique position of having the most time to spend with a patient – so you could potentially catch a detail on history or physical, etc. that others have missed

Working in the healthcare team

- There is still very much of a “pecking order” in medicine – be aware of how it works and mindful of your expected place in it, while also recognizing the opportunities that you have to help to maintain the kind of team atmosphere needed for delivering quality patient care
- Although this should go without saying, it is worth repeating – always be respectful to all the people you work with and be mindful of your unique role within a professional environment that has traditionally been viewed as very hierarchical
- Remember that nurses, pharmacists, nutritionists, and other allied health professionals have often been doing their jobs for years, know much more about certain issues than your attending, and are often excellent teachers

- Be aware of your limits and try to make it a habit to admit or ask when you aren't sure about something – your supervisors can often tell anyway, and you do a better job of gaining their trust by being up front
- Remember that you have the freedom to ask lots of questions NOW because you may unfortunately feel less and less able to ask questions as you move further through your training (fortunately, clerks are expected not to know stuff, but residents are)
- Don't be pushed into performing a procedure that you're not comfortable doing – a good supervisor will recognize your maturity in saying "I'm not comfortable with this procedure. Can you walk me through it or can I watch this one and do the next one?"
- There may sometimes when you disagree with a supervisor about an issue related to patient care or you don't understand why a particular decision was made – in these cases, it is usually best to approach your supervisor one-on-one about this or consider asking a resident first for their opinion on what to do

Dealing with Death and Dying

- Despite your and your team's best efforts, some of your patients will become terminally ill or die under your care; you should acknowledge your feelings and consider discussing your reaction to the patient's situation/death with your team or other students if they are receptive
- Remember, as we've known all along and as we officially learned in psychiatry…grief is normal
- Be aware of the tendency for all health professionals in training to start distancing themselves from patients at the expense of keeping a human perspective
- Pay close attention to how CODE status is discussed, as this is a very important skill and a challenge to do well, even for seasoned clinicians.

"Limited Learning" Situations

- There will inevitably be times where you find yourself in situations where the potential for learning is limited, for example:
    - A clinic is cancelled
    - You spend more time observing and following around a supervisor than getting to practice and do things yourself
    - A supervisor chooses to let you see only one or two cases while she/he sees the rest on their own
    - A surgeon in the OR asks you to hold a retractor for a prolonged period of time while standing in a position from where you can't see a thing
    - You are assigned to take care of a ward patient for whom there are no active issues
    - Nobody pages you to let you know that your obstetrics patient is about to deliver
- Remember that these situations happen to all medical students (everywhere)

- Many of these situations can be improved with communication efforts and/or creatively adapting to the situation
- Unfortunately, some are not easy to resolve and may simply end up being instances where you have to make the best of a challenging situation
- Consider how to improve the situation for others who follow you, whether through communication, evaluation, etc.

V. PLANNING FOR CaRMS [back]

Thinking about CaRMS while you're in the middle of clerkship can be stressful. Rest assured that everybody gets through it successfully every year – and that McMaster students as a whole continue to have one of the best match results of any school in Canada!!!! Here are a few things to keep in mind…

Knowing What Lies Ahead

- You probably have some idea at this point of what kinds of programs you may want to apply to – each program's application requirements are listed on the CaRMS website
- As you go through clerkship, take advantage of your exposure to residents (especially), attendings, other students, etc. to get their opinion of the different programs that you are thinking about – chances are that somebody you run into has helpful information to offer about a specific program you may be interested in; picking this up here and there as you go along helps you be more informed when deciding which programs you'll eventually apply to (residents can often put you in contact with other residents in programs you want to find out more about)
- All CaRMS applications are due in late November
- Your CaRMS application will include the following:
    - Personal letters to programs (mainly explaining your interest in these programs) – these take longer than you think
    - Mid-clerkship transcript (collected by September)
    - CV (completed online)
    - Reference letters (each program typically requires at least 2, usually 3, sometimes more)
- As with applying to anything, set early deadlines for yourself with room to spare
- Most interviews are in January, during a national interview period (some programs have available dates in December); match day is late February/early March
- You will get more detailed information about the actual application process as the time nears, so don't worry too much about this now, just know that it's down the road.

Electives

- As you've known all along, plan ahead as elective spots fill up quickly
- All electives serve three main purposes:
    - Provides a valuable learning experience;
    - Gives you a sense of what it's like to work in a particular specialty in a particular location; and
    - Gives you a chance to show who you are and what you can do
- In pre-clerkship electives, the first two purposes are the most important
- In clerkship electives, the third purpose becomes increasingly important
- If you plan to apply to programs far from Hamilton, it's highly recommended that you do electives there or at least in the general vicinity, so that you know what you're getting into and you can "prove" in your future CaRMS applications/interviews that you have a serious interest in going out there for residency (this especially applies to across-country locations)
- Know that some programs have a reputation for "favouring their own" and will not even consider you as a serious CaRMS applicant unless you've done an elective there (find out from your seniors which programs this applies to)
- Being "elective-experts," McMaster students tend to shine the most by the time they've reached their clerkship electives – so use the self-directed learning skills you've picked up at McMaster to your greatest advantage and you'll likely do well.

Getting Reference Letters

- Most people are afraid to ask a supervisor for a reference letter, but know that supervisors are totally used to it and even expect it – after all, it happens to them every year
- Most programs want reference letters from an attending, but a few will accept one letter from a resident (check the CaRMS website for info on this). Some programs may require at least one letter from a resident, so be mindful of this and plan accordingly.
- A common time to ask for a reference letter is at the end or just after finishing your rotation with that supervisor, while you are still fresh in their head
- In some situations, you may want to ask up front at the beginning of a rotation, so that your supervisor pays more attention to how you do; in other situations, a supervisor may even offer to write a letter for you before you even ask (unless you know for sure you won't need it, always politely accept in this situation because you will have the chance to be very selective about which of your letters go where during the CaRMS process)
- It is totally ok to ask for a letter from somebody you worked with months ago, though you many need to do some extra work to remind them of who you are and what you did
- Let your letter writers know that you will give them the CaRMS material when it is available in the summer (along with stamped and addressed envelopes, etc.; some will ask for or find it helpful to also get from you a copy of your resume) – then give them an early deadline to get it into CaRMS by.

VI. BALANCE [back]

Work and Life

- Make a conscious effort to balance work and the rest of your life – ignoring your own needs as a whole will affect your clinical performance in the end
- Stay grounded in friends and family
- Remember that your friends in clerkship are going through the same thing you are and “debriefing” can be a way to help each other
- Eat well, SERIOUSLY
- Exercise, SERIOUSLY
- Consider devoting a large amount of time each week to doing completely fun, relaxing, non-medicine stuff (ex. a “day-off” or “night-off” depending on what kind of rotation you are in)
- REMEMBER what your priorities are throughout this process:

    - YOUR HEALTH and WELL BEING
    - YOUR PATIENTS
    - YOUR LEARNING