

STUDENT CLERKSHIP GUIDE

A COMPREHENSIVE GUIDE TO CLERKSHIP
AT THE OTTAWA HOSPITAL

Gemma Cox and Stephanie Lubchansky

MD 2015 CANDIDATES

SPECIAL THANKS

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A FEW WORDS FROM THE EDITORS IN CHIEF...

This guide was created to help orient you, the incoming clerkship class, to the many experiences that you will encounter over the course of this year. Included are in-depth descriptions of all core rotations, important administrative information, useful resources, and key clinical topics to assist you in achieving success. This year will be difficult, but it is our hope that this guide will help with your transition and allow you to make the most of each rotation.

The University of Ottawa Clerkship guide was created in extensive collaboration with the Clerkship Committee, Rotation Coordinators, Rotation Directors, MS3 Presidential Committee, Student Council representatives, University of Ottawa residents, and MD2015 classmates. Our sincerest thanks is extended to all of those involved in bringing this project to life.

While we have done our best to make this guide as comprehensive and accurate as possible, schedules, rotation breakdowns, contact personnel, etc. change frequently. As such, this guide should be used just as that, a guide. Students are encouraged to refer to their one45 and uOttawa emails for the most up to date information regarding their rotation.

Good luck!

- Stephanie and Gemma, Editors in Chief, MD Candidates 2015

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WELCOME TO CLERKSHIP!

You all deserve a huge congratulations! The past few years of lectures, CBLs, PSD, practical exams, and OSCEs have been preparing you for these next two years! No longer will your days be spent sitting in a classroom staring at your computers or in CBL rooms practicing physical exam skills on standardized patients; now the time has come to practice what you've learned in clinical settings with real, live patients.

Now, we understand that your initial response to this is probably to want to run home and hide under your bed covers because you're not ready for real life. This is totally NORMAL! And as much as clerkship is scary and, at times, overwhelming, it will be one of the most thrilling and exciting times in your medical career.

Let's be honest, the hours are long, the work is hard, and there will be (many) times when you feel like you know absolutely nothing, but as you progress through your rotations, you will become more comfortable with your histories and physical exams, you will be able to come up with a thorough and relevant differential, and you will learn more than you ever could imagine! And let's not forget that this is the time when you will get to try many specialties which will help you find that one thing that you love and want to do for the rest of your life.

So how are you supposed to balance the clerkship workload, studying, being active, and having a social life? There is no magic recipe for having it all, but one thing we've learned is that it takes practice. And while you might not have it all at the same time – like when you're on Internal Medicine, with an upcoming exam and two call shifts in the next 5 days – it is possible to maintain normalcy during clerkship.

All jokes aside, clerkship will be one of the hardest, but most rewarding times in your life. You may spend hours taking a history, days trying to remember the doses of various antibiotics, weeks tracking the progress of a patient, but you only have these two years to explore all the amazing specialties that medicine has to offer. Take advantage of every opportunity, ask lots of questions, and don't be afraid of making mistakes, we all do, but that is how we learn.

On behalf of all the writers of this clerkship guide, we wish you the best of luck in clerkship and hope this guide will make the transition smoother and easier.

HOW TO RANK YOUR TRACK

Do I like Psychiatry? Should I get internal medicine over with right away? Is pediatrics during the winter a bad idea? How do I decide?

First things first – remain calm! Selecting a track can be very overwhelming and seem like the biggest decision that you will make during medical school, but rest assured, it's not! After speaking with various upper year medical students, residents in a variety of specialties (including psychiatry, dermatology, and internal medicine), newly practicing physicians, and nearing the end of our rotations, it is clear that regardless of your rotation schedule, things will work out in the end.

Now that that is all cleared up, you will probably still be wondering which track you should choose. There are many ways to approach picking your rotation schedule and below you'll find information about third year, as well as ideas and tips for approaching this decision.

REMEMBER, whether you start with internal medicine or psychiatry, you will learn a lot during clerkship, you will be challenged in each rotation, and you will become prepped for the years of residency and medical practice that lie ahead in the not so distant future.

WHAT IS A TRACK?

Everyone in third year will complete eight blocks that are each six weeks long. The eight rotations are listed below along with a breakdown of how you'll be spending your weeks.

Internal Medicine

- Six weeks of CTU (clinical teaching unit)

Emergency Medicine & Anesthesia

- Four weeks of adult emergency medicine (average 3 shifts per week + teaching shifts)
- Two weeks of anesthesiology

Pediatrics

- Three weeks of pediatric wards
- Two weeks of pediatric emergency medicine (3-4 shifts + teaching shifts)
- One week of neonatology

Mandatory Selectives

- One week of ophthalmology
- One week of Otolaryngology (ENT)
- Two weeks of either pediatric surgery or a pediatric medicine subspecialty (cardiology, endocrinology, hematology, respirology, community pediatrics, nephrology, child and youth protection)
- Plus two weeks of either dermatology, radiology, pathology, geriatrics, and palliative care

Surgery (if completed in Ottawa)

- One week of surgery boot camp

- Two weeks of general surgery
- Two weeks of urology or orthopedic surgery
- One week of your choice of surgical subspecialty, including plastic surgery, cardiac surgery, thoracic surgery, or neurosurgery

Obstetrics and Gynecology (if completed in Ottawa)

- One week of OBGYN base camp
- Two weeks of community OBGYN
- The remaining three weeks will vary depending on which site you are at (General vs. Civic)
 - Labor and Delivery (General, Civic)
 - Maternal Fetal Medicine/High Risk Obstetrics (General, Civic)
 - Gyne-Oncology (General)
 - Gynecology (Civic)
 - Follow the Chief Resident (General) – equivalent to gynecology at the Civic

Psychiatry

- Academic week at the beginning of the rotation
- Three weeks of Adult Psychiatry
- One week of Child Psychiatry
- One week of Geriatric Psychiatry

Family Medicine

- Five weeks of family medicine with your assigned preceptor
- Academic week composed of lectures and workshops

HOW DO I CHOOSE?

It is important to recognize that one track does not fit all. Deciding on a track can be done by considering the following: when you want the longest hours, surgery versus medicine, what type of summer you'd like to have, what your friends are doing, when to do the rotation you think you're interested in.

- You will start clerkship after nearly three months of summer when you will be refreshed, energetic and excited. As such, many people choose tracks that start with the “harder” or “more demanding” specialties, such as Surgery, OBGYN, or Internal Medicine (Groups A, B, E and F).
- Do you like seeing the light of day? Do you want to be going to the hospital for 5:30 AM in 2 feet of snow?
 - If not, you may want to consider doing your surgical rotation earlier on in the year (Group E or F) or once those winter months are far behind you (Groups A, B, C, or D)
 - You may also want to avoid Internal Medicine or Pediatric Wards during the Winter as the patient/workloads are historically much heavier at that time

- Still unsure if you want a medical versus surgical specialty? Doing internal medicine or surgery early on in your year can help you figure out which road you want to venture down.
- Regardless of what track you pick, you only get one week – that's right, ONE WEEK – off during the summer of your third year. So one question to ask yourself is what type of summer do you want to have?
 - If you are in groups A and B, you will be on Family/Psychiatry, which are historically less time consuming specialties, during the warm summer months. However, that would mean starting the year off in Internal, Emergency Medicine and Anesthesia.
 - If you are in groups C and D, you will be on your Surgery/OBGYN rotations. These two rotations are known to be long days and hours. While many elective surgeries and clinics have shorter hours during the summer months, rotations like general surgery, labor and delivery, gynecology, and orthopedics will still have early mornings and late nights. If you are planning to do your surgery/OBGYN specialties rural, the hours are more variable and they may be less tiresome.
 - In groups E and F, you will be on Mandatory Selectives/Pediatrics. Mandatory Selectives are composed of many specialties that are mostly clinics and/or have elective surgeries. As such, hours in the summer are variable, but shorter. Pediatrics is also known to be slower in the summer, even during your three weeks of pediatric wards.
 - In groups G and H, you will be on Internal/Emergency Medicine. Again, internal medicine has long hours and can be very exhausting. Though, like pediatric wards, it is known to be slower in the summer. Emergency medicine has set 8 hour shifts, with 2 teaching days per week, and Anesthesia is usually 7:30 AM – 3:00 PM Monday to Friday, with some variation.
- Don't really care about what rotation you start/end with? Not sure which specialties you like? Want to try to maximize the social opportunities in clerkship? Try and get into a group with your friends. Having friends in a clerkship group can be useful in a few key ways:
 - You can study together! If you're the type of person who likes to study in groups or ask questions to your friends, having a friend or few friends in your clerkship group may be beneficial.
 - You can vent to each other...and they'll understand what you're going through! Clerkship can be difficult, exhausting, and straining on your emotional and mental health. Having someone to talk with who has been through what you're experiencing will be very useful in clerkship.
 - You will actually get to see each other...on a semi-regular basis. Being in a different clerkship group than your friends doesn't mean you will never see them, but it does make it much more difficult to do so. And while you won't always be at the same site or with the same preceptor as other students in your rotation, you will see them a lot for weekly teaching sessions, base/boot camps, and exams.

- In many rotations, you work on a team of 3-4 people (internal medicine, pediatric CTU, general surgery), so it is nice to have people in your group that you would want to work with
- “I think I like _____ (insert specialty here), when is the best time to do that rotation?” If you are one of the “lucky” ones who know which specialty you’d like to do for the rest of your life or you have a few specialties in mind, you may wonder when it is best to do that rotation. Here are a few things to consider:
 - Every rotation is going to have a learning curve, some more than others. So regardless of when you do a rotation in something you’re interested in, you may not be a rock star on the first day.
 - Many people try to avoid putting the rotation they’re most interested in first in their schedule so that they have time to adjust to clerkship. *So, for example, if you think a surgical specialty is in your future, groups E, H and G may be good for you!*
 - Being in these rotations will allow you to get more comfortable with clerkship lifestyle and expectations before you get to the specialty you think you love.
 - Additionally, it will allow you to explore other interests and have something to compare your surgical rotation to.
 - If you are the type of person who has many interests and cannot narrow it down to one, consider picking a rotation that has a few of your interests close together. *For example, if you are considering OBGYN and Family Medicine, being in groups E and F will allow you to have both those rotations completed by end of February...perfect timing for when you’re planning 4th year electives!*

JUST REMEMBER: If in the end you get put in a rotation where the specialty you want comes first or last, OR you get your fifth choice group rather than your first, it’ll all work out by the end of third year. As long as you show up, show interest, complete your work, and be respectful to the healthcare team and patients, you will do well in clerkship!

THINGS I WISH I HAD KNOWN BEFORE CLERKSHIP

What to take with you from pre-clerkship:

- **Make the most of your PSD sessions!** This cannot be emphasized enough. Regardless of which rotation you begin with, you will be expected (and trusted!) to perform a complete history and physical exam on your patients. Your assessment will be considered accurate, and usually won't be repeated by the residents or attendings. You will also rarely receive so much focused attention and feedback on your skills... so hone them while you can!
 - History: in addition to the standard questions, know which associated symptoms accompany disease in various systems; ex cardiac – chest pain, SOB, palpitations, etc
 - Physical; **practice building your 'mental library' of normal findings.** It is the only way to recognize abnormal.
 - Don't worry if you're unsure, or forgot to ask something; **admit when your findings are incomplete.** This is completely acceptable!
 - **Review your PSD booklet before beginning your rotations.**
- **Make the most of anatomy, radiology and ECG sessions!!** Though they may seem esoteric right now, the ability to **interpret chest and abdominal x rays** will go a long way. Have an approach to MSK injuries. **Understand basic ECG's.** You will not have as much time to learn this later.
 - You do not need to be an expert by any means, but by making good notes now, you will have a good source to use to refresh when needed
- **Learn your antibiotics!** Know which drugs are used for common problems, and which bugs are responsible (pneumonia, UTI, skin infections, meningitis, preoperative, sepsis).
 - On internal medicine, you will be provided with a summary sheet of which antibiotics cover which bugs. It is extremely helpful, so try to get your hands on it early!
 - There is an extremely useful resource on OACIS that has guidelines for empiric antibiotic coverage in common problems.
- **Approach CBL cases as though they are real patients!** This is where you will start adapting your brain to clerkship-style thinking. Even if the session is titled "leukemia in adults", approach the case as you would on the wards; develop a differential and think about relevant diagnostic investigations.
- **Understand the big picture!** Pre-clerkship is not about doing well on your tests; it's about building a foundation of knowledge. You aren't expected to know details; you are expected to understand basic physiology and recognize common presentations.
- **Do pre-clerkship 10 hour electives!** Not only will this help you become more comfortable in the hospital environment, but will help you tailor your interests early on, and significantly reduce the stress of choosing a specialty!
- **REMEMBER: IT IS OK IF YOU FORGET OR DON'T KNOW!** But the more knowledge you bring with you into clerkship, the easier your life will be.
- And most of all: **Be willing to take risks; answer questions, suggest a treatment plan, think of a differential.** If you're too afraid to make mistakes you will not learn.

How to prepare for clerkship:

- **Make the most of link block!** You will learn the essentials of progress notes, fluid balance, how to write a prescription etc. These lectures are VERY USEFUL! The clinical

week is your chance to “practice”- try to get an understanding of the hospital system, learn how to write notes, observe the way rounds work. It will help you feel more comfortable once clerkship starts.

- **Try to review a basic approach to major topics** that will come up in third year; chest pain, shortness of breath/cough, abdominal pain, decreased level of consciousness.
- **Take some time to organize your life**; clean your apartment, organize your office, and get everything ready. Having quick meals prepped and in the freezer makes life on busy rotations that much easier.
- **Talk to the upper years** if you have questions!

Valuable tips:

- Let the attendings and residents know which rotations you’ve done, and areas you feel you need to improve. They will try to tailor your learning to this.
- Treat each rotation as though it is the specialty you want to pursue. You will get the most out of your experience, both in terms of what you learn and your evaluations.
- **Dress professionally** regardless of how casual your residents and attendings may be; at the very least, it will help your patient’s take you more seriously. That said **wear good comfortable shoes**; invest in a good pair of insoles. Your feet will ache. Trust us.
- **Study as you go**. Yes, it is exhausting. No, you won’t want to. But take it from us, you will learn MUCH more if you do. Review your cases and your PALS on a consistent basis. When you have studied a topic and then see it in practice, you will remember the information much more easily and pick up on more details. On the other hand, if you absolutely can’t, you can still do fine, but it will take a lot more effort towards exam time.

THINGS TO EXPECT IN 3RD YEAR

What do you do when melena hits the fan?

Let's face it, as much fun and excitement as this year will bring, there will be times when you want to throw your stethoscope away, sit down, and cry into your not-so-pristine white coat. Although everyone's third year experience will be unique, there are certain common situations that tend to occur, and we hope this section will help you to prepare for and/or aid you in preventing them. Always remember that whatever may be occurring, it isn't the end of the world, you can always adapt, and there is always someone who can help you out, you just need to know where to find them!

You will forget things and feel stupid...

This is an inevitable feeling that every medical student will experience time and time again, no matter how much you've studied during your pre-clerkship years. This does not mean you aren't a good student, or didn't prepare adequately, or aren't smart enough to be a doctor. You are still a medical student, and this is your first time applying all the knowledge you've worked to accumulate over the last two years. You are not expected to be an expert cardiologist after sitting through 5 weeks of cardiology lectures and writing one exam. It takes many years to learn and re-learn the same information before it truly becomes natural. When asked a question, take a few seconds to actually think before blurting out "I don't know"; chances are you'll remember something, and even if you don't, it's no big deal. Yes, even if you re-read that exact topic the night previously. The brain works in funny ways, especially when under pressure.

Though this may seem like an obvious point of reassurance, there will be times when you forget to remind yourself of how much you've achieved and have to be proud of.

You will make a mistake or forget to do something relating to patient care...

Doctors are human beings too, and "to err is human"; this is even truer for medical students who are adapting to a new environment, new procedures, and holding responsibility for real patients for the first time. Whatever your mistake, the most important thing is to acknowledge it and get help from the necessary individuals in order to rectify the situation and prevent adverse outcomes – which will most likely be non-existent to small. Always own up to your mistakes and tell whomever is involved; it's better to get criticized for an error you've admitted to making rather than one you were caught trying to hide. You can always go back and change an unprocessed order or add a new order on for something you forgot. But don't forget to get it co-signed by a resident first!

You will dislike someone on your team...

Whether it be your staff, a specific resident, the nursing team, unit clerks, patients or even another classmate, you will undoubtedly encounter individuals that aren't on the same wavelength as you, and with whom you don't naturally click. Remember that most interpersonal conflicts are due to misunderstandings or a lack of communication. Try not to take it personally – that person may be having a tough time in their personal or professional life. Do your best and maintain your personal standards of professionalism, even if the other individual doesn't seem to. Take the high road.

An important issue in this regard relates to the feedback evaluations both students and their teams complete. These evaluations are meant for constructive criticism to help improve that individual's performance. Refrain from insults, derogatory comments, or unnecessarily blunt remarks. No matter how much you may have disagreed with the individual, these kinds of comments will do no good, and only reflect poorly on you. They may also seriously hurt someone who could be experiencing personal stress, and be completely unaware of how their behaviour has impacted you.

Conversely, try not to get too shaken up if you receive a bad evaluation. Yes, your pride and/or feelings may be hurt, but put it in perspective. That individual is likely acting on their own emotional reaction to the situation, and thus their comments are not necessarily reflective of your actual performance. Maintain your own personal standards and hold your head high.

However, if you experience a situation or receive an evaluation that you feel goes beyond the realm of appropriate feedback and becomes inappropriate, don't let it go. Follow up with the rotation director, or if that makes you uncomfortable, with the student affairs office. Another option is to file a professionalism complaint. The official procedure for this can be found on the uOttawa Professionalism website. The faculty is here to support you, and you will not get into trouble for reporting something that you feel was in any way inappropriate; just be sure to go about it in a professional way!

You will want to cry...

Maybe you're overtired, or perhaps feel overwhelmed by the level of responsibility assigned to you. Perhaps you made a mistake and your attending called you out. Worst of all, you may experience a patient situation that is profoundly sad, such as witnessing your first death, or a traumatic code. We are all human, and tears are a human reaction to distressing situations.

Do your best to maintain composure and focus on the task at hand. If necessary, excuse yourself to the bathroom and take a few deep breaths before rejoining the team. No one will fault you for this – they will most likely be feeling similarly down and be fully supportive.

One situation that merits further discussion is the grief you may experience (and most likely share) with a patient or their family. It's ok to feel emotional, as death is often a sad event, and your ability to empathize with your patients is one of the advantages you have as a medical student. Depending on the situation, it's ok to share a moment of grief with a patient or their family that you've connected with. Unlike the residents or attending, you have yet to be exposed to death and loss on a regular basis. Your team has been in the hospital much longer than you, and may already be accustomed to these situations. As such, they may be better at distancing themselves from the moment in order to finish the task at hand. Overall, these experiences will prepare you for some of the difficult situations you will encounter in your career and exemplify the significance of the therapeutic alliance.

That said, if an experience was particularly traumatic to you, don't be afraid to talk about it with your residents and staff. They've been there too, and will be able to relate. The process of sharing is often cathartic in and of itself. If you need further counselling, the Student Affairs Office always has professionally trained counsellors available to offer support as well.

You will meet someone attractive at work...

...Just as you would in any other environment. Regardless of the situation, be mindful of your professionalism values and ethical responsibilities. This isn't *Grey's Anatomy*, but gossip does still spread like wildfire. Before acting on any of these situations, remember that one day in the not so distant future you will be applying to CaRMS, perhaps to a program at this same hospital, and that these people could end up being your colleagues for another five years. At the very least, you will be seeing the same people repeatedly as you progress throughout your rotations; avoid any complications by keeping things as professional as possible.

Your professionalism tactics will be tested...

Though mention of the word "professionalism" may be met with many groans during pre-clerkship, it is an issue that's extremely relevant to your experiences in the upcoming year. The situations discussed during your professionalism sessions do happen, so be mindful of the values and principles you've learned thus far. This applies to your interactions with patients and staff, your discussions with other classmates, your activities on social media, and even the way you dress. Whether you are consistently professional or not, you will leave a big impact on those around you; ensure it's the kind you want.

You will be proud of yourself...

This is an incredibly tough, but equally rewarding year, and at the end of it, you will truly start to feel like "a real doctor". Good luck, enjoy it as best as you can, and take the time to laugh. You've earned it!

SMARTPHONE/IPAD APPS THAT ARE USEFUL FOR CLERKSHIP

Organizational and Office:

- AwesomeNote HD: \$8.99; includes calendar, to do list, reminders, shopping lists, and much more.
- Goodreader: \$4.99; great for storing PDF versions of textbooks (many of which are free!)
 - Ibooks is a similar application that allows you to store PDF versions of textbooks for free
- Office2HD: \$7.99; great for note taking, storing handouts/algorithms, and papers.
- Evernote: free; excellent for quick notes you take on wards; can take pictures of handwritten notes and store them under topic headings!

Diagnostic Apps:

- Qx calculate: free; for clinical calculations or diagnostic criteria
- Pocket Guide to Diagnostic Tests: \$44; Very expensive BUT for those of you less than confident in clinical biochemistry, this excellent reference app is extremely helpful
- ECG Guide by Qx MD: \$0.99; ECG reference as well as samples

Medical Reference:

- UpToDate: free if you connect via hospital network; everything you could possibly want to know, but can be lengthy at times. Excellent resource for prescriptions!
- Medscape: free; similar to uptodate but in more succinct format
- MD on call: \$4.99; quick reference on how to manage common problems you'll encounter on the wards while on call, for example new onset fever, increased shortness of breath, or hypertension. It has a great approach to abnormal lab results, like electrolyte and glucose abnormalities. VERY useful on internal medicine, especially when you get a call from the floor and need help determining the severity of the problem.
- Epocrates or Lexicomp: free (but lexicomp requires subscriber information): good drug reference but can be a little difficult to use
- The Family Medicine Clerkship Handbook; a quick reference for common presentations, which can be downloaded as a PDF version onto iPads/smartphones.

Anatomy:

- Visible Body: \$29.99; expensive, but this is better than most anatomy textbooks. 3D enlargeable images of structures and the ability to add or remove systems (such as skin, muscles, bone), as well as details for each structure

Clinical Skills:

- Physical Exam Essentials: \$2.99; a good, concise review of history and physical exam skills by system
- Nerve Whiz: free; reference guide for neurological problems; tells you which nerves are involved with which systems
- (Another option is to load the PDF version of your PSD booklet onto your ipad)

Other great apps and their reviews can be found at www.imedicalapps.com

T-CLERK

As a part of the third year curriculum, students are expected to document the clinical problems and procedures they have faced during their rotation on an application called “T-Res”. This application is also used by residents and staff to record clinical and academic activities.

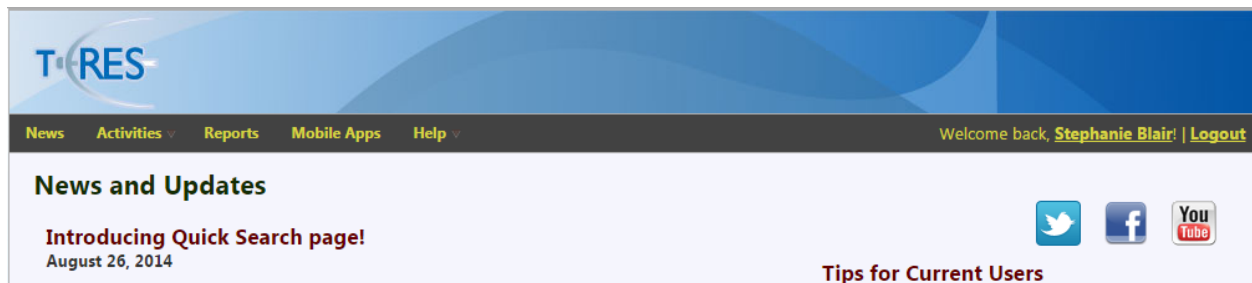
Each rotation will have its own set of ‘T-Clerk clinical encounters that students should meet during that six week block; there are also clinical encounters for Link Period. For example, during Anesthesia, you are expected to perform at least one IV insertion independently and on a real patient.

The T-Clerk clinical encounters are available at the Undergraduate Medical Education website (http://www.med.uottawa.ca/Students/MD/eng/t_clerk.html).

It is very important that you keep your T-Clerk up to date as completing these encounters is a mandatory component of each rotation and failure to do so would be deemed unprofessional. Our suggestion is to try to update your T-Clerk daily using the application that is available for android, iPhones and iPads. If you do not update your T-Clerk for more than 7 days, you will receive an automated email from the Clerkship Director reminding you to complete your T-Clerk tasks.

How to use the T-Res website:

Once you sign into T-res, you will see the following page:



If you want to input an activity, click on the ‘activities’ tab and choose ‘enter new activity’. This will bring you to the following page:

Enter New Activity

Activity Type: Patient Encounter

Activity Setting

Date*
18-Sep-2014

Site
Civic Campus

Preceptor
Type to search

Rotation
Paediatrics

Location
Ward

Allied Health

Patient Interaction

Scenario
Type to search

Problems
Type to search

Self Evaluation

Role
3-Present hist/exam

On this page, you can log your most recent activities. Firstly, select your activity type – procedure or patient encounter. You will have encounters to meet in both these categories. Select the correct date and rotation for each activity. Based on the complexity of the case, you may be able to cover multiple problems. Add in all the relevant information, then click ‘save’.

Tracking your progress and submitting your T-Clerk reports:

At the end of each rotation you will be required to provide proof that you have completed your T-Clerk encounters. This requires generating two 018b reports. You can access this report at any point during your rotation and it will show you which encounters you have successfully completed and which are still pending. To access this report, click on the ‘Reports’ tab. Then select 018b – Trainee Goal Activities Count.

Reports		
Name	Description	
018b - Trainee Goal Activities Count	Displays expected goals, goals achieved and the number of activities still pending.	<input type="button" value="View Report"/>
024 - Role Played By Trainees For Attending Physicians	Displays the average percentage of time spent in different roles (e.g. Observer, Assistant, Primary, etc.), depending on the trainee's year of training. Also displays a further breakdown per preceptor/supervisor in the program, to make it possible to compare the level of responsibility that trainees get under specific preceptors vs. the average for the entire program. For example, if a particular preceptor/supervisor has a higher than average rating for trainees in the Primary role, it could be an indication that he/she is more willing to let a trainee handle a case on his/her own, whereas if it is a lower than average rating, that preceptor/supervisor could be a bit more cautious.	<input type="button" value="View Report"/>
030 - Pick List Items	List items and their hierarchy for items available in activity dropdown lists.	<input type="button" value="View Report"/>

You will be directed to the following page:

[Back to T-Res](#)

Goal Config	Problems by rotation ▼	Start Date	8/1/2014 12:00:00 AM	View Report
End Date	9/18/2014 12:00:00 AM	Filter By	- ALL - ▼	
Role	<Select a Value> ▼	Completion Status	▼	

To generate your 018b report, fill out the appropriate information. This report separates activities into problems and procedures, rather than patient encounters and procedures. You should generate a report for both. Your report will look like the following:

[Back to T-Res](#)

Goal Config	Problems by rotation ▼	Start Date	8/1/2013 12:00:00 AM	View Report
End Date	9/29/2014 12:00:00 AM	Filter By	Obstetrics-Gynaecology ▼	
Role	- ALL - ▼	Completion Status	- ALL - ▼	

1 of 1 Find | Next



018b - Trainee Goal Activities Count

Goal Config: Problems by rotation

Discipline Standard: Ottawa Undergrad/Program: Ottawa Undergrad

Reporting Period: 8/1/2013 to 9/29/2014

Role: ALL

Trainee: Lubchansky, Stephanie Blair

Rotation: Obstetrics-Gynaecology				
Problems	Goal	Achieved	Pending	Completed
Abdominal Pain	1	14	0	√
Abnormal Uterine Bleeding	1	8	0	√
Abortion (Spontaneous)	1	3	0	√
Antenatal Care	5	7	0	√
Antepartum Hemorrhage	1	1	0	√

Save a copy of your reports in a PDF format and send them in to the appropriate rotation coordinator.

PARKING IN CLERKSHIP

During your clerkship rotations, in addition to your daily clinical duties, you may be expected to attend lectures, academic half-days, or clinics at the various TOH sites and hospitals separate from the site you are assigned to. For example, during your psychiatry rotation, academic half-days are at the Royal Ottawa Hospital and during the Anesthesia and Emergency Medicine rotation, all academic half-days are held at the Civic campus. As such, it is important to know where and when parking is available at these locations.

Medical Student Parking Pass

Each year, one student in the Anglophone class is assigned as “Parking Officer”. This person is in charge of organizing parking passes at the General and Civic campuses. For each rotation/block, there are a certain number of parking passes that are assigned to medical students. Spots will be distributed randomly via lottery/draw based on the demand.

At the Civic, the parking pass is for the Champagne Lot, which is at Carling Ave and Champagne Ave. There are shuttles running every 10 minutes that take you from the lot to the front of the Civic. Shuttles usually stop by 5:30 PM. If you are on call or have an evening emergency room shift, you can park at the P2 lot (main lot near the Civic, Heart Institute and SIM centre) after 2:00 PM until 9:00 AM the next morning. On weekends and holidays, students with the Champagne lot parking pass can park in the P2 parking lot during their shifts or 24 hour call.

At the General, the parking is in Tempo A. The pass will work in the General parking garage on evenings (after 2 PM), weekends and statutory holidays. Evenings begin at 2:00 PM and you must leave the lot by 9:00 AM the next morning to avoid paying.

The cost of the parking passes are \$95.25 per rotation.

For more information, contact your class's parking officer.

RGN Parking Pass:

Students can purchase a parking pass to RGN either month by month, September to April, or for the full year. The prices for these passes are online at:

<http://www.protection.uottawa.ca/en/Longtermparking-RGN.html>.

If you choose to park at RGN without a parking pass, the rates are: \$4.50/hour to a maximum of \$16.00/day.

Public Parking at the Civic Campus:

Parking at the main P2 lot at the Civic is maximum \$13.00/day. There is street parking along Ruskin Ave for two to three hours at a time.

Intercampus Shuttle Services:

Run daily between the General, Civic, and Riverside. The shuttles leave every half hour from the General Campus on the :00 and :30, from the Riverside on the :10 and :40, and arrive at the Civic on the :30 and :00.

LOCKERS

Depending on the rotation you are on, you may find yourself carrying around a lot of items at the hospital on a daily basis (white coat, iPad, clipboard, pens, notes, lunch, etc.). So, in an effort to prevent students from getting chronic back pain secondary to heavy bags or backpacks, there are lockers available at the General, Civic, and CHEO for student use.

General Campus:

The student lockers are located behind Module G. In order to secure a locker, you must put your lock on a locker that is empty and then email the hospital coordinator in charge of the lockers with your name and which locker you have chosen. You can also include how long you will need the locker; for example, if you have Internal Medicine and Acute Care Medicine at the General, you can request to keep the locker for all 12 weeks.

The coordinator at the General Campus is Hilary Gore (hgore@toh.on.ca).

Civic Campus:

The student lockers at the Civic are located on B3 (near the OR change room) and A6 elevators. As with the General campus, students are welcome to place their locks on empty lockers and must email the coordinator their name and locker number.

The coordinator at the Civic Campus is Debbie Hall. The email to contact is lockersCIVIC@toh.on.ca.

CHEO:

Students must go to the Security Office on the main floor (near the ER and student call rooms) to obtain a locker. There is a \$15.00 deposit for the locker, which will be returned once you have returned your locker key. Lockers are located on the bottom/1st floor; there are multiple areas where your locker may be located, including near the CHEO cafeteria and by the Resident's lounge.

There are daily lockers available on the bottom floor near the cafeteria. These lockers can be used by staff throughout the day until 11:00 PM. However, they do get taken quite quickly, so if you are planning on using a locker on a more regular basis, it may be best to get your own locker from security.

FOOD SERVICES DURING CLERKSHIP

It's 3 AM, you've been at the hospital since 6:45 AM the previous day, and your resident tells you to eat something and try to get some sleep while there is some down time. The question you ask yourself is: what can I get to eat??? This situation will inevitably happen to you at some point during clerkship, so it is important to know the ins and outs of food services at the hospitals, as well as restaurants in the area (especially those that deliver!). Of note, 24 h options are very limited at both campuses, so you may want to bring your own snacks or meals. Finally, if you are truly desperate and stuck in Emerg at 3:45, there's always a cupboard with biscuits and crackers; just ask one of the nurses/residents.

General Campus:

- Café 501
 - o Monday to Friday: 8:00 AM – 6:30 PM
 - o Weekends: Closed
 - o Holidays: Closed
- Second Cup
 - o Open 24 hours a day, 7 days a week
- Tim Hortons
 - o Monday to Friday: 6:30 AM – 9:00 PM
 - o Weekends: 7:00 AM – 7:00 PM
 - o Holidays: 7:00 AM – 4 PM
- Convenience Store (Beside Second Cup)
 - o Monday to Friday: 7:00 AM – 8:30 PM
 - o Weekends: 10:00 AM – 4:00 PM
 - o Holidays: 10:00 AM – 4:00 PM

CHEO:

- Rainbow Café (1st Floor near Max Keeping Wing)
 - o Monday to Friday: 6:30 AM – 2:00 PM
 - o Weekends: Closed
 - o Holidays: Closed
- The Oasis Café (Main Level near the Entrance)
 - o Monday to Friday: 7:30 AM – 11:00 PM
 - o Weekends: 7:30 AM – 11:00 PM
- Delivery Options:
 - o Same as above

Civic Campus:

- The Tulip Café
 - o Monday to Friday: 9:00 AM – 6:00 PM
 - o Weekends: Closed
 - o Holidays: Closed
- Second Cup
 - o Open 24 hours a day, 7 days a week
- Tim Hortons
 - o Monday to Friday: 6:30 AM – 9:00 PM

- Weekends: 7:00 AM – 7:00 PM
- Holidays: 7:00 AM – 4 PM

Heart Institute (near the Civic):

- Tickers Café (Main floor of the Heart Institute)
 - Monday to Friday: 9:00 am – 3:00 PM
 - Weekends: Closed
 - Holidays: Closed
 - Tip: Best lunch at TOH!!

Riverside Campus:

- Coffee Shop (Main Floor near Entrance)
 - Monday to Friday: 7:00 AM – 4:00 PM
 - Weekends: Closed
 - Holidays: Closed
- Le rendez-vous Cafeteria
 - Monday to Friday: 6:00 AM – 2:00 PM
 - Weekends: Closed
 - Holidays: Closed

All Campuses:

Vending machines with drinks and snacks.

Delivery Options:

- Greek on Wheels: (613) 235-0056
- Sala Thai: (613) 521-1102
- Green Papaya: (613) 231-8424
- Thai Coconut: (613) 225-1238
- Gabriel Pizza: (613) 310- 7777
- Pizza Pizza: (613) 737- 1111
- Swiss Chalet: (613) 733- 7231
- St. Hubert: (613) 526-1222

CALL ROOMS

During third year, five out of the eight rotations require students to be on call. Mandatory Selectives and Family Medicine generally do not have call, but it will vary on your preceptors and sub-specialties; you will not have any overnight shifts or overnight call on your Acute Care rotation. As such, it is important to familiarize yourselves with where the call rooms are located at the various hospitals.

General Campus:

Call rooms are located on the 3rd floor. Depending on which service you're on, you may have a call room specifically assigned to you or you may have to sign up for one of the "house staff/resident" call rooms. General Surgery, OBGYN, and Internal Medicine all have rooms assigned for students/residents on the team. You MUST sign up for your call rooms – there are sign-up sheets on the doors of each room.

NOTE: although there are rooms assigned to the Internal Medicine teams (A, B, and C), on any given night, there may be a resident and medical student on for your team; do not assume that you will have access to your team's assigned room!

Civic Campus:

Call rooms at the Civic are located on the 3rd floor of the Parkdale Clinic (you will be shown these during the relevant rotation orientations). On the morning of your call shift, be sure to sign-up for a room by writing your name on the sheets on each door. As above, the room assignments to given teams/residents/students are not always respected, and it's best to go by the sign-up sheets on each door.

A word to the wise: the parkdale call rooms are very chilly! Some items that students may choose to bring include their own blanket, pillow, earplugs etc, but most likely you will not have much time to sleep.

If you are doing your OBGYN rotation at the Civic, the student call room is located in the main building, on the 4th floor across from the D4 Clinic, near Labour and Delivery Triage. This allows you to get a quick nap between deliveries while staying close to the action.

CHEO:

During your three weeks on pediatric wards, you will be expected to do four (plus/minus one) call shifts. There are two call rooms available for medical students and they are located on the main/2nd floor near the security office. The rooms are assigned based on which team you are on call for. Students who are on call for Red Team (4 East) will be in one room, and students on call for Purple/Bronze Team (3 East, 4 West, 4 North, 5 East) will have access to the other room. These rooms are equipped with a private washroom, single bed, bedside table, and desk with CHEO computer.

HOW TO TAKE A HISTORY

Being able to take a complete and thorough history is an invaluable skill in clerkship. Whether it occurs in the emergency room or on the wards, medical students are frequently the first to see patients during their initial work-up and aid in collecting pertinent information to help the medical team decide on further investigations and management. Although taking a history will be modified based on the specialty you are in, there are basic components that will always be included and that students should not miss.

1. Identification (ID) – this will include information such as the patient's name, age, gender, and MRN. In specialties like psychiatry, the ID will be more detailed and include the patient's relationship status, occupation, living situation, and number of dependents.
2. Reason for Referral (RFR) – unless you are on your emergency medicine rotation, consults that students perform will be requested from another specialty. The reason for referral or RFR should be a short section that explains why you were asked to see the patient. *Note: you may also use "chief complaint (CC)" instead of RFR.*
3. History of Presenting Illness (HPI) – this section of the history provides the details relevant to why the patient is being seen. A significant portion of the time spent with a patient will be focussed on this section. The HPI should focus on the timeline and events leading to admission/coming to the hospital. For taking this history, there are many mnemonics that can be used, but one of the most common is the **LMOPQRST** structure. It is also important to ask about **associated symptoms**, which will vary depending on the nature of the chief complaint. Additionally, you always want to ask the patient has ever had an issue similar to this before (**déjà vu**) and how it has affected them.
 - **Location**
 - **Management** – Have you taken anything for it?
 - **Onset** – When did the issue begin? What were the events surrounding it?
 - **Precipitating/relieving factors** – What makes it better? Does anything make it worse?
 - **Quality** – If the chief complaint is pain, is it sharp? Dull? Throbbing? Burning?
 - **Radiation** – Does it stay in one place? If not, where does it go? Is it shooting pain?
 - **Severity** – On a scale of 1 – 10, how do you rate the pain? 10 being the worst pain of your entire life and 1 being barely noticeable.
 - **Timing** – Is the pain/issue constant? Does it wax and wane? Is there a particular time of day when it is worst?
4. Past Medical History (PMHx) – there are many ways of completing this section of your history. While nothing will replace the information that is obtained by asking the patient about their PMHx directly, it is almost impossible to remember every possible condition that could be contributing to their current illness. A useful question to ask patients is "are there any medical conditions you are followed for regularly?" With the use of Electronic Medical Records (EMR), much of a patient's medical history is available to you before you even meet them. Information from the patient, their EMR, and collateral (family

members, friends, family physician) can help you provide your residents and staff with a complete past medical history.

5. Past Surgical History (PSHx) – information for this section, like the PMHx, can be collected from the patient and their EMR. It is important to include the following details in this section:
 - When was the surgery?
 - Was it scheduled or emergent?
 - Who performed the surgery and at which hospital?
 - Were there any complications?
 - What type of anesthetic was used (general, epidural, spinal, local)
6. Family History – any history of the current condition should be explored, as well as other conditions that may present in a similar manner. Since most patients will not have a list of their family member's medical issues, it is your responsibility to ask the patient about common and/or relevant conditions that may be associated with the chief complaint. For example, if a patient presents with diarrhea, it is important to ask about a family history of inflammatory bowel disease and celiac disease.
7. Medications – be sure to include dose, time of day they are taken, route (PO = by mouth, subcutaneous injection, IV). Ask about any recent changes or additions to their medications, which can exacerbate pre-existing medical conditions. Many medications can be used to treat different illnesses, for example, beta blockers can be used for angina, cardiac arrhythmias, while gabapentin is used as an anti-epileptic as well as for neuropathic pain. You must find out why the patient is on the medication and how effective it is for that issue.
8. Allergies – while it is important to ask about food and seasonal allergies, you want to make sure to ask specifically about medications and the associated reaction. For example, if a patient states they are allergic to penicillin, it is important to know the severity of the reaction (rash vs. anaphylaxis).
9. Social History – this section will include information about the patient's occupation, marital status, and substance use. Substances you want to ask about are alcohol, cigarettes, cannabis, and other illicit drugs. In addition, you want to be able to quantify their substance use.
 - Alcohol – How many drinks per day? Per week?
 - Cigarettes – How many cigarettes per day? How long have they been a smoker?
 - Cigarette smoking is generally reported in **pack years**: # of packs/day x # of years they have been smoking.
 - If they say they do not smoke **currently**, you should ask if they have **ever** smoked
 - Cannabis and illicit drug use – Yes or No. If they have used, when? What route? How often?

ADDITIONAL INFORMATION

As previously mentioned, each specialty will have a slightly different focus when performing a history. Below are some additional sections or topics to cover based on specialty:

1. Psychiatry

- a. Included in the HPI:
 - i. Screen for depression (MSIGECAPS)
 - ii. Screen for mania (GST PAID)
 - iii. Screen for anxiety (general anxiety disorder, panic disorder +/- agoraphobia, OCD, PTSD)
 - iv. Screen for psychosis (hallucinations, delusions, negative symptoms of schizophrenia)
- b. Past Psychiatric History
 - i. What was the diagnosis? When was it made? What treatments has the patient had for this diagnosis (pharmacological, psychological)?
 - ii. Have there been any hospitalizations for psychiatric illness? If so, when were they and how long?
 - iii. Is the patient followed by a psychiatrist or other healthcare professional for this diagnosis?
 - iv. Is there any history of self-harm or suicide attempts? If so, when? How many? How often? What were the circumstances?
- c. Forensic History
 - i. Past criminal activity
 - ii. Any incarceration?
- d. Suicidal and homicidal ideation, plan and intent
- e. Mental Status Exam (ABC STAMPLICKER) – the Psychiatry “Physical” Exam
 - i. Appearance
 - ii. Behaviour
 - iii. Cooperation
 - iv. Speech
 - v. Thought form and content
 - vi. Affect
 - vii. Mood
 - viii. Perception
 - ix. Level of consciousness
 - x. Insight and judgement
 - xi. Cognitive functioning
 - xii. Knowledge base
 - xiii. Endings (suicide)
 - xiv. Reliability

2. Obstetrics and Gynecology

- a. Obstetrical history
 - i. How many pregnancies? What were the outcomes? You should present this information in the following form: G (gravida = how many pregnancies), T (term = how many babies born after 37 weeks GA), P (preterm = how many babies born between 20 and 37 weeks GA), A (abortions), L (living)

- ii. For each pregnancy, you want to know how far along the pregnancy went, gender of the child, birth weight, method of delivery (spontaneous vaginal delivery, assisted vaginal delivery, c-section), and any complications during the pregnancy and the delivery.
 - iii. It is also important to note how these pregnancies were conceived – natural, intrauterine insemination (IUI), in vitro fertilization (IVF).
- b. Gynecological history
 - i. Age of menarche
 - ii. Date of last menstrual period (LMP)
 - iii. Frequency of menstruation - cycles can be anywhere from 21-35 days in length
 - iv. Length of menstruation
 - v. Features of menstruation – Menorrhagia? It is important to quantify because what is “heavy” to one woman may be light to another. Dysmenorrhea? If so, do they require medication? You can use **LMOPQRST**.
 - vi. Is the patient sexually active? If so, what form(s) of contraception are they using? How long?
 - vii. History of sexually transmitted diseases – if positive, were they treated? When? Partner as well?
- 3. Pediatric – has many of the **same, plus additional** components of an adult history
 - a. History of Presenting Illness
 - i. OPQRST + PREVIOUS (ie. Past episodes) and PROGRESSION of presenting symptoms
 - ii. When was child last well? How did current complaint develop
 - iii. Establish child’s baseline and how it has changed in terms of:
 - 1. Nutrition (For infant’s include feeding details – Breast vs. formula, supplementation, frequency, and duration)
 - 2. Growth and Development (how does he/she compare to siblings/friends)
 - 3. Level of Activity (keeps up with friends? Tires easily? Energetic? Quiet?)
 - 4. For infants include baseline and current urine output (wet diapers) and BM
 - iv. Recent exposure: sick contacts (family, school, care providers), recent travel
 - v. General: **Activity, Appetite, Attitude/Energy** (3 A’s of pediatric illness)
 - vi. Infant: are they consolable? Crying all the time?
 - b. Past Medical History:
 - i. Ongoing diagnoses
 - ii. Resolved diagnoses
 - iii. Early history (if relevant):
 - 1. Prenatal maternal details: Mother’s age, gravida, term, live births, outcomes etc (ie. GTPAL)
 - 2. Planned vs. unplanned pregnancy, onset of prenatal care
 - 3. Important details of pregnancy: substances (including medication), sickness, screening
 - 4. Birth history: Spontaneous vs induced, vaginal vs C/S, any complications, bw, apgars

5. Post-Natal: NICU required, resuscitation required, length of hospital stay before discharge
- iv. Infancy History:
 1. Common problems: jaundice, poor feeding, difficulty breathing, inadequate weight gain
- v. History of Hospitalizations and Surgeries
- c. Medications, Immunizations, and Allergies:
 - i. OTC and prescribed medications
 - ii. Allergies: if present, check for atopy (eczema, asthma) as well as parental history of atopy
 - iii. Asthma: smoke, pets, carpets, allergens, family hx of atopy/asthma
- d. Family History
 - i. Health status of family members, number of siblings, childhood diseases
 - ii. Consanguinity, genetic pedigree
 - iii. Relevant family history of disease (include autoimmune history if type 1 DM, asthmatic, etc.)
- e. Social History
 - i. Who lives at home? Primary caregivers? Parental occupation
 - ii. Attend daycare?
 - iii. Stressors: relationships, finances, substance use?
 - iv. School and friends (if applicable)
 - v. Healthy Active Living: Exercise, sports, social outlets
- f. HEADDSS History – adolescent interview
 - i. General: Interview teens alone, and assure confidentiality
 - ii. Home: who lives there, how do they get along
 - iii. Education/employment: grade level, attendance, favorite/least favorite courses, employment for \$ or ‘experience’?
 - iv. Activities: what do you do for fun/on weekends? Do you think you have enough friends? What extra-curriculars do you do?
 - v. Drugs/Substances: Have you ever tried... x y z; frequency, quantity
 - vi. Dieting: concerned about weight/shape? Ever tried to change it? Binge/purge?
 - vii. Sexuality: Same sex, opposite sex, both? Ever been sexually active? Number of partners, age, STIS history, protection, pregnancy
 - viii. Suicide/Depression: MSIGECAPS screen, thoughts of hurting self/others
 - ix. Safety: seatbelts, bike helmets, guns at home, ever felt unsafe?
- g. Physical Exam
 - i. General Inspection: Sick or Well? LOC/mental state – irritable vs. calm vs. lethargic. Any distress? Well nourished? Developmental status (any delay?). Any dysmorphic features?
 - ii. Anthropometrics – Growth curve for height (supine length until age 2), weight, head circumference.
 - iii. Vital signs: Temperature, HR, BP, RR, oxygen saturation
 - iv. HEENT:
 1. Hydration: mucous membranes moist? Tears? Skin turgor? Sunken eyes? Appropriateness of vitals?
 2. Dysmorphic features, skull shape and size
 3. Otoscopy; oropharynx
 4. Neck: lymphadenopathy

- v. Cardiovascular:
 - 1. Inspection: chest shape (pectus excavatum – connective tissue disease with cardiac symptoms)
 - 2. Palpation: heaves, thrills, displaced apex
 - 3. Heart sounds: audible S1, S2? Extra heart sounds?
 - 4. Murmurs: timing, quality, location, intensity, radiation
 - 5. Perfusion: peripheral pulses (femoral in all infants), capillary refill, skin colour
- vi. Respiratory:
 - 1. Chest wall deformity?
 - 2. Air entry bilaterally? To the bases? Any adventitious sounds?
- vii. GI/GU:
 - 1. Distended or bulging abdomen? Tender to palpation or percussion? Peritoneal signs? Organomegaly? Bowel sounds present?
 - 2. Neonate: check for imperforate anus and undescended testicles
- viii. Neurological:
 - 1. Milestones: gross and fine.
 - 2. Infants: check for signs of spina bifida
 - 3. Neonates and young infants: presence of primitive reflexes
 - 4. General motor tone
- ix. Skin:
 - 1. Rashes, petechiae, purpura
- x. MSK:
 - 1. Neonates and infants: Ortolani and Barlow maneuvers for developmental dysplasia of the hip.

ADMISSION ORDERS

So you collected a complete and accurate history, finished your physical exams, and have presented this data with the relevant lab work and investigations to your senior resident and staff, and they want you to admit the patient – what do you now? Admission orders! An easy way to approach admission orders is using the acronym **ADD DAVI₄D**:

1. **Admit** patient to _____ (SPECIALTY) under Dr. _____ (ATTENDING STAFF).
2. **Diagnosis** – include the suspected diagnosis. If a diagnosis is uncertain, you can write the issue plus “NYD” (not yet diagnosed). Examples:
 - a. Acute Appendicitis
 - b. Ectopic Pregnancy
 - c. Psychosis NYD
3. **DNR Status** – do NOT write DNR status! Instead, you write the patient's category status: Category 1, 2, 3; if unknown, do not write anything. Someone may see DNR and not read the rest.
4. **Diet** – examples include: DAT = diet as tolerated, renal diet (low K and low Na), heart healthy (low sodium, low fat), diabetic diet, NPO = nothing by mouth.
5. **Activity** – AAT = activity as tolerated; bed rest; fall risk
6. **Vitals** - every 4 hours (q4h), every 8 hours (q8h), in the morning (qAM), at shift changes (qshift)
7. **Instructions to nurse** – this may include daily weights, capillary blood sugar monitoring, monitoring urine output, etc.
8. **I.V. Orders** – examples:
 - a. I.V saline lock (ensures patient has IV in place, but nothing running through it),
 - b. IV TKVO (to keep vein open) = very low rate to keep IV patent (10-20 ml/hour)
 - c. IV rate with IV fluid type
9. **Investigations** – blood work, radiology, EKGs, consultations
10. **Isolation status** - airborne, contact, droplet
11. **Drugs** – this includes all the medications the patient needs. This section must include the drug name, dose, route of administration, how frequently it is to be given, and if it is continuous or as needed (PRN). Don't forget the 6 P's:
 - a. Pain
 - b. Pus (antibiotics)
 - c. Poop (laxatives or stool softeners)
 - d. Puke (antiemetics)
 - e. Prophylaxis (DVT/PE)
 - f. Past medications (home meds)

TIPS FOR WRITING ADMISSION ORDERS

- Avoid abbreviations – drugs and diseases can be confused if you use abbreviations. While it may take more time to write out the entire word, it will save you from having to clarify your orders in the future.
- All orders need to have the date, time, signature and printed name with your “rank” (MS3, MS4, R1, etc.). You should use the 24 hour clock for orders.
- *And remember that all your orders need a co-sign before your patient can get any care
*it is your responsibility to get orders co-signed**

SAMPLE ADMISSION ORDER

Case

- Ms JB – 75 y o woman you are admitting to hospital for hip fracture requiring surgical repair. She will be admitted under Dr Lewis
- She will be going to the OR within the next 24 hours as soon as there is OR time available
- Her past medical history is significant for atrial fibrillation and hypertension
- Her medications include coumadin 2 mg po daily, metoprolol 50 mg po bid and ramipril 5 mg po bid
- She is having moderate pain from the hip fracture

Admission Orders

1. Admit to orthopedic surgery under Dr Lewis
2. Diagnosis: right hip fracture
3. CPR and Plan of Treatment: Category 1, see attached order sheet
4. NPO
5. Bedrest until OR – non-weight bearing
6. Vital signs q 8 hours
7. Start intravenous and infuse 2/3 / 1/3 plus 20 mmol KCl at 75 mL/hour
8. Stat INR now – please call MD with result
9. CBC, electrolytes, BUN, Cr now and tomorrow AM
10. ECG now
11. Medications – see medication reconciliation form
12. Tylenol 325-650 mg po q 4 hours prn for pain
13. Hydromorphone 0.5 mg sc or 1 mg po q 4 hours prn for pain
14. Metoclopramide 5-10 mg iv or po q 6 hours prn for nausea
15. Anaesthesia consult – notified and consultation request filled

HOW TO WRITE PROGRESS NOTES

Progress notes are important form of communication of a patient's medical progress, whether it be on the wards, in the emergency department, or an outpatient clinic. Progress notes are used by all members of the multidisciplinary team and, therefore, need to be concise and accurate. There are two formats for writing progress notes – the 'SOAP' format and the 'issue based' format. The SOAP note can be used for patients with a single issue. Issue based progress notes are best used when a patient has a multiple concerns. The main difference for issues based notes is that you have multiple assessments (each issue) and each assessment has its own plan.

Every note needs a date, time, and identifying information about the writer (clinical clerk – CC; medical student – MS). All notes should begin with an identifying statement, such as "75 year old female admitted for exacerbation of COPD". The final component of the note should include a disposition or discharge plan (e.g. home, long term care facility, etc.).

Things to consider:

- Avoid abbreviations – it may take you a minute longer to finish the note, but it will ensure that there is no confusion about what you are prescribing or ordering
- Document all findings and be specific
 - Include pertinent positives and negatives
 - If something is not included, it will be assumed that it was not done/asked

SOAP Note:

S – Subjective (patient's perception)

O – Objective (includes the physical exam, relevant laboratory testing, and/or imaging)

A – Assessment (your impression of the situation)

P – Plan

Sample Note:

Medicine – Medical Student

February 9th, 2014

75 year old woman from home admitted 2 days ago with gastroenteritis and dehydration

S = feels better, only 5 bowel movements in the past 24 hours, taking fluids orally

O = looking well, BP 165/90, afebrile, JVP 3 cm, mucous membranes moist, abdomen is soft, non-tender with no evidence of peritonitis

K = 3.7, Cr = 100, stool positive for Norwalk virus

A = Resolving gastroenteritis secondary to Norwalk virus

P = 1) advance diet today, discontinue if fluids

2) remove urinary catheter

3) physiotherapy consult

4) home in 24 hours if tolerating diet and ambulating

Name, MS 3, signature

HOW TO WRITE A POST-OPERATIVE NOTE

Whether you are on your surgery, obstetrics and gynecology, ENT, or Ophthalmology rotation, all completed procedures will require a post-operative note. This note highlights pertinent information regarding the procedure, why it was done, findings, complications, and diagnoses. It is expected that the medical student will write the post-operative note.

The following template can be used in most surgical specialties, however, not all headings will be required for all surgeries:

- Surgeon – Who is/are the primary surgeons?
- Assistant – This includes residents and medical students. Be sure to include the rank of each assistant beside his or her name.
- Anesthesia – Name of anesthesiologist and type of anesthesia used should be noted.
- Pre-operative Diagnosis
- Post-operative Diagnosis (usually the same as the pre-operative diagnosis)
- Procedure
- Findings – What was observed/found in the OR
- Pathology – Samples or specimens taken during the procedure
- Complications – Were there any unexpected issues or problems that arose during the procedure? What was done?
- Drains – Does the patient have drains in place from surgery? This can include a Foley catheter, Jackson Pratt (JP) drain, etc.
- Estimated Blood Loss (EBL) – This is the best guess at how much blood was lost during the procedure itself
- Disposition – How was the patient when they left the OR? Where are they going now (PACU, ICU, ward)?

NOTE: It is important that the information in this note is correct, so if you are unsure about something that happened during the surgery, be certain to ask your residents and/or attending staff for help.

HOW TO WRITE A DISCHARGE SUMMARY

Discharge summaries are the main way that information is passed from the treating team in the hospital to the treating team in the community. Discharge from hospital is a time of transition and proper communication can help ensure that appropriate measures are taken and that proper patient follow-up occurs.

Discharge summaries should be timely and concise. They should include relevant information, medication reconciliation and have a follow-up plan.

Many students fall into the habit of 'copying and pasting' the consultation note into the discharge summary and completing everything at the last minute. The best way to write a thorough and accurate discharge summary is to take the time to update it every day starting from admission.

Practical tips:

- Put yourself in shoes of GP getting report – what do you need to know?
- Figure out how to get information to GP in timely fashion
 - Use patient as courier or call GP yourself
- Be diligent with medications – huge source of error and big patient safety issue
- Make sure follow-up plan in place especially for results pending at discharge and "backup plan" indicated
 - Who to call if something going wrong or more information needed.
 - Advice given to patient about when to return to hospital or seek medical care
- Do not use abbreviations – receiving physician may not understand or use the abbreviation to mean something else
 - Example: d/c – does this mean discharge, discontinue, or something else?
- Get feedback about your discharge summaries
- At CHEO, you will be expected to dictate your discharge summaries and they should only be started AFTER the patient is discharged. The pediatric handbook that is provided during the rotation has a good outline for what should be included in your discharge summary and in what order.

Sample Discharge Summary:

Name: Patient X
Admission Date: March 10th, 2012
Discharge Date: March 17th, 2012
Campus: The Civic Campus, The Ottawa Hospital
Unit A5
Physician: Dr K Wooller
Service: General Medicine A

Diagnosis:

Most Responsible Diagnosis: Cellulitis
Preadmission Diagnosis: Diabetes
Post-Admission Diagnosis: Renal Failure
Preadmission Diagnosis: Hypertension

History and Physical Exam :

67 yo M with 2 weeks of redness, swelling, pain of right arm. He has associated. Fever and chills

on exam: T= 38.8, RR20, BP 109/70, HR 98

right arm – red, swollen, indurated up to axilla with some pus filled vesicles.

Heart Sounds normal, JVP not visible, no edema, mucous membranes dry

Pertinent investigations on admission included a high white cell count (30) and elevated creatinine (270). His glucose was 30.

He was admitted to hospital for cellulitis

Investigations:

US Limb: abscess in upper arm measuring 5 x 7 cm with surrounding edema

Blood cultures: moderate growth of methicillin-resistant staphylococcus aureus. Sensitive to clindamycin, septria, vancomycin.

March 17, 2012 WBC 8

March 10, 2012 Creatinine 270

March 17, 2012 Creatine 110

CXR – normal

Echocardiogram: no vegetation, normal valves and LV function

Course in Hospital:

This patient was admitted with cellulitis, elevated blood sugar and acute kidney injury. Issues were as follows:

1) Cellulitis and abscess: Arm US showed abscess which was drained by interventional radiology on March 11. He was treated with antibiotics (initially cefazolin but changed to vancomycin on March 12 once culture results available. Both blood and abscess cultures grew MRSA. He was followed by infectious diseases in the hospital (Dr G Rose). An echocardiogram was done to look for signs of endocarditis and was normal. He will finish another week of antibiotics and see infectious diseases for reassessment.

2) Acute kidney injury: likely due to pre-renal due to infection, poor oral intake and hyperglycemia. He was treated with iv fluids and his creatinine slowly normalized. He was also using ibuprofen for pain at home and we recommend he discontinue this as it can contribute to kidney injury.

3) Diabetes: Patients blood sugars were uncontrolled initially. He met the dietician and diabetic nurse educator and was started on gliclazide in addition to metformin which he was on previously. We have sent a referral to endocrinology (Dr Dora Liu) for further care. On discharge his blood sugars were 7-10.

Discharge Plans:

Allergies: no known allergies

New Medications:

1. Vancomycin 1 gram iv q 12 hours for 7 days
2. Glucalazide 30 mg oral daily

Medications to be stopped:

1. Ibuprofen 600 mg oral daily – stopped due to renal dysfunction

Services on discharge:

1. CCAC

Follow-up Management Plan and Recommendations:

1. Family doctor in 1 week. Please repeat electrolytes and kidney function and check blood sugar results.
2. Follow up with Dr. Rose of infectious diseases. His office will call you with your appointment.
3. Follow a diabetic diet as suggested by the dietician and check your blood sugar daily until you see your family doctor. The diabetes clinic (Dr. Liu) will call you with an appointment in 2 – 3 months.
4. Return to hospital if fever, increased arm redness or pain, or new diarrhea.
5. Call Dr. Wooller's office if you or your family doctor have any questions (613-737-8899).

INTERNAL MEDICINE

Internal Medicine is described as one of the busiest and most demanding rotations of clerkship, but also one of the best opportunities for learning (and the learning curve is steep!). It is also when you will most “feel” like a doctor, as students have the opportunity to be directly involved in patient care during the entire Clinical Teaching Unit (CTU) rotation. For the English stream, this rotation consists of 6 weeks on the CTU, which refers to the general medicine wards at either the General Campus or the Civic Campus.

This section serves to outline the key things for clerkship students to know and be aware of before they begin their internal medicine rotation. While it is not all encompassing, it will aim to ease the transition for clerkship students into this busy rotation

The following section will outline:

- I. Important Contacts
- II. Who's who: CTU teams
- III. What to expect
- IV. Day to day schedule
- V. Keeping track of patient information
- VI. Teaching during CTU
- VII. Recommended readings
- VIII. How to study during CTU

I. IMPORTANT CONTACTS

- Internal Medicine Clerkship Hospital Coordinator:
 - o Fatim Chaki (fchaki@toh.on.ca)
- Internal Medicine Clerkship Director:
 - o Dr. Vladimir Contrera-Dominguez (vcontreras@toh.on.ca)
- Associate Internal Medicine Directors:
 - o General Campus: Dr. Isabelle Desjardins (idesjardins@ottawahospital.on.ca)
 - o Civic Campus : Dr. Justine Chan (juchan@toh.on.ca)

II. WHO'S WHO: CTU TEAMS

Each hospital has 3 separate medicine teams with their own patients called MEA, MEB and MEC. Your team will consist of medical students, junior residents (off-service residents and first year internal medicine residents), senior residents (2nd year internal medicine residents), and one attending staff. In rare circumstances you may also have a “junior staff” that is a 4th or 5th year internal medicine fellow.

The residents and staff on your team will change 1-3 times during your rotation.

Each team will find its own way of running things, but in general the responsibilities are as follows:

- **Medical students:** daily care of 1-4 (often more if your level of confidence is appropriate) patients + overnight call
- **Junior residents:** daily care of ~4-7 patients + overnight call

- **Senior residents:** Oversee the coordination of the entire team. They are responsible for assigning patients, seeing new admissions, and following the daily progress of patients on the team. They also lead team rounds.
- **Attending staff:** general supervision of the team and collaboration with the senior resident and the rest of the team members.

III. WHAT TO EXPECT

Note: a more thorough description is provided in the official Internal Medicine Orientation booklet

You will typically be assigned 1-4 patients on your team, and are expected to be the expert on these patients! This means knowing all of the pertinent details related to their admission (HPI, past medical history, medications, **social concerns**), daily changes in their status (fevers, worsening/improving symptoms, nutrition status, pain management), as well as their management and plans for discharge, such as returning to hospice/nursing home, returning to care of family, etc. You will also be responsible for updating the team about your patients' well being during morning and afternoon rounds, and raising any concerns.

This is a lot of information, and learning to think about all of these aspects is a skill that takes time to develop! But you will certainly acquire and develop this ability as the rotation advances.

Day to Day:

Though schedules vary amongst the hospitals, students are generally expected to work Monday-Friday from ~7:00 AM to ~5:00 PM, plus call shifts. You will pre-round on your patients (7:00 – 8:00 AM), attend morning report (8:00 – 9:00 AM), go to team rounds (9:00 – 10:30/11:00 AM), follow up with changes decided on during rounds, attend afternoon rounds (usually at 4:00 PM, but depends on your staff/senior), finish up any outstanding tasks from morning or afternoon rounds, and go home.

Daily Re-evaluations for Pre-Rounding:

Aim to review these things for EACH patient BEFORE morning rounds:

- 1) Review nursing flow sheets for vitals and any overnight issues. Flow sheets are located outside the door of each room. Discuss any major issues with nurse.
 - Respiratory rate/O2 requirements and method of administration (room air, nasal prongs, CPAP at night)
 - Temperature: new fevers, trends over the last 24 hrs
 - Consider lab investigations as needed if fever + infectious symptoms are seen
 - HR: tachycardia? Bradycardia? Irregularity? Need for ECG?
 - BP: hyper/hypotensive?
 - Check hydration/fluid status
- 2) Nutrition and Fluid balance:
 - Foley catheters
 - Amount
 - Appearance of urine collected
 - Date of insertion
 - IV fluids

- Type and rate
 - Start date
 - Confirm anticipated stop date
- Nutrition: drinking/eating, NPO status, swallowing ability
- Bowel movements: present? Solid/loose/diarrhea? Bloody? Flatus?
- Any nausea or vomiting?
- 3) Re-assess pain/symptom management and PRN meds:
 - Ask patient “how are you feeling today”; ask about pain, constipation, N/V, sleep, anxiety/agitation
 - Do a quick review of systems (ROS): H/A, SOB, CP, abdominal pain, urinary symptoms, bowel symptoms
 - Check nursing medication administration record (MAR): if using frequent PRN’s consider increasing their regular dose
- 4) Medications:
 - Check the nursing MAR for medications the patient receives regularly, and ensure they have been receiving them
 - Ensure the patient is on appropriate prophylaxis (e.g. DVT prophylaxis)
- 5) Follow up Imaging/Lab tests/Orders:
 - Check Oasis for any new results and trend results (compare to previous baseline if available)
 - Check follow-up tests have been ordered (e.g. CBC every 3 days)
 - Check imaging results and call radiology if necessary to clarify
- 6) Follow up with consults, including those to other services/allied health:
 - Specialties that were consulted will leave their recommendations in the chart. Do not be afraid to call and clarify if necessary.
 - Ensure you share information from consults with your team
 - Follow up with physiotherapy, occupational therapy, social work, CCAC, etc. as needed
 - If >24 hrs has passed since the consult was requested, call and clarify
 - Place new consults EARLY, preferably before 12:00 pm. For most services, it is necessary to call the service in addition to sending a paper consult.
- 7) Check the orders for any new additions to your patient’s plan. Many different people review your patient – this is how to clarify what everyone wants! Ensure previous orders have been completed.
- 8) Discharge Planning: Consider disposition from the beginning!
 - Start your discharge summaries on the day you receive your patient and update them daily
 - Barriers to discharge: O2 requirements, Foley catheters, IV meds/fluids, nutritional concerns, social issues, psychiatric issues, symptom management
 - Target to discharge before noon
 - Confirm follow-up is arranged
 - Write an order to the clerk - “Please arrange follow up with ____ service for ____ date”
 - Clarify follow-up plans from other consulted services
 - Call family members/RN’s to arrange transport as soon as possible
 - Call patient’s GP to update them if possible
- 9) Order in which you see patients:
 - Start with critically ill patients, then discharges for the day, then others

IV. DAY TO DAY SCHEDULE

Morning Rounds (target time is usually 45 min – 1 hour):

Presenting your patients:

- State patients name, age, and reason for admission (chief complaint)
- Give a problem based summary of their active issues, ending with their discharge plans/social concerns

Afternoon Rounds:

At the end of the day to recap pertinent issues regarding patients and any changes during the day.

On Call:

During the week, call shifts begin with handover rounds in the afternoon. You will meet with the resident who is on call for your team for the night. You do not need to write additional progress notes on patients, as they've already been seen that day, but if a new issue arises overnight, you should write a note detailing the events.

Consults will usually be given to medical students after 5:30 pm. You will be paged by the on-call senior to see a new admission in ER and expected to obtain a full history and physical examination, consider your differential diagnosis, and propose a management plan for their admission. You will then review with your senior, write the admission orders, and finalize your admission note. Seniors often appreciate it if you take the initiative to write admission orders before you review, even if they are wrong. Consults may take anywhere from 2-4 hours depending on the complexity; a good goal to have is 2-3 hours. You are allowed to consult resources, and many students find it helpful to do so, especially in the beginning. Students can expect to see between 0-3 consults per call shift, but on average will see 1-2. You will usually have time for 2-4 hours sleep once your consults are completed and you've reviewed with the senior.

Medical students are also first-call for floor issues regarding their patients. Common reasons for calls include new fevers, shortness of breath, chest pain, order clarifications, and requests for PRN medication. A good way to minimize these calls during the night is to 'round' on your own after handover, and ensure things like PRN Tylenol or Gravol are already ordered. Document all issues that you are paged about during the night in the patient's chart.

The next morning, you will pre-round on all of your patients, write notes, and attend morning handover rounds, during which you will discuss any issues overnight, as well as present the patients you've admitted (note: you are not expected to pre-round on new admissions). You will be expected to implement any changes to management plans that are decided on during rounds before you go home. Once all of your duties are complete, you are free to go home and SLEEP! Unfortunately, medical students are often kept until 11 or 12.

Extra tips:

- Remember to get the code status on all patients you admit
- Try to get the collateral history from family members, if you are concerned the patient is unreliable

- Complete the death certificates if patient passes away and call your staff to make him/her aware
- Maintain communication with your patient's family regarding plans, progress and discharge on a regular basis
- Bring extra sweaters +/- blankets – call rooms can be quite chilly
- Bring snacks and dinner

V. KEEPING TRACK OF PATIENT INFORMATION

While on CTU, you will need to develop a system to keep track of important daily updates for your patients. Students often write directly on the ward lists, in coiled notebooks, or on scrap paper. Important info to keep track of includes: daily vitals, medications, new symptoms, plan updates, labs/imaging, and consults. Whatever system you decide to use, ensure that all information is disposed in the confidential binders when not needed anymore. Failure to do this is a violation of the confidentiality policy and has serious legal implications – therefore, do not take personal patient information, results or records home.

VI. TEACHING DURING CTU

As the name implies, CTU or clinical teaching unit represents a teaching block for both residents and students, and there are many different times when teaching takes place.

Formal Teaching:

- Grand Rounds: Organized by the Department of Medicine, they occur every Tuesday mornings at 8AM in the Auditorium (at both campuses). There is no Morning Report on those days but you are expected to attend Grand Rounds (unless you are post-call).
- Morning Report:
 - o All three medicine teams meet daily in the conference room before team rounds.
 - o A senior resident will often give a presentation a particular topic, and is usually followed by an interactive discussion of an interesting case encountered on the wards.
 - o Clerks will be pimped on easier questions pertaining to the case, while the more complex questions will be directed to the junior and senior residents.
 - o Participation is encouraged...and you will often be called on! But you do not need to worry, as this is a friendly collegial teaching activity
 - o Attendance is mandatory (unless you are post-call)
- Problem Assisted Learning sessions (PALs):
 - o PALs are teaching sessions held several times per week for medical students only.
 - o These sessions are lead by content experts, and serve to review important and common topics encountered on CTU, such as COPD and CHF.
 - o There are also 4 formal physical examination sessions held throughout the rotation, which review important physical exam skills.
 - o These sessions are also mandatory (unless you are post-call)
 - o Be on time and make sure that you have reviewed the cases prior to the session

Informal Teaching:

A significant amount of informal teaching takes place on CTU within individual teams. Both staff and senior residents on each team will try to regularly reserve time to review important topics that you have identified. Although CTU is busy, teaching with your team should not be overlooked, and if you feel that it has been, speak up!

Frequently, medical students will also be asked to present a topic of their choice to their team at afternoon rounds. This is a great opportunity to learn and to impress your team with your communication skills. There are also “bedside teaching” sessions, during which your staff or senior will review a patient’s history and/or physical exam with the students on your team. The frequency of these sessions completely depends on your staff or senior.

Medical students, especially those doing CTU early on in the year, should feel comfortable approaching their residents and staff with questions they have. Do not be afraid to contact your senior if you are confused about your patient’s condition or management plan. However, try to think of possible answers first – it will be appreciated by your residents and will help you to become a better self-learner.

It is absolutely normal to feel overwhelmed by the amount of responsibility that is given to clerks on CTU. However, if you consistently feel out of your depth, or that you are not getting enough support, be sure to contact the education coordinators with your concerns.

What you put into your CTU rotation will directly determine what you get out of it, so be proactive!

VII: RECOMMENDED RESOURCES

Depending on your learning style, you may find the following resources advantageous:

- Toronto Notes
 - Key facts, memory aids
- Approach to Internal Medicine: A resource book for clinical practice by David Hui
 - A Toronto-Notes style summary of pertinent details of various IM topics
- Blueprints Series: Medicine, by Vincent B. Young
 - More detailed and wordier than Toronto Notes, but still very concise.
- The Massachusetts General Hospital Handbook of Internal Medicine by Marc S. Sabatine
 - Similar to David Hui’s Approach to Internal Medicine
- UpToDate
 - Often a bit too much detail, but good for in depth discussion
- CaseFiles Medicine
 - Good for patient-based learning styles; great for reviewing cases you’ve seen on the wards
- One45
 - Teaching, tools, information relevant to your Internal Medicine rotation

VIII. HOW TO STUDY DURING CTU

Many students find daily review during their rotation to be unrealistic due to time constraints and fatigue. If this is the case, aim to set aside a few hours every week to review important topics and cases you've encountered.

Key Topics to Know:

1. Key conditions:
Know the basics in terms of clinical presentation, diagnosis, treatment, and prognosis:
 - COPD, CHF, pancreatitis, liver disease, cancer complications, PE, Delirium/Falls, pneumonia, syncope/falls, fever NYD, UTI's, Diabetes
 - Many of your patients will have these conditions even if admitted for something else, and you will be expected to manage it all
2. Key Symptoms:
Have a good approach to the following, including ddx, hx, pex, and work up
 - Chest pain, SOB, GI bleed (upper and lower), dizziness/decreased LOC, fever, abdominal pain
3. Medications:
Know when to use them; the doses can always be checked in a book/uptodate
 - Antibiotics!! This cannot be stressed enough. Understand the different classes and which abx are used to treat common infections
 - Anti-nauseants, anti-GERD, laxatives
 - Diuretics
 - Anti-hypertensives
 - Anti-arrhythmics
 - Analgesics: know the opioid conversion
 - Know which drugs exacerbate delirium and which are used to treat it
4. Imaging and ECG's
You will be in charge of following the patient's imaging studies; even if the radiology report is not yet available. Make sure you have a basic approach!
 - Have a good approach to a chest x ray
 - Understand when to order a CT chest, CT abdo, CT head, leg Doppler u/s
 - Be able to read an ECG
5. Clinical Biochemistry
Be able to interpret common lab tests; again, you are the one expected to do this! Understand when a change in lab values is significant versus not.
 - CBC-D, aPTT/PT, INR, LFT's, Cr/BUN, electrolytes (Na, Cl, K), extended electrolytes (Mg, Ca, PO₄), FeNa, fibrin, D-dimer, albumin, OGTT, urine routineµscopy, urine dipstick, blood gases (acid-base, PCO₂)
 - Know when to order a blood culture, urine culture, stool culture

EMERGENCY MEDICINE

The Acute Care block consists of 4 weeks emergency and 2 weeks anesthesia, and the majority of students find it incredibly valuable in terms of learning. Emergency medicine provides the opportunity to see a wide variety of patients, practice minor procedures such as suturing, and potentially witness (and assist) in life-threatening trauma cases. It is also a fantastic environment to interact with a wide variety of allied health care workers, including nurses, paramedics, PCA's, RT's, pharmacists, CCAC nurses, ECG techs, social workers, and psychiatric emergency workers.

Emergency medicine as a specialty is highly unique. Like family medicine, a broad scope of knowledge and skills is needed. However, ER physicians must also develop the highly specialized skill set involved in acute resuscitation, critical care, and the management of large-scale disasters. Unlike internal medicine, the goal of the ER physician is to rule out the most deadly "black box" diagnoses – the ones that can kill the patient – rather than to provide a specific diagnosis. However, they should also consider the most common diagnoses responsible for the patient's presentation. This is especially important when it comes time to request various consult services. In this regard, the Emergency Medicine rotation is especially useful in pushing students to develop their ability to form differential diagnoses.

I. IMPORTANT CONTACTS

- Hospital Coordinator:
 - o Margaret King (mking@toh.on.ca)
- Rotation Co-Coordinators:
 - o Dr. Alena Spacek (alenaspacek@rogers.com)
 - o Dr. Stella Yiu (shmyiu@yahoo.ca)
- Department Website: www.emottawa.ca

II. SITE LOCATION: CIVIC VS. GENERAL

Civic: With the addition of the Heart Institute and the Trauma Unit, the Civic Hospital receives some of the more intense cases that the general does not. For this reason, the Civic is often a competitive site for the clerkship rotation.

General: The General Hospital sees your basic 'bread and butter' Emergency Room cases, including (but not limited to) abdominal pain, abnormal menstrual bleeding, minor MSK complaints, etc. Because of the General's Cancer Center and Eye Institute, problems related to these services are also seen here

Montfort: This is the hospital for the French students.

III. STUDENT SCHEDULE

Students will have roughly 3-5 eight-hour shifts per week (11 – 12 total), from either 8:00 am – 4:00 pm or 4:00 pm- midnight (these times may differ slightly depending on site and type of shift). You will not be required to do any overnight shifts (Yippee!!). This schedule is both good and bad as you will have some weeks with multiple days off, but this may mean you work both Saturday and Sunday. Switching shifts, though not encouraged, is possible (with a good reason), provided that someone else in your group is willing to switch with you.

During your shift you will work one-on-one with an Emergency staff physician, who will be able to give you direct feedback to help improve your clinical skills and develop diagnostic and management approaches. Such close contact with a staff doctor is rare, and the emergency physicians are renowned for their teaching skills...SO, make the most of this experience!

General Guidelines

Ensure you dress appropriately; you may choose to either wear scrubs or your own clinic-appropriate clothing. Before your shift, introduce yourself to your preceptor and determine how they would like things to run. Some preceptors may opt to select appropriate cases, while others prefer you to take patients as they come. Preceptors will often ask you what your objectives for the shift are, so it is good to come prepared with those.

You will see your patient independently. Unlike internal medicine, you are not expected to review the past history of admissions on OACIS prior to assessing your patient, but you are expected to read the nursing/triage notes. Introduce yourself as a medical student and name the attending you're working with. Explain that you will be reviewing with the attending physician. Take a focused history and perform a physical exam (this should take about 15- 20 minutes). If at any point in time the patient looks very ill or you feel uncomfortable, stop and immediately notify the nurse and/or staff physician. It is especially important in acute situations to recognize your own limitations and seek help early.

After you have completed your assessment, find your preceptor and tell them you have a case to review. You will then go back and re-assess the patient together. Remember, all patients seen by students must be seen by the staff ED physician prior to their discharge home. Finally, do not take on any new patients in the last 30-60 minutes before your shift ends! This will ensure you get home on time. If you have a teaching session the next morning, your evening shift will end at 11:00 pm, instead of midnight.

Types of shifts:

Note: Patients are triaged when they arrive at the hospital. They are sent to the various divisions of the ER based on chief complaint, symptoms, vitals, risk factors, etc. Depending on which area of the ER you are in, you may see more or less of specific presentations than others.

- Urgent Care: There is a lot of turnover in Urgent Care and students will be exposed to a wide variety of complaints varying from chest pain to vaginal bleeding. Depending on the chief complaint, students may be asked to interpret imaging or blood work. Much like in a busy family doctor's office or clinic, it is important for student focus on the reason that the patient came in today; however, many of these patients may have never been to the ER before, and you are still expected to gather all pertinent past medical/surgical history, etc.
- Observation Unit: Patients in the OBS beds often have complex, but stable medical issues. These patients frequently have long past medical histories and medication lists. Typically, the time spent with these patients will be more extensive than with patients in urgent care.
- Emergent Care and Resuscitation: Students are often scheduled for shifts in 'Resus', but end up spending their time in between Resus and Emergent care.

- Resuscitation houses the sickest patients and this is where students will see incoming trauma patients, acute coronary syndrome initial management, stroke codes, and anaphylaxis. Students should listen for codes being announced over the PA system, as those can be excellent learning experiences.
- Emergent Care will have patients who require more frequent monitoring of vitals and often have a cardiac monitor (HR, O2 Sat, BP). Common presentations include chest pain, weakness, syncope, uncontrolled hypertension (hypertensive urgency and emergency).
- Triage Shift:
 - During one of your EM shifts in this rotation, you will spend the last two hours of your shift learning the principles of triage with the triage nurses. The goal is to give students an understanding of the concept of triage and prioritization of care, as well as to learn how to perform a rapid triage assessment.
- Paramedic Ride-out:
 - You will accompany a team of paramedics in a 12 hour ambulance shift either during the day or overnight. Important: the role of the medical student is strictly as an observer. ENSURE YOU DRESS APPROPRIATELY FOR THE WEATHER! You will likely be outside for a good portion of the shift.

IV. ORGANIZED TEACHING

Supervised clinical teaching shifts

Groups of 4-6 students will meet with a staff or senior resident, who will observe your history and physical examination skills on real patients in the ED. The preceptor then leads discussions of the cases seen, as well as other pertinent skills, such as ECG's, X-Rays, slit lamp use, and casting. Each student will have teaching shifts on two half-days per week (in addition to your regular shifts), for a total of 6-7 of during the rotation.

The main goals of these teaching shifts are:

- how to do a focused **ER** history and physical exam, based on the patient's complaint
- how to identify and elicit pertinent positive and negative findings
- how to be concise and efficient
- appropriate ordering of tests, based on the patient complaint, history, and physical exam
- basic interpretation of test results e.g. CXR, ECG, labs
- demonstrate an organized and effective approach to the following common emergency room presentations: abdominal pain, chest pain, shortness of breath, decreased level of consciousness, headache, weakness

Procedure Skills Lab

One half day of your rotation will be spent at the SIM center in a supervised skills lab. You will review basic skills essential to functioning in the ED, which includes suturing and wound care, IV insertion and phlebotomy, Foley and NG catheter insertion, and lumbar punctures. This may be review for some, but pay attention! The value of these skills cannot be over-emphasized.

PALs

These are student-led tutorials of various topics. Each student is assigned a case to present at some point during the rotation, and a tutor (usually a senior resident) will attend and evaluate each session. Further instructions will be provided during your rotation orientation. **Note: It is advised you put a lot of effort into these presentations; they will form the basis of your study guides for the exam.**

ACLS

All students will attend an ACLS lecture that covers basic and advanced airway management, dysrhythmia recognition and treatment, in addition to 8 hours of cardiac arrest simulation practice that includes training in defibrillation, cardio version, and external pacing techniques. You will be provided with a series of ACLS algorithms to memorize, which will later be assessed in two very realistic ACLS simulations. You absolutely must know these algorithms before your simulation! You are required to pass the ACLS simulations in order to complete your emergency rotation.

Grand Rounds

Emergency Grand Rounds are “optional”, and occur on a weekly basis on Thursday mornings. If you have a daytime shift on Thursday, your preceptor may excuse you for grand rounds. However, the ER is a very busy place and preceptors may not always remember that there are grand rounds, so don't be afraid to be excused for them as they can be extremely interesting and informative!

VI. GENERAL TIPS

- Pre-determine your goals for the shift; most preceptors will ask what it is you'd like to focus on so reflect on this in advance!
- Don't see more than one patient at a time! Don't ever pick up a second chart before you've reviewed your first with your preceptor (even if you seem to be waiting around for an eternity, unless your preceptor instructs you to).
- Remember to sign up for your patient on the clinical whiteboard! Similarly, if your patient has been discharged, don't forget to sign off.
- Remember to write the time that you first see the patient at the top left hand corner of the chart. You can either copy the vitals and ID from the nursing notes, or re-assess yourself (this may be necessary if the patient's status has changed).
- Attempt to generate a “top 3” Differential Diagnosis before presenting to your preceptor. This includes the top 3 most likely diagnoses and top 3 most deadly diagnoses to rule out. The ability to think of a differential diagnosis is one of the key skills students take away from this rotation.
- Copy lab values onto chart as they become available! This may be before you've seen the patient/on the original nursing note. Check your patient's labs while you are waiting to present other patients.
- Re-assess your patients as necessary! Your patients are still under your care after you've presented to your preceptor; don't forget to re-assess and follow up on consult services, lab work, and orders.
- Remember (and remind your preceptor) that you need to eat! It's your job to request a lunch break, not theirs to offer, although many will.

- Listen for the return of consulted services paged on the overhead; don't be surprised if they call you "Dr. So and So". To consult a service, click the "consult" box on the clinical whiteboard and write the service name, example "cardiology". The clerks will page them and then call your name overhead, which beats waiting around at a phone for a service to call you back!!
- Don't worry too much about patient flow. Your main goal is to take a thorough (but focused) history and physical exam; leave the time management issues to the staff physicians. One patient per hour is a good rule to aim for.

VII. HOW TO PRESENT A PATIENT IN THE ED

Presenting patients in the ED is quite different from your internal medicine rounds. In general, attempt to use the following template:

- Begin with:
 - ID, pertinent past medical history, chief complaint, and what you think the problem is
- Followed by:
 - Further details, including HPI, pertinent negatives and positives, and plan
- Example:
 - "80 year old male with previous MI in 2012 presents today with CP, which I believe is angina. The patient experienced an episode of pain that began x hours/days ago and lasted xx hours/days (ie. OPQRST). The pain was not pleuritic (trying to rule out other 'must not miss' diagnoses of chest pain, such as PE), has no risk factors or symptoms of DVT, no ripping pain through his back (aortic dissection). I think we should do an ECG and CK/Troponin and give him ASA and Nitroglycerin."

Common Problems and Procedures in the ED:

Approach to:

- I. Chest Pain
- II. Abdominal Pain
- III. Headache
- IV. Altered level of consciousness/falls
- V. MSK complaint

Conditions:

- I. MI
- II. Stroke
- III. C-spine Fracture/Injury
- IV. GI bleed
- V. AAA

Procedures: (only 3!)

- I. Suturing
- II. Fracture reduction and casting
- III. CPR

Imaging:

- I. Chest X-ray
- II. C-spine X-ray
- III. Abdominal X-ray/CT
- IV. MSK X-ray – for fractures
- V. Head CT – for acute bleeds and space occupying lesions

VIII. ABSENCES:

If you are sick or for cannot make your shift, call the emergency department (General Campus 613-737-8899 ext. 79002 or Civic Campus 798-5555 ext. 19002) and let your assigned supervisor know. You also need to notify the following people by email: Margaret King (mking@toh.on.ca) and Denis Vadeboncoeur (medyear3@uottawa.ca).

IX. EXAM

The Emergency Medicine written exam consists of a combination of multiple choice and short answer questions. The content is based primarily on the material provided during your various teaching activities: PALs, lectures, ACLS, etc.

X. RECOMMENDED RESOURCES

- Dr. Yiu has spearheaded an online teaching initiative called FlippedEM. These are succinct youtube videos that are excellent for studying and general performance during your shifts: <http://flippedemclassroom.wordpress.com/>
- ABCs of Emergency Medicine: This book is available as a PDF online (type “ABCs of Emergency Medicine” into your search engine) and is an excellent resource for studying for the exam, as well as for some common presentations in Internal Medicine.
- ECG Review: Dubins guide, as well as the video series “Life in the Fast Lane”: <http://lifeinthefastlane.com/ecg-library/>
- Casting: videos are provided by the University of Ottawa; ensure you review them prior to your casting workshop. <http://www.med.uottawa.ca/procedures/cast/>
- ACLS: Most students focus on memorizing the algorithms provided by the department (which can be found on one45). Highlights of the 2010 AHA CPR and ACLS Guidelines can be downloaded from the following link: http://static.heart.org/eccguidelines/pdf/ucm_317350.pdf. The full 2010 Guidelines can be downloaded from the following link: http://circ.ahajournals.org/content/vol122/18_suppl_3/

ANESTHESIA

Anesthesia is a two week rotation coupled with Emergency Medicine, and most students find it to be quite a relaxed experience. As a discipline, Anesthesia integrates the principles of physiology and pharmacology with hands on procedures, such as administration of medications through IV's, epidurals, inhalation, etc.

During your rotation, you will be expected to learn various procedures, including IV insertions, tracheal intubation, bag-mask ventilation, laryngeal mask airway insertion, and application of monitors (ECG, BP, SaO₂). The key theoretical knowledge to take away from this rotation includes important peri-operative considerations, fluid management, blood transfusion, and post-operative pain management, as well as an understanding of various induction agents and analgesics, and complications faced by anesthesiologists in the OR.

I. IMPORTANT CONTACTS:

- Undergraduate Rotation Director:
 - General Site Coordinator: Dr. Nikhil Rastogi
 - Civic Site Coordinator: Dr. Leo Jeyaraj
- Hospital Coordinator: Julie Ghatalia (uganesthesia@ottawahospital.on.ca)
- Site Contacts:
 - General Campus: Francine Gravel (TOH General, CCW Rm 1401)
 - Civic Campus: Kelsey Larocque (B310)
 - Julie Ghatalia (uganesthesia@ottawahospital.on.ca; 613-798-5555 ext. 17886)

II. SCHEDULE

You will be assigned to a different staff anaesthesiologist each day and will accompany them in all of their assigned cases that day. The OR usually operates (pun!) from 7:30 am - 3:30 pm, which is a nice change from the night shifts and call duties of emergency and internal. On Wednesdays Rounds are at 0715 and the location will be posted. You will also have one evening “call” during your two weeks. At 4:00 pm you will report to the designated emergency OR and meet with the resident on call. You are expected to assist them with their duties until 10:00 pm; you are then expected to work the next day. These call shifts are usually very quiet, but you may have an emergency case (or two), especially if you're at the civic, and a trauma code is called – the anesthesiologists are in charge of airway management!

On the first day of your rotation you will meet with either Kelsey or Francine (see above) at 7:30 am. Wear business casual clothing but don't worry too much about your outfit as you will be changing into scrubs as soon as you arrive. You will then have a site-specific tour and orientation. On subsequent days, arrive between 7:10-7:20 to change into scrubs and report to the OR before 7:30. The schedules for the next day's ORs and assigned anesthesiologist are available in the anesthesia office/lounge any time after 2 PM. You should review your patients beforehand on OACIS. Head to the OR by 7:30 and introduce yourself to your preceptor. You will then begin setting up IV bags/tubing, and may complete the pre-operative assessment. The first OR case will start at 7:50 am. It is VERY important that you arrive on time for the pre-operative assessment; if you have not met/assessed the patient, you will not be allowed to assist with their procedures during in the OR.

Pre-Operative Assessment for Anesthesia: This is a focused history and physical exam of information pertinent to the use of anesthetics in the OR, and includes:

- Past medical history, medications, allergies (specifically to drugs and anesthetic agents)
- Personal and family anesthesia history (“Have you ever been told you were a difficult anesthetic case?”)
- Airway, respiratory, and cardiovascular assessment and physical exam
 - o Airway exam includes examination of:
 - Mouth opening – 2-3 finger breadths is normal
 - Mallampati score – a score of 3 or 4 may indicate that this will be a difficult intubation
 - Thyromental distance – the distance between the thyroid and the tip of the jaw; normal value is 3-4 finger breadths
 - Dentition – ask about any loose teeth, crowns, bridges, or dentures during your history
 - TMJ Dysfunction
 - Cervical spine mobility – flexion/extension of the cervical spine

Acute Pain Service (APS)

You will be assigned one day on the APS service, during which you will visit various wards throughout the hospital (including the ICU and post-trauma unit) to see patients with issues related to pain management. On your assigned APS day, wear business casual attire (NOT SCRUBS), and arrive at 7:45 as per usual. Page the APS nurse (provided in the welcome package you receive). The first half of the day is spent rounding on patients with the APS nurse; the second is spent re-assessing difficult patients with the APS physician.

Evaluations

You will be provided with a series of daily evaluation cards to give to your preceptor at the end of each shift. Make sure that all the information including your preceptors name is filled in. Your preceptor will then forward these to the rotation director.

III. GENERAL TIPS

- Prior to your first shift, review the lecture videos. They are very helpful for orienting yourself to the OR.
- The schedule for the next day is available in the Anesthesia lounge at approximately 2 pm. Check which preceptor/OR you’re assigned to and take note of the patients to be seen. You can look up their **peri-operative summaries** on OACIS for an idea of their relevant issues. If you’re gunning for an anesthesia residency spot, head to the Anesthesia library (access code 2020) to review these cases in a more detailed Anesthesia textbook. This will help familiarize you with particular considerations for that surgery.
- Make yourself useful to your preceptor; in addition to doing the pre-operative assessment, offer to help set up IV bags and other equipment, draw up medications, and insert IV’s.
- Reflect on goals you would like to accomplish each day and let your preceptor know what they are; examples: IV insertion, intubation, understanding inducing agents. They will tailor your experiences accordingly.

- Anesthesia shifts are a time where many medical students get 'pimped' about major anesthesia topics. Common questions asked are: what is included in the airway assessment, risk factors for difficult intubation, risk factors for difficult bag-mask ventilation, risk factors for post-operative nausea and vomiting, differential diagnosis of shock, and toxic dosages of local anesthetics.
- Bring your iPad into the OR! You will often be sitting around during the surgery, and if your preceptor has not sent you to go and read in the lounge, your iPad will be invaluable to make good use of the time. But remember to use technology appropriately in the clinical setting, which means no Facebook or social texting.
- **Review the WHO ladder for analgesia prior to your APS shift!** Additionally, the SLM we were provided in the Integration Unit on Pain Management will be useful for this day.

IV. TEACHING

Lectures

There are several mandatory power-point lectures that have been pre-recorded with audio instruction, which you should review as your schedule allows. These are available on one45, as well as in the Anesthesia Department computer labs at both campuses. The anesthetist will often dismiss you during the case, after the induction, if there are no learning opportunities to be found. During this time you may return to the anesthesia office and review the lectures.

Rounds

Resident Rounds are at both campuses; these take place weekly in the Anaesthesia department. Grand Rounds take place at both campuses weekly and are mandatory. These do not occur during the months of July and August.

V. EXAM

The exam consists of 20 MCQ's and 3-4 CDMQ based on the rotation objectives. The anesthesia exam is worth a smaller percentage of your final grade from the Acute Care rotation, due to its shorter duration (2 weeks anesthesia versus 4 in EM).

V. RECOMMENDED RESOURCES

The primary textbook recommended for this rotation is the "Ottawa Anesthesia Primer" by PJ Sullivan (available both in print and as an iPad compatible e-book). It was written by physicians and residents at the University of Ottawa and is an excellent resource, though quite lengthy. More information can be found here: <http://www.anesthesiaprimer.com/>

As you will discover, the exam is largely based on two documents, conveniently titled "Must-Know" and "Should-Know". These documents basically summarize the content of the lectures and textbook into a manageable format/size. They will likely be floating around your year so be sure to ask your classmates/students in the year above.

A free iBook available on iTunes is "Understanding Anesthesia, A Learner's Guide". This was developed by McMaster School of Medicine and is very useful for those lull periods in the OR!

PEDIATRICS

Pediatrics is considered one of the “big three” rotations (in addition to CTU and surgery). There are many aspects of care unique to pediatrics from both the medical and psychosocial perspectives, and your prior rotations will not necessarily be of much help to you. That being said, the pediatrics rotation will help you build a valuable skillset that is applicable to family medicine, psychiatry, obstetrics, and community emergency medicine.

The pediatrics rotation at UOttawa consists of 1 week NICU at the TOH General and Civic campuses, 3 weeks pediatrics wards at CHEO, and two weeks of Pediatrics Emergency at CHEO. The French and English streams are combined for this rotation, and you will be split into smaller groups to rotate through each section.

Additionally, you will have the opportunity to do a number of pediatric sub-specialty selectives during your Mandatory Selectives rotation, including pediatric cardiology, nephrology, neurology and gastroenterology, as well as pediatric surgical subspecialties. For those of you interested in pursuing a career in peds, these rotations are equally useful as they provide a much broader experience than you will receive on the wards.

I. IMPORTANT CONTACTS

- Hospital Coordinator:
 - o Bonnie Landon (landon@cheo.on.ca)
- Rotation Co-Coordinators:
 - o Dr. Marc Zucker (zucker@cheo.on.ca)
 - o Dr. Gabrielle Weiler (gweiler@cheo.on.ca)

II. PEDATRIC CTU

Description:

Three weeks of inpatient service; essentially CTU for peds. Experiences will greatly depend on which team (ie ward) you are placed on; Red, purple, or bronze. Red team gets the highest flow (ie most discharges) and sees the most bread-and-butter; in winter this means RSV. Purple and Bronze see a variety of other medical issues. Your team will consist of a senior pediatrics resident, a junior pediatrics resident, 1-2 off service family medicine residents, and 2-4 medical students, in addition to a staff pediatrician.

Responsibilities:

Very similar to CTU; you will be given your own patients to follow and manage as well as do consults when on call. One bonus- med students are not first call for floor issues overnight.

Schedule:

You will meet with your assigned team at 8:00 am for handover rounds each day in the Doctor's Lounge on the basement level of CHEO. The information for each team's patients is organized in chart format, including the reason for admission, initial history/physical exam, pertinent past medical history, current medications, and current issues (including overnight issues/plan updates from the previous day). The chart is updated and printed prior to handover each day by whichever medical student is on call the previous night. **Do not forget to update the chart when you are on call**; it will interfere with the functioning of the entire team, and your seniors

will not be very sympathetic. It is kept on a shared drive on the computers at the nursing station for each team. Your residents will provide you with further information. After handover post-call students/residents are relieved and allowed to go home. The rest of the team will have about 30 min – 1 hour to prepare for rounds. This includes gathering very specific information about your patients, including:

- **Most recent vitals and last fever**
 - o How high
 - o Method of measurement was used – oral, rectal, axillary
- **Urine output**
 - o Calculated in cc/kg/hr → **minimum acceptable UO is 1 cc/kg/hr**
 - o You can calculate UO manually by dividing the total recorded UO by the weight of the child and the number of hours over which it was measured
 - o UO is very important in pediatrics, as they are much more susceptible to dehydration and its detrimental effects than are adults.
- **PO Intake:**
 - o Liquids – clear or regular
 - o Solids – if your patient is old enough; amount
 - This is especially important for infants, who should be feeding between **every 3-4 hours for 10 minutes per breast.**
 - You should also note any **vomiting.**
- **Voiding and Bowel Movements:**
 - o Last BM and consistency, or for infants, **number of wet diapers**
 - 6 wet diapers per day is considered normal for infants
- **Symptoms:** Pain management, nausea, coughing, breathing, etc.
 - o Are they improving?
- Overnight issues (ask the nurse and check sunrise)
- **Medications:** check that all pertinent meds have been given at the appropriate time
- **Parents:** ask how they are doing in terms of stress, sleep, and taking care of other children at home. Remember that on pediatrics you treat the whole family, not just the patient.
- **Examine your patient** with a focus on whatever systems are relevant

If you are a pediatrics keener, consider going an extra 30 minutes early - before morning handover – to gather this information; you will be less rushed and feel more confident about your daily assessments.

Rounds:

Rounds on pediatrics are 'bedside' in nature, meaning that the entire team will walk from room to room to discuss each patient individually. Patient presentation is a very specific process and you will be given a 'script' of sorts to help you organize yours. Stick to this script as closely as possible; pediatrics residents are known for their attention to detail and they will greatly appreciate your efforts to improve efficiency. Rounds may take anywhere from 2-4 hours, depending on the number of patients on each team. Wear comfortable shoes and put a granola bar in your pocket. After rounds, you will have time to carry out your tasks for the day and do your discharge dictations. Depending on your senior, you will handover any information from the day to a resident on your team before going to your PAL (see below) or will meet again for formal handover rounds after the PAL around 5:00 PM, and then go home. Students on call will be expected stay overnight, but are only responsible for new admissions.

When you are doing an admission, the senior resident will likely have already written the admission orders and determined the plan; you will assess while the patient is waiting for transfer up to the floor. Your contribution will be writing the admission consult, which will later be placed in the patient's chart, and adding them to the team's chart (see above). While this may seem redundant, the admission consults are excellent learning opportunities, so try and approach them with enthusiasm. You will have a better learning experience if you do not read the admission orders prior to your assessment and try to think of how you would manage this patient.

Tips:

- Know your pediatric vitals! Especially temperature and route of measurement (oral vs rectal vs axillary). You will be provided with a summary chart in the pediatric handbook; keep this with you!
- The pediatric handbook contains a detailed guide to the pediatric history and physical examination, which is extremely useful for admissions. Seniors will expect you to have asked all these questions when you are reviewing with them!
- Consider attaching a small (non-choking hazard) toy to your stethoscope; it will be very useful while trying to distract a screaming two year old.
- Stickers are always appreciated!
- Be patient.
- Remember that the parents are patient's
- Update the parents as frequently as possible; most of their anxiety will stem from feeling "out of the loop"
- Spend time with your patient and try to get to know them as much as possible. It will greatly enhance their trust in you and as a result the quality of care you're able to provide.

III. PEDIATRIC EMERGENCY MEDICINE

The pediatric ER block at CHEO functions much like the adult ER at TOH. You will be assigned 1 – 2 shifts per week, either from 8 am – 4 pm, 4 pm – midnight or 5 pm – 1 am, and a specific preceptor for each shift, with whom you will review your cases.

IV. NEONATOLOGY

Your week of neonatal pediatrics involves routine discharge visits done by community pediatricians, as well as two days in the NICU at the civic or the general, where you will be assigned some patients to follow.

The NICU is a tightly controlled environment, and with good reason, as the patients are usually extremely fragile. Do not be surprised if you are not allowed to examine your patient because they are sleeping; try and time your visits to coincide with the feeding schedule.

You will be provided with a booklet of objectives to complete and relevant information to assist you throughout the week; this will describe all other pertinent details to the rotation. You must complete the booklet and hand it in at the end of the rotation. Your rotation will be INCOMPLETE until you have done so.

V. ORGANIZED TEACHING

Formal teaching takes place every Wednesday afternoon in the form of academic half-day. This will be shared with the students from Mandatory Selectives and will include content from both rotations. Additionally, students will have an hour of PALs every day from 4:00-5:00, covering specific topics presented by yourself and your classmates. These teachings are **extremely** useful for exam preparation and success on the wards in general. Each student will be assigned a specific topic during orientation, as well as a content expert (a staff physician at CHEO) to liaise with while preparing your presentation. It is recommended that you prepare these sessions with the exam in mind, and base the content off of the learning objectives, as these will be your primary study material for your exam.

There are also grand rounds once a week – free food and interesting lectures – with the entire pediatrics faculty, and other members of the multidisciplinary team. There may be other lunchtime teaching rounds depending on which service/team you are on.

VI. RECOMMEND RESOURCES

The organizers of the pediatrics rotation have provided extensive resources for your use, and these are available on the one45 website under “links and handouts”. These include detailed physical exam guides for children of different ages and with specific conditions, as well as lectures covering relevant topics discussed during academic half days.

CLIPP cases are incredibly useful for preparation and study. These are a series of 32 online modules developed for medical student learning; very similar to a CBL case. You will be required to complete three cases over the course of your rotation, but it is recommended you complete more on your own time, and in preparation for the exam. You must spend a minimum of 30 minutes on each required case for it to be considered complete. The login information will be provided to you at orientation.

A list of cases by topic can be found at

http://www.med-u.org/virtual_patient_cases/clipp/

VII. EXAM

The exam consists of the regular written end of rotation exam, as well as a pediatric OSCE. The coordinators will provide you with ‘blueprints’ that detail the specific topics you should study, and these are extremely helpful. The OSCE will have real children as standardized patients, so make sure you are comfortable speaking with them!

VIII. HOW TO STUDY DURING PEDIATRICS

Like Internal Medicine, many students find the paediatrics wards rotation too busy for daily review. Again, if this is the case, aim to set aside a few hours every week to review important topics and cases you’ve encountered.

Focus on the lectures presented during PALs and academic half day, as these will form the majority of material on the exam. For a list of key topics and conditions, refer to the “handouts/links” section for Pediatrics on one45

VIII. MISCELLANEOUS

- **CHEO ID badges** will be issued to each student on the first day of their rotation, which you will wear in addition to your Uottawa ID badges. This badge will allow you access to the Doctor's Lounge, Locker Rooms, and Clinical Learning Labs.
- **Lockers** are available for medical students, but are pooled with those for the residents, so sharing is often inevitable. A \$15 deposit is required and will be returned at the end of the rotation.
- **Call rooms** are provided for medical students on call for the purple/bronze and red teams. These are located on the 2nd floor behind the ED. They are private rooms and you get your own bathroom – YAY!

MANDATORY SELECTIVES

The mandatory selectives block is a smorgasbord of different pediatric and adult specialties from which students will rank their preferences and (hopefully) be assigned to. The purpose of the rotation is to allow students to experience the adult and pediatric ambulatory component (outpatient clinics) of different subspecialties. These include adult/pediatric otolaryngology (ENT), ophthalmology, adult/pediatric dermatology, radiology, radiation oncology, palliative care, geriatrics, pediatric surgery, pathology, and pediatric cardiology, gastroenterology, and nephrology. You will partake in three or four specialties over the course of your six weeks. Everyone will complete a week of ENT and a week of Ophthalmology.

While lacking in continuity, the selectives rotation allows students to develop a much deeper understanding of issues that are highly relevant to everyday practice in general surgery, internal medicine, family medicine, and paediatrics, and for this reason is extremely valuable.

I. IMPORTANT CONTACTS

- Hospital Coordinator:
 - o Pierre-Olivier Auclair (manselec@uottawa.ca; 613 562 5800 ext. 8625)
- Rotation Coordinators:
 - o Anglophone Stream: Dr. Safeena Kherani: (safeenakherani@gmail.com)
 - o Francophone Stream: Dr. Nita Scherer: (nita_scherer@yahoo.ca)

II. SUBSPECIALTIES

ENT:

Description:

One week rotation through civic, general, and CHEO campus clinics and OR. At CHEO you may have the option of participating in the inpatient service, as well as outpatient clinics. Experiences will differ in terms of topics, hours, responsibilities, etc.

Responsibilities:

Highly variable depending on where/what you will be doing; likely a combination of OR assists and working in pediatric and adult ENT clinics.

Tips:

- Read up on the surgeries before hand!! The ear is very small, and the screen is not great. If you do not know what the procedure is, you will not understand a thing, which translates to extreme boredom.
- Review the anatomy of the ear! Dynamite comes in small packages and the relevant anatomy here is quite complex. A thorough understanding will significantly improve the depth of your experience.
- Review how to use an otoscope, and what to look for
- **Key questions for the clinics:**
 - o For any ear complaint, assess these major issues:
 - Hearing loss
 - Tinnitus
 - Vertigo/dizziness
 - Otalgia

- Otorrhea
- (bonus: prior history of ear conditions)
- Tonsils and adenoids
 - Infections
 - Tonsil stones
 - Symptoms of OSA
 - Snoring
 - Excessive daytime sleepiness
 - Hypertension
 - Morning headache
 - Falling asleep during activities/work

Useful Resources:

- Primary Care Otolaryngology – American Academy of Otolaryngology
- Learn ENT app – created by a previous uOttawa medical student and current ENT resident at Ottawa

Ophthalmology:

Description: One week rotation at either the TOH General Eye Institute or Riverside hospital, spent observing in the OR, minor clinic procedures, or outpatient follow-up appointments.

Tips:

- **Know an approach to the Red Eye!** You will see many, many red eyes.
- Review the systemic diseases with end-stage effects on the eye (ex. DM...)
- Review retina anatomy and how to use a fundoscope

Radiology:

Description:

A combination of CT, emergency, musculoskeletal, neuroradiology, and chest imaging. You will receive your schedule by the Thursday prior to your rotation via email.

Resources:

The “Ottawa radiology” online teaching module and pre-test quiz must be completed over the weekend prior to commencing your rotation. Once completed, you will be able to access the mandatory learning content to be reviewed over the week, which must be completed in order to access the post-test at the end of your rotation. You will also be given two cases during the week to prepare as a teaching file. Examples and instructions are available on the handouts/links section of one45 under Mandatory Selectives.

Pediatric General Surgery:

Important Information:

A ‘welcome letter’ will be sent to you in addition to several other important documents via email prior to commencing your rotation. These contain information regarding scrub-in technique, lockers, ID badges, dictations, etc.

Pathology:

Description:

The selective rotation is organized by the division of anatomical pathology, which is oriented toward the morphological, structural and functional consequences of injurious stimuli on cells, and the patterns of host reaction to these stimuli. You will assist in the pathological evaluation of various surgically removed tissues and cytology samples, observe and assist with autopsies, and learn procedures involved in preparing and diagnosing frozen sections.

Important Information:

WHMIS training is required; complete the online training prior to your rotation.

Student Testimonial

Free food on multiple occasions! Students can request to see an autopsy, which is an experience many of us have not had before! Use the experience to gain appreciation for how pathology works alongside the clinician and to get the 'big picture' of the different areas of pathology.

Warning- forensic autopsies are extremely graphic, and require a relatively iron stomach to participate

Geriatrics:

Description:

You will be placed at either the General, Civic or Elisabeth Bruyere Hospital. At the Civic or General, you on the inpatient consultation service. At Bruyere, students will be assigned to either the palliative care unit (inpatient) or palliative pain and symptom management consultation service (outpatient).

Important Information:

An orientation email will be sent to you prior to your start date describing your role and specific objectives for the rotation.

Dermatology:

Description: One week spent in a variety of outpatient clinics either at the Civic Parkdale Clinic, General, or CHEO.

On your first day of the rotation, you will meet with Dr. Jackson, a dermatologist who will take you through a variety of images with common dermatological lesions and ask you to describe them. Take the time to review dermatology terminology before you begin the rotation as it is expected that students will be able to appropriately describe what they see in clinic.

Throughout the week, you will work with a variety of Dermatologists, and will see "bread and butter" lesions, such as eczema or seborrheic keratosis.

Students are expected to attend Thursday afternoon rounds at the Civic Campus Parkdale Clinic from 12-2 PM. Patients are brought into the clinic with interesting diagnoses or findings for students, residents, and staff to view and ask questions about. After all the patients are seen, the group goes to the Bickell room (across from Tim Hortons) and discuss the cases.

Important Information: You will receive your schedule prior to the start date. Always call the clinic beforehand to check that it has not been cancelled. Many clinics are cancelled during the summer months.

Pediatric Cardiology:

Description: This is a two-week rotation in the outpatient cardiology clinics at CHEO for congenital heart disease and arrhythmias. Time will also be spent in the conference rounds weekly (discussing interesting cases between different hospitals, coordinating also with pediatric cardiology) and occasionally inpatient rounds (though not mandatory). You will be given a (large) booklet of useful articles covering important topics.

Responsibilities: Depending on the preceptor you will be expected to assess patients independently (history and physical) and occasionally complete the dictation.

Tips:

- Know common pediatric murmurs! Most importantly, know the difference between benign and organic (ie pathological) murmurs.
- Know how to read an ECG (obviously)
- Do the reading! There is a lot of unscheduled “free” time; read the resources provided as it will do wonders for your learning and performance in clinic.
- Be CONFIDENT! Pediatric cardiologists are a quirky bunch- respect, confidence and a tasteful sense of humor can go a long way in forming relationships with them.

Pediatric Gastroenterology:

Description: This is a two-week rotation in the outpatient gastroenterology clinics at CHEO. During the rotation, students will get to attend outpatient clinics for general GI issues, inflammatory bowel disease, liver disease, and eosinophilic esophagitis. Additionally, students are scheduled to attend endoscopic ORs throughout the rotation.

Responsibilities: Depending on the type of clinic (follow-up versus new patient), students will either observe the preceptor/resident or complete the appropriate history and physical exams. In the OR, students will observe the various procedures.

III. HOW TO STUDY IN MANDATORY SELECTIVES

The exam covers important topics from all of the available subspecialties, and as a result is extremely broad and considerably difficult. Because you can only select three or four out of the available subspecialties to experience, you will inevitably be tested on specialties you have not experienced; this can be a daunting realization for most students. Don't stress too much over this fact; you will not be able to learn absolutely everything for each subspecialty, so don't even try. Focusing on the objectives for these rotations is a must for guiding your studying.

You will be sent a blueprint with the number of topics to be covered and the priority weighting assigned to each; it is suggested you use this to guide your studies.

Useful resources can be found on one45 under the handouts and links section.

SURGERY

So you want to be a surgeon, or at the very least, want to look good on your core surgery rotation...well every person will have a slightly different experience, but there are some things that are universal about surgery at the Ottawa Hospital, even in rural/community settings.

First things first, contrary to what some of you may believe, your surgery rotation will not be 6 weeks of you running the show in the OR, nor will you be expected to. A lot of the surgery rotation is about being a good team player and providing help to the surgeons and residents in the OR, clinic, ward and emergency department.

I. IMPORTANT CONTACTS

- Hospital coordinator:
 - o Amy Whyte (awhyte@toh.on.ca)
- Administrative Assistant
 - o Katanya Lionel-Walsh (klionel@toh.on.ca)
- Rotation Director:
 - o Dr. B.K. Lam (bklam@ottawaheart.ca)

II. SURGICAL BOOT CAMP

Starting in the 2013-2014 school year, each surgical rotation will begin with a weeklong “boot camp” to help prepare students for their upcoming block by outlining important topics and issues they will encounter during their five weeks on the service. The current organization of the boot camp is a combination of clinical skills workshops, including suturing, intubation, laparoscopy, incision and drainage, and specialty based quizzes.

Attendance at the boot camp is **mandatory**. While the quiz marks do not contribute to your final surgery mark, students must achieve an average of at least 60% overall to pass and avoid remediation. Quiz topics include general surgery, orthopedics, urology, plastic surgery, vascular surgery, thoracic surgery, neurosurgery and pediatric surgery. An email detailing the schedule of the quizzes, topics for each quiz, as well as helpful resources for review will be sent out by the surgical coordinator prior to the beginning of boot camp.

III. WHO’S WHO: ACS TEAM

During your two weeks of General Surgery you will be on the Acute Care Service (ACS). This service is extremely busy at times and your role on the team will be diverse. The team usually consists of one senior general surgery resident and anywhere from two to four junior residents (on and off service). Each week a different staff will be rotating through ACS and this staff will likely be different than the staff on call overnight; as such, you will have the opportunity to work with multiple staff throughout your two weeks. However, on ACS, many of your interactions will be with your senior and junior residents.

IV. ROTATION EXPECTATIONS, STARTING ON DAY ONE

Starting a new rotation can be an anxiety provoking matter and since every rotation and specialty is different, the expectations of the students will vary as well. ACS is a very demanding rotation – the hours are long, the mornings are early, the consults are time consuming, and the ORs can be quite lengthy.

Morning rounds on ACS begin at approximately 6:00 AM every morning Monday through Friday. Rounds usually begin at 7:00 AM on weekends. Students are expected to arrive 5-15 minutes before rounds begin to help gather the patient charts, print the service's list of patients, and begin writing progress notes. **On your first day of ACS**, it is suggested that you arrive before 6:00 AM, dressed in scrubs, to introduce yourself to your team and to get (quickly) acquainted with the ward.

Depending on the number of ORs scheduled for the day and when they begin, rounds can be extremely fast paced and the residents will expect you to keep up, even if this is only day one of clerkship/the rotation. By arriving a bit before rounds start, you can give yourself some time to review the nursing flow sheets for the patients on the service, and review any issues that may have occurred overnight. The senior resident on your team will be running rounds and students, along with junior residents, are expected to help write the progress notes, orders, and to check on any pending blood work, diagnostic imaging, pathology, or consult notes.

Once rounds are complete, the senior resident will go directly to the OR. Junior residents and medical students will be left to divide up the work to be done. Depending on the number of pending consults, discharge summaries, and floor issues, students may have the opportunity to go to the OR as well. However, the ACS team receives all the consults from the emergency department throughout the day, and as such, students are often sent to begin the consultation. Consults are a great learning experience – you will work on both your history and physical exam skills, in addition to formulating a differential diagnosis and management plan for the patients.

Dress code – scrubs, scrubs, and more scrubs. Your time on ACS will be split between the wards, the emergency department for consults, and the OR. Students will be expected to arrive in scrubs each morning, as there may not be time later in the day to change. Navy blue surgical scrubs are now being dispensed through the ScrubEx machines at both the General and Civic Campuses. Students will be given 2 credits for scrubs for their rotations. Students are required to wear these scrubs when entering restricted access areas (including the OR). Fittings can be done in the Logistical Services Department at the Civic and General campuses – you must bring your TOH ID badge. At the Civic, fittings can be done in the C Building basement next to the mailroom between 0700-1500 and at the General on the Main Level next to the mailroom from 0700-1500.

- Civic Campus: there are 2 dispensing units for scrubs – one in the male locker room and one in the female locker room lobby. Collecting machines are available in the locker rooms as well. There is a combined collecting/dispensing machine on the C4 elevator landing on the 4th floor.
- General Campus: there are dispensing and receiving units in the male and female locker rooms on the main level. There are two combination dispensing/receiving units: Eye Institute lobby on the main level and in the Birthing Unit locker room.

Baby blue scrubs are still available in the male and female locker rooms at both campuses. At the General campus, the entrance to the locker rooms is located near the Tim Hortons, across from the Eye Glasses shop and parking pay station. Walk down the hall from the entrance, and go through a second door; the lockers will be in the next hallway and require your Ottawa Hospital badge for entry. At the Civic campus, locker rooms are located on the 3rd floor. Take the “B” elevators to floor 3 and when you get out, you will be at the medical student lockers. Turn right when you exit the elevators, and then turn right again. Walk through the double doors

and then on your right hand side will be the door to the locker rooms. Again, you will require your Ottawa Hospital ID badge for entry. These scrubs are available in a variety of sizes.

V. SCRUBBING IN

Medical students will frequently have the opportunity to go the OR. Your role in the OR will depend on the type of case, but commonly, students are there to lend an extra set of hands to the surgeons, whether it be for retraction, directing the camera during laparoscopic procedures, or as a first assist on-call or resident academic days.

You will be expected to scrub and gown appropriately for the procedure and know the “do’s” and “don’ts” of the sterile field. During ‘Link Block’, there will be a session on proper scrubbing techniques, as well as how to gown and glove appropriately. As well, there are videos available via One45 that instruct the proper way to scrub.

When entering the OR, you should always introduce yourself to the staff and to the OR nurses. If you will be scrubbing in or assisting in any sterile procedures, you should tell one of the scrub nurses your glove size. As well, writing your name on the white board (there is one in every OR) with your glove size will also help the nurses when completing the nursing OR record and prepping for the next case.

While scrubbing in as a student is not as glamorous as you may have thought, it gives you the opportunity to practice some of the skills you worked on during your boot camp, namely suturing and laparoscopy. When the surgeons are finishing off the case, they usually leave the suturing/stapling for the residents and other medical learners. Often senior residents will offer students the opportunity to help close up the surgical site, but if that is not the case, students should feel comfortable asking to do so.

At the end of the case, the students can help clean up the patient and with transport to the Post-Anesthesia Care Unit (PACU), as well as writing the post-operative note (see Documentation section).

VI. CALL

During your two weeks on ACS at the General or Civic, you will be expected to complete 3 call shifts – two weekday (Monday – Friday) and one weekend (Saturday or Sunday). Your call schedule will be sent to you by the department coordinator. If you want to switch call shifts, you can email the coordinator for this request.

Call begins at approximately 5:00 PM and it is expected that the student be present at handover between the day team and the overnight/call team. During handover, the on call team will be told about any pending consultations and any emergency surgeries that have been added to the OR list. At handover you will meet your senior resident and any junior residents who will be on with you for the evening.

Once handover is complete, you can discuss with your residents what your expectations and objectives are for the night ahead. If you haven’t had much OR time or haven’t had the opportunity to suture, let them know as call is a great time to get more hands-on exposure (since there are fewer learners at night).

Typically, if there are no pending consults or ORs booked, residents will take your pager number and send you off to study, eat, or sleep. **Take this time!** Nights on call are

unpredictable and there is no way of knowing when you may get another chance to rest or eat. Ensure your residents have your pager number and then make use of the time you have off.

At uOttawa, medical students are not “first call” for surgery, which means you will not be called by the floor nurses if there is an issue with a patient on the ward like you would be on Internal Medicine.

The next morning, medical students are expected to attend and participate in morning rounds. Once rounds are complete and all progress notes are complete, you are free to go home. Ensure your residents know that you are post-call before leaving so that you are not given an unexcused absence.

Communication is key during clerkship – each rotation is busy and residents and staff will likely not remember when you are post-call or have academic days. Be sure to let them know this information in advance, in addition to when it is relevant so that your team is not spending time looking for or paging you.

VII. SURGICAL SUBSPECIALTIES

If you are completing your surgical rotation in Ottawa, then during your 5 weeks in hospital you will have the opportunity to work on two to three different surgical specialties. Every student must complete two weeks of ACS. Students will complete two weeks of either urology or orthopedics. Your final week on surgery can be done in one of a number of specialties, including plastic surgery, vascular surgery, thoracic surgery, neurosurgery, cardiac surgery, urology, orthopedics, pediatric surgery, pediatric sub-specialties, or you can choose to complete a week in a general surgery subspecialty (breast, colo-rectal, or hepatobiliary).

Prior to the start of your surgical rotation you will be contacted by the surgery coordinator to send in your surgical subspecialty preferences and rankings. Unfortunately, not all specialties are offered at both campuses, so you may be at different campuses during your subspecialty weeks.

While you are on your surgical subspecialties, you will likely be expected to complete call. These call shifts are different than ACS in that they are only until 10:00/11:00 PM at night AND you do not get a post-call day. Depending on how many students are on the service, you may have your pick of call days or have to coordinate with others. During your two weeks of Urology or Orthopedics, you will be expected to complete 3 calls – 2 weekday and 1 weekend. Weekend calls begin at 7:00/8:00 (check with your senior ahead of time) and are only until 11:00 PM – you are NOT expected to stay overnight. Urology has home call, which means that if there are no pending consults or work to be done, you are free to leave the hospital, as long as you can return within 20-30 minutes if you are paged.

VIII. STUDYING IN SURGERY

Surgery is one of the busiest rotations in clerkship with some of the longest hours. It can be very difficult to find time to study when you get home at night after being at the hospital since the wee hours of the morning. The best advice we can give is to read around your cases. For example, in General Surgery, you will see a number of small bowel obstructions, appendicitis, and cholecystitis; take some time after you see a patient, or that night, and read about the disease process you saw – it will help you with future cases and make it easier to remember.

Unfortunately, due to time limitations, you will not get exposure to every surgical specialty. Getting together with other students in your group and discussing the important or high yield cases in the sub-specialties is a useful way of learning new material.

IX. RECOMMENDED RESOURCES

- Current Diagnosis and Treatment by Lange
 - Available through the UOttawa Library website
 - Includes most surgical specialties that are being tested on the exam
- Toronto Notes
 - Overviews of all major surgical specialties with clinical pearls and mnemonics to help remember key points
- Case Files: Surgery
 - Over 60 clinical cases that cover a wide variety of specialties
 - Applicable questions at the end of the case
- Urology learning resource (recommended by Dr. Roberts):
<http://www.auanet.org/education/medical-student-core-content-and-other-resources.cfm>

OBSTETRICS AND GYNECOLOGY

Welcome to the world of women and babies! Obstetrics and gynecology is one of the few specialties that has it all: medicine and surgery; and your obstetrics and gynecology rotation will be just that – a mix of OR, ward and clinic. Like all experiences in clerkship, your OBGYN rotation will vary from hospital to hospital and depending on the city you do it in, but you can expect to see and do a lot. Students in OBGYN have the opportunity to deliver their first baby, assist on C-sections, antenatal care and follow-up, and get their hands dirty in the OR with hysterectomies and hysteroscopic procedures. One thing you can expect from OBGYN is a busy rotation – babies don't know what time it is and one way or another, they have to come out!

I. IMPORTANT CONTACTS

- Hospital coordinator:
 - o Hilary Gore (hgore@toh.on.ca)
- Rotation Director:
 - o Dr. Laura Hopkins
- Civic Site Lead
 - o Dr. Pam Berger

II. BASE CAMP

The Department of Obstetrics and Gynecology has created a weeklong series of lectures, workshops, Simulation and Enrichment Topics to help prepare clerkship students for their upcoming rotation and future careers. This is a great time to get a handle on some of the bread and butter topics of OB-GYN. It is important to take advantage of this week as students will be taught by many of the residents and preceptors they will be working with during the five week rotation. The lectures cover most of the exam material and are a great study and reference resource.

In addition to lectures and workshops, students will be assigned one topic to present to the group at the end of the week. Topics include: pelvic masses, breech presentation, menorrhagia, and amenorrhea. The exercise is supposed to be fun and educational, so no need to stress about it...and there are no marks involved either!

III. WHO'S WHO?

During your five weeks of clinical OBGYN you will have the opportunity to work with attending staff, residents, L&D nurses, and other student learners. Depending on what week you are on, you may be working on a team with two to three residents or one on one with a staff in their clinic. It is a great opportunity to see how different physicians work and will help you develop your skills as a future clinician

IV. ROTATION BREAKDOWN

Like every other rotation, OBGYN is six weeks long. The first week of your rotation will be in Ottawa at base camp. If you are completing your OBGYN rotation in Ottawa, you will be doing two weeks of community obstetrics and three weeks in hospital.

Community obstetrics can include antenatal clinics, gynecology clinic, urogynecology, and even OR days (depending on your preceptor). Generally students are assigned to two or three staff

for their community weeks since the staff have clinics, OR days, and L&D call and it is very difficult to be with one person for the full two weeks. These two weeks are more relaxed and the hours tend to be much less than while in the hospital.

While in hospital, you will be exposed to three different subspecialties. At the Civic Campus these will be:

- Labor and Delivery
- Maternal Fetal Medicine (High Risk); and
- Gynecology.

At the General Campus, you will do three specialties of the following four:

- Labor and Delivery
- Gyne-Oncology
- Follow the Chief Resident (similar to Gynecology at the Civic)
- Maternal Fetal Medicine (High Risk)

If you are completing your rotation at one of the rural locations (Cornwall, Cobourg), you will spend your first week in Ottawa (base camp) and the remainder of the rotation in your respective community. The breakdown of your rotation is dependent on your preceptor and the community.

V. ROTATION EXPECTATIONS, BEGINNING FROM DAY ONE

Expectations of students differ depending on what part of the block you are in.

Community - You will be performing histories and appropriate physicals, and likely will have the opportunity to do small procedures, like IUD insertions, polyp removals, endometrial biopsies, and PAP smears.

Labor and Delivery - You will be part of a team consisting of OBGYN residents, family medicine residents, and other students. There is a staff on call during the day from 8 AM – 5 PM and the overnight staff arrives at 5 PM for handover. Students should arrive at 7 AM for handover and print a list of patients on the obstetrics roster. After handover, the list will be broken up amongst the team members and everyone will round on their post-partum patients. After you have rounded on your patients, you write your notes in their post-partum charts. Once you are finished rounding, you are able to go help at triage, go to the OR for C-sections, or follow patients that are in labor. Don't forget about the "Bs" of post-partum rounding:

- Bleeding – ask about lochia (vaginal bleeding); make sure to ask about quantity, clots, and colour of blood
 - Comparing the amount to the patient's period may help with quantifying the amount of blood
- Belly – there is any pain? If so, is it being appropriately treated?
- Bottom – any hemorrhoids?
- Baby – NICU?
- Booboos – lacerations, C-section
- Bowels – had a BM yet? Passing flatus?
- Bladder – voiding well? Any hematuria?

- Breasts – ask about breastfeeding, bottle feeding
- Blues – postpartum blues are extremely common and it is important to screen for this before moms go home
- Birth control

Civic Campus:

Maternal Fetal Medicine – Composed of clinics and rounding on antenatal patients. Arrive for handover at 7 AM and you will be expected to round on the antenatal patients admitted to the hospital. Typically there is a senior resident on service who will be rounding with you. Clinic typically begins at 8:30 AM and patients are scheduled until 3:30-4 PM. Each day is clinic for a different staff, some of whom you may work with on call, in the OR or during your week of L&D.

Gynecology – During this week you will be working with two to three residents and potentially another student. The team meets at the L&D nursing station on D4 at 7 AM for handover. Then you will round with the team on post-operative patients on the floor. After rounding (much like surgery), the residents will head to the OR and students will have the opportunity to assist and scrub in on procedures. Students also are expected to help with consults that come up throughout the day while the residents are scrubbed in. Students are expected to stay until 5 PM for handover, but if there are no consults and the ORs finish early, you may be excused earlier.

General Campus:

Maternal Fetal Medicine – Similar organization to the MFM week at the Civic.

Gyne-Oncology – This week can be very emotionally draining. It is a mix of OR, wards, and clinics. You will meet with your team (2 senior residents and possibly another medical student) at the 8 west nursing station for rounds at 7:00 am. It is expected that you arrive early to collect the charts, check overnight vitals, and start writing progress notes. After rounding, the residents will head to the OR and students will have the opportunity to assist and scrub in on procedures. Students are also expected to help with consults that come up throughout the day while the residents are scrubbed in. You should also work on updating discharge summaries throughout the day. Students are expected to stay until 5:00 pm for handover, but if there are no consults and the ORs finish early, you may be excused earlier. Once or twice during the week, you will be able to attend Colposcopy clinic at the Riverside. This is a great opportunity to practice pap smears and interact with oncology outpatients. The wards can be very hectic and a lot of the management may seem over your head, but clinics are a great time to ask questions one on one with staff. Make sure you call the clinic ahead of time as they often get cancelled.

Chief Resident – Similar to gynecology at the Civic, during this week you will be working with two to three residents, and potentially another student. The team meets at the 8 west nursing station at 7:00 am for handover. You will round with the team on post-operative patients on the floor. After rounding (much like surgery), the residents will head to the OR and students will have the opportunity to assist and scrub in on procedures. Students also are expected to help with consults that come up throughout the day while the residents are scrubbed in. Students are expected to stay until 5:00 pm for handover, but if there are no consults and the ORs finish early, you may be excused earlier. During this week, you will also have the opportunity to attend menopause and urogynecology clinics at the Riverside after rounding. Make sure to call ahead as clinics are often cancelled.

Student Testimonial – Cornwall Placement

You'll get 5 weeks in Cornwall where you get continual experience in labour and delivery, OB clinic, and gynecological clinic and surgery.

During my time in Cornwall, I worked with an OBGYN whose schedule was: Pre-natal Clinic on Monday, Gynecology Clinic on Tuesday and Wednesday, OR on Thursday and Clinic on Friday. I had the opportunity to do colposcopy and had a lot of hands on experience in the office: practising Leopold's manoeuvres, SFH, endometrial biopsies, PAP tests and swabs, and even a couple IUD insertions. Clinic was a great place to practice contraceptive counselling. Expect lots of young patients, including pregnant 16-21 year olds and 24 year olds with 3 kids and wanting tubal ligation. Be aware that it's quite a different population than you encounter in Ottawa.

The learning is very self-directed; there weren't any official sit down lessons with my preceptor, it was more asking questions and discussing them during clinic. Students have the opportunity to scrub and assist for surgeries, which involves holding instruments or being in charge of moving the uterus.

I got hands on exposure in quite a few deliveries. By making myself available outside my call and working with the case room nurses, I got extra opportunities to practice my skills. Go out of your way to ask women if you can do a cervical check, and try to coordinate it with the nurses, so you go when they are doing their next one and compare if you feel the same thing. The nurses were great and extremely helpful with learning this skill.

There was a lot of continuity of care between seeing women in the hospital and then seeing them when they came into labour at the hospital, which was a positive experience for me. It was great to build that longitudinal relationship.

- Mimmi Thompson, MD 2015 Candidate

VI. CALL

When completing your OBGYN rotation in Ottawa you will be expected to complete four call shifts (3 weeknights and one Saturday or Sunday). These call shifts won't necessarily be when you are working on the wards or in hospital. Call is always for Labour and Delivery regardless of what week you are on. Shifts begin at 5:00 pm and end by 8:00 am the next morning. Call is extremely variable – there may be 10 babies born in one night or none; there will be consults in the ED that can come at 10:00 pm or 4:00 am; but ultimately, call is what you put into it! If you want to gain the most out of your OBGYN call, and you only have four in five weeks, here are a few things to do:

- Discuss your goals for call with your resident at the beginning of the night – if they know your expectations, you'll get more out of the night
- Write your name and pager number on the whiteboards so the nurses know who you are; as well as the whiteboard at the Labour and Delivery triage station.
- New in the Fall of 2014, "Delivery Pagers" will be introduced to facilitate notification of house staff for deliveries.
- Buddy up with a nurse and give them your pager so you'll be called when a delivery is happening or when they'll be doing an exam
- Stick around the nursing station – the clerk and charge nurse always have an idea of what is going on, who is actively in labor, if a patient needs an exam, etc.

VII. RECOMMENDED RESOURCES

- Toronto Notes – Obstetrics and Gynecology Chapters
 - Breakdown of antenatal care, common issues that arise in pregnancy, the stages of labor and L&D complications
 - Overview of STIs, contraception, and gynecological procedures
- Case Files – Obstetrics & Gynecology
 - Sixty real-life cases that illustrate essential concepts in OBGYN
 - Each case includes a complete discussion, clinical pearls, references, definitions of key terms, and review questions

PSYCHIATRY

Welcome to the world of Psychiatry! It is a very diverse field, and in Ottawa, students have the opportunity to complete their rotations at The Ottawa Hospital-General or Civic Campus, the Queensway Carleton Hospital, the Royal Ottawa Mental Health Centre, the Brockville Mental Health Centre or to an approved DME site, such as Orillia or Guelph. Regardless of where students complete their rotation, they will see a wide variety of psychiatric illnesses and disease processes, ranging from depression to schizophrenia or anorexia nervosa to REM sleep disorders.

I. IMPORTANT CONTACTS

- Hospital Coordinator:
 - o Carmen Lefebvre (Carmen.lefebvre@theroyal.ca)
- Rotation Director:
 - o Khalid Bazaid (kbazaid@cheo.on.ca)

II. ROTATION BREAKDOWN

During this rotation, students will complete four weeks of general adult psychiatry – either in Ottawa (at the General, the Civic, or the Royal Ottawa Hospital) or rural, one week of child/adolescent psychiatry, and one week of geriatric psychiatry.

This rotation starts with the Psychiatry Academic Week followed by 3 weeks of adult psychiatry (at the General, Civic, Queensway or The Royal), one week of child/adolescent psychiatry and one week of geriatric psychiatry. Students may also be assigned to a Distributed Medical Education (DME) site like Brockville or Orillia. These students will complete 4 weeks at their DME sites, which will meet the University of Ottawa rural requirements. Students will be expected to receive both an adult and a geriatric psychiatry experience at their DME site and will return to Ottawa for the last week of the rotation and spend 1 week in child/adolescent psychiatry.

Child and Adolescent Psychiatry:

Your week of child/adolescent psychiatry can be in a variety of places. Students may get to work on the psychiatry ward at CHEO, at a CHEO clinic, at the Royal Ottawa, or at a private office off site. Additionally, some preceptors go into elementary/middle schools to provide help or counselling, and students are encouraged to participate. Closer to your psychiatry rotation, you will receive an email from the coordinator with your placement and preceptor(s). Depending on your comfort level (and your preceptors), students may complete assessments on their own, do consultations, or participate in group or family sessions. This week really solidifies that children aren't little adults, they are their own separate entity!

Geriatric Psychiatry:

While on Geriatric Psychiatry, students are generally split between the wards and outpatient clinics at the Royal Ottawa Hospital. The Geriatric ward is much like the general psych ward or internal medicine ward – patients are admitted with a variety of illnesses and issues and followed closely by a Geriatric Psychiatrist. You will often be assigned patients to follow and write notes on. Some students will be assigned to a staff who works at the Geriatric Day Hospital at the Royal. This program consists of patients with psychiatric illnesses, but are well

functioning and do not require admission, as well as patients who have dementia in addition to or in lieu of mental health disorders. Lastly, you may have the opportunity to go to retirement or nursing homes with your preceptor; it is a great opportunity to see some of the long term care facilities in Ottawa that you will be referring patients to or receiving patients from in your various rotations, especially internal medicine.

What you will be doing during your three or four weeks of general adult psychiatry is quite variable and will be touched upon in the following sections.

III. GENERAL INPATIENT PSYCHIATRY BY LOCATION

TOH General Hospital:

General and Civic Hospitals: At the General campus, students will be completing their three week rotations in one or more of the following: general psychiatry (wards), consult liaison, eating disorders, perinatal mental health, or outpatient clinics.

- Wards: Students will be assigned to a specific preceptor and will follow the preceptor's assigned patients for the three weeks
- Consult liaison: Students will be a part of the consult liaison team, which consists of psychiatry residents, off service residents and an attending staff. This team will see patients in the ER and on other wards that require psychiatric assessment.
- Eating Disorders: Students will see patients with eating disorders admitted to the wards, in day hospital, and as outpatients. This diversity allows you to see patients with eating disorders at each stage of the disorder and is a very unique learning experience.

TOH Civic Hospital:

At the Civic students will complete 3 weeks on the inpatient psychiatry ward. Again, you will accompany your assigned preceptor and resident in following their patients for the duration of your rotation. The inpatient ward at the Civic is for general psychiatry and as such is a mixed bag of bipolar affective disorder, psychotic disorders, mood disorders, dementia, and even delirium. Even if your team is not following a specific patient, you are still welcome to peruse their chart and management plan to gain more exposure to different cases.

Royal Ottawa

There are a variety of subspecialties at the Royal and students may be assigned to Sleep Psychiatry, Schizophrenia, Forensics, , Geriatrics, or Anxiety and Mood Disorders. Students will accompany their assigned preceptor who may have a preferred specialty or see a variety of patients.

IV. CALL

Students completing their rotation in Ottawa are expected to do five overnight call shifts during the six week rotation. Of these five call, two will be on weekends (Saturday or Sunday). Call begins at 5 PM on weekdays and ends the following morning after post-call supervision.

Post-call supervision is when you and the resident(s) you were on with overnight meet with the attending staff and discuss the cases that came in. It is also a good time to talk about any topics you are unsure of or that were related to your cases from the night.

Psychiatry call is 'home call', which means that as long as you are able to get to the hospital within 30 minutes of a call/consult, you can go home when it is quiet and there are no pending consults. Many students choose to stay at the hospital during the weekday calls for two main reasons:

1. Less work/energy to get to bed once you're done a consult or get up once you get a call;
2. If you don't work past midnight during your call shift, you do NOT get a post-call day. It is an unwritten rule, and expected, however, that residents and medical students take a post call day regardless.

Call shifts will be spent in PES, which is the Psychiatric Emergency Services. PES is located in the ED at both the General and Civic campus. There is no emergency department at the Royal. As such, if a student is doing his/her rotation at the Royal, they will be assigned to do call at either the General or the Civic. PES consists of 4 rooms and a separate, locked area for staff, nurses, and clerks.

NOTE - Ensuring safety while on call:

Many of the patients who are seen in PES have been deemed at risk of harming either themselves or others, and have often been brought into hospital involuntarily (by the police, concerned family, etc.). They are often angry and some may even display aggressive behaviour. Rest assured that the PES nursing staff and security guards are well equipped to handle these situations, and consequently adverse incidents are rare. You will always have multiple people supervising you and help is always close at hand. However, if at any point in time you do not feel comfortable interviewing the patient, it is perfectly acceptable (and expected) for you to leave the room and alert your team.

V. TEACHING IN PSYCHIATRY

Much like Family, Surgery and OBGYN, Psychiatry has an academic week which happens the first week of the rotation. All Psychiatry lectures are given this week. These lectures cover topics such as Dementia, Depression, Personality Disorders, and Psychosis. There is a lot of overlap from the information presented in second year, but as clerkship students, you are expected to know dosages of drugs, as well as their classes, side effects, and indications, which is a step up from the expectation in Unit III.

The sessions are taught by physicians in the field, as well as residents and fellows. These sessions are mandatory and attendance is always taken. This is another opportunity to discuss cases you have seen and ask any questions regarding topics that you find difficult or confusing.

VI. RECOMMENDED RESOURCES

- Toronto Notes
 - Covers adult, child, and some geriatrics
- Weekly lectures
 - These lectures will cover objectives and major topics in Psychiatry
- CaseFiles Psychiatry
- Lectures from Unit III in second year

FAMILY MEDICINE

Welcome to the amazing world of family medicine. This rotation, much like internal medicine, pediatrics, and emergency medicine, will expose students to a wide variety of disease processes within various age populations. Many students will be placed in offices within the Ottawa area, but nearly half of you will get to experience rural family medicine in cities as close as Arnprior or Kemptville or as far away as Moose Factory.

The people you meet, work with and treat will be from all walks of life and this rotation will exemplify how diverse medicine can be. As with any other rotation, your family medicine rotation will be what you make of it – if you put in the time, seek out experiences, and ask lots of questions, you learn a lot in these short five weeks!

Family medicine is different from other rotations in that you will be spending your entire rotation, with the exception of the orientation week, with one preceptor. After this rotation, many students are able to get reference letters and outstanding performance nominations, as preceptors have sufficient time to evaluate the student's skills, monitor their progress and determine their strengths and weaknesses.

I. IMPORTANT CONTACTS

- Rotation Coordinator:
 - o Donna Williams (dwilliams@bruyere.org)
- Rotation Director:
 - o Eoghan O'Shea (eoshea@bruyere.org)

II. ACADEMIC WEEK

Each family medicine rotation will end (week 6) with an academic week, which includes lectures, mindfulness and visual thinking strategy workshops, and field trips. This week aims to introduce students to frequently encountered topics in family medicine, how to maintain mental health, and the role of allied health professionals in this medical specialty. Schedules for this week will be sent to you by Donna Williams approximately 10-14 days prior to the start of your rotation and be available on one45.

Important things to note:

1. Students are expected to complete two allied health professional visits during their family medicine block. These can be done at any point during the six weeks outside of clinic time. Allied health visit options include: alcoholic anonymous group meetings, working with a pharmacist, occupational therapist, physiotherapist or wound care nurse, or visiting a senior's home. A more thorough list will be provided by Donna Williams prior to your family medicine rotation.
2. Punctuality during this week is VERY important. Students who arrive late to lectures and workshops will have to complete a 250 word summary on the topic you missed within three days of the date of the missed module. Unfortunately, many of the lectures/sessions are scheduled in various locations around the city (Bruyere, St. Vincent, Riverside Campus and Melrose), so be aware of where you are supposed to be and have a reliable way to get there!

III. CLINICAL DUTIES

For the first five weeks of this rotation, you will be working closely with one family doctor in their clinic/office. Your role and level of independence will vary somewhat depending on who you are working with, but it is helpful to understand the types of patient visits you will be exposed to and the goals of each.

1. Annual Physical Exam (Periodic Health Exam)

The purpose of the annual physical is to catch up on all of your patient's active issues. During the history, review all conditions in the 'problem list', ask about progression or the development of complications, and verify whether the patient is receiving treatment, and whether they are compliant. Obtain a full review of systems. Ask about general energy level, ADL's, nutrition, living situation, whether the patient is still driving, and any other psychosocial issues.

Complete a physical exam. You may find the following approach helpful: General appearance (posture, hygiene, dress), HEENT, MSK (check for spinal process tenderness), occiput to wall distance, skin, cardio/peripheral vascular (especially in males > 70; note if any pulsating abdominal mass), respiratory exam, abdominal exam, breast and pelvic exam (+/- pap and swabs) in females, and a prostate and testicular exam in males.

Routine bloodwork includes tests that assess the status of existing conditions and those used to screen for other conditions not yet diagnosed. Your patient's specific profile will determine which tests you choose, but they may include CBC-d, BUN/Cr, ALT, random blood glucose (fasting if known diabetic), and a lipid profile for patients at increased risk of cardiovascular disease.

2. Follow-up for a specific issue

Less holistic than the annual physical, this appointment is tailored to the patient's specific complaint. Beforehand, review the patient records for previous notes pertaining to this issue. While taking the history, be sure to identify the timeline and functional impact of the complaint – **why this issue and why now?** Complete a physical exam of the relevant systems only. Consider any useful investigations that may be ordered.

3. Paediatric Visits

During your family medicine rotation you will also be expected to complete well-baby visits for infants and check-ups for children. It is therefore important to know your paediatric milestones and immunization schedule.

4. Other

Other types of visits you may see include immunizations and boosters, retirement home visits, psychosocial counselling appointments, prescription requests/refills, and visits with family to discuss an elderly patient's general ability to cope.

General Tips:

- Arrive 15-20 minutes before the first appointment, and review the patient list for the day. This allows you to read up on the conditions to be seen that day
- Review basic procedures and skills such as how to take a BP, give a vaccine, and perform phlebotomy. Let your preceptor and their RN's know that you would like practice performing these procedures!
- Review your OSCE skills book well! This is one of the best rotations to improve your physical exam skills

Depending on where you do your family medicine rotation, you will be exposed to different patient populations. However, in every family doctor's office, there are a number of chief complaints you should expect to see. You will also be expected to perform periodic health examinations no matter where you are.

Common Chief Complaints and Diagnoses encountered in Family Medicine:

1. Headache
2. Rhinitis (allergic, viral)
3. Sore throat (GAS vs. viral)
4. Asthma
5. COPD
6. Hypertension
7. CAD
8. Diabetes
9. Abdominal Pain
10. Thyroid Disease
11. Joint pain - back, knees, etc.
12. Urinary Tract Infection
13. Mood and Anxiety disorders
14. Arthritis

The Family Medicine department provides students with a [family medicine handbook](#) to be used during the rotation. It includes diagnosis and management information for many of the common conditions seen in clinic (see above) and will be a great resource during the rotation and while studying for the exam.

Students are expected to attend all clinical duties that their preceptor is scheduled for. This may include night clinics, weekend/emergency clinics, or house calls. Again, depending on your preceptor and the community, you may have the opportunity to do emergency room shifts, obstetrics, palliative care, anesthesia, etc. **If you have an interest in any specialty within the realm of family medicine, be sure to inform your preceptor in advance and they may be able to set up extra learning opportunities during your rotation.**

Every family doctors office is different in terms of set-up, multidisciplinary team, and expectations of students. The purpose of this rotation is to learn the necessary skills and information that will prepare you for a career in family practice. However, the objectives for the family medicine rotation are broad, and if you do not feel that you are getting the necessary exposure, inform your preceptor and they can help you reach your goals! For example, in many family health clinics, immunizations and shots are performed by nurses. If this is the case in

your clinic, you should coordinate time with the RN and your preceptor to spend on practicing giving immunizations and shots.

IV. HOW TO STUDY DURING FAMILY MEDICINE

One of the best things about family medicine is that we receive a lot of teaching, lecture material, and resources that can be used throughout the rotation and while studying for the exam.

Although schedules will vary, there tends to be more time outside of clinical duties, allowing students to review pertinent information more consistently. Many physicians, residents, and upper year students suggest reading around your cases from the day and this will help consolidate your knowledge. Alternatively, if there are topics you are interested in reviewing, you can ask your staff to see cases with those specific presentations at your next clinic. All students learn differently, so find what works best for you!

V. RECOMMENDED RESOURCES

- Toronto Notes
 - Family Medicine chapters provides short breakdowns of common FM presentations
- [Family Medicine Handbook](#)
- UpToDate
 - Excellent resource in clinics for medication dosages
- Anti-infective Guidelines for Community Acquired Infections (available for purchase online at <http://www.mumshealth.com/guidelines-tools>)
- Case Files Family Medicine

PREPARING FOR FOURTH YEAR

So here you are, about to become a fourth year medical student! There is so much ahead of you in the next year, but it will go by in a flash! Electives, CaRMS, interviews, Match Day, LMCC and it all culminates in one very special day: graduation! You have been working hard for the past three years in medical school, and many years before that in anticipation of the day that you will be called a doctor for the first time...and that day is almost here!

Fourth year is different from any other year in medical school! Aside from the four weeks of mandatory selectives, you are able to choose HOW and WHERE you would like to spend your 18 weeks of electives. There are some limitations to setting up your electives and those will be outlined below.

I. ELECTIVE PLANNING 101

During your fourth year, you will have 18 weeks of electives to set up. Ten weeks of elective time are from September until the middle of November and these are known as the “pre-CaRMS” electives. During these 10 weeks, students set up electives in the specialties and cities they would like to explore before applying for residency. These ten weeks are also important for learning about the different residency programs, meeting residents and staff in your field of interest, getting reference letters for your applications, and most importantly, writing your CaRMS applications.

In November of 2014, a new application system was introduced that will streamline the electives application process for medical students entering their final year of training. This system allows students to apply to electives at the various undergraduate medical programs in one, harmonized place. As such, students will no longer need to apply to individual schools and will be able to track the progress of their applications. It will abolish the concept of “double booking” electives and provide transparency to the elective application process. For more information about this application system, refer to the system’s website (<https://www.afmcstudentportal.ca/>).

Students may ask “what is the best way to organize my electives?” The truth is, there is no perfect formula for setting up fourth year electives or deciding which schools to go to. The best advice we can give is to take your time and consider not only what programs you are interested, but what institutions are important for you to visit. In our experience, students in the year above you and first year residents (who have just been through this process) are the best resources for electives and CaRMS related questions. Again, there is no right answer for how to organize electives or how to apply to CaRMS, but these colleagues can give you examples about what did and did not work for them during their final year.

Another common question is “how early should I start applying?” Each university has its own deadlines for elective planning; as a general rule, schools will not accept applications for electives more than nine months or less than six weeks in advance of the start date of an elective. However, some schools limit their applications to four or six months in advance. The best advice we can give for this is to refer to each individual schools visiting electives website.

If you have any questions or concerns about fourth year, there are many resources available for you. Consider making an appointment with one of the Student Affairs Office advisors (<http://www.med.uottawa.ca/Students/StudentAffairs/eng/index.html>) or the uOttawa electives coordinator, Julie Clavelle (elective@uottawa.ca).

II. FOURTH YEAR MANDATORY SELECTIVES

In fourth year, students must complete four weeks of selectives – two weeks of Internal Medicine subspecialties and two weeks of surgical subspecialties. Much like in third year, students will be assigned to a rotation group in fourth year. The only difference among the various rotation groups is when students will complete their mandatory selectives. Below is an example of the timeline of fourth year electives and selectives by group.

DATE	GROUP 1	GROUP 2	GROUP 3	GROUP 4	GROUP 5	GROUP 6
Sept. 8 – Nov. 15						
10 WEEKS OF ELECTIVES						
Nov. 17 – Nov. 21	ELECTIVE	ELECTIVE	ELECTIVE	ELECTIVE	SURGERY Selective	INT. MEDICINE Selective
Nov. 24 – Nov. 28	ELECTIVE	ELECTIVE	ELECTIVE	ELECTIVE	SURGERY Selective	INT. MEDICINE Selective
Dec. 1 – Dec. 5	ELECTIVE	ELECTIVE	ELECTIVE	ELECTIVE	INT. MEDICINE Selective	SURGERY Selective
Dec. 8 – Dec. 12	ELECTIVE	ELECTIVE	ELECTIVE	ELECTIVE	INT. MEDICINE Selective	SURGERY Selective
Dec. 15 – Dec. 19	INT. MEDICINE Selective	ELECTIVE	ELECTIVE	SURGERY Selective	ELECTIVE	ELECTIVE
VACATION: December 22, 2014 to January 2, 2015						
Jan. 5 – Jan. 9	INT. MEDICINE Selective	ELECTIVE	ELECTIVE	SURGERY Selective	ELECTIVE	ELECTIVE
Jan. 12 – Jan. 16	SURGERY Selective	INT. MEDICINE Selective	ELECTIVE	ELECTIVE	ELECTIVE	ELECTIVE
TBC: NATIONAL INTERVIEWS: January 17 - February 8, 2015 (3 weeks)						
Feb. 9 – Feb. 13	SURGERY Selective	INT. MEDICINE Selective	ELECTIVE	ELECTIVE	ELECTIVE	ELECTIVE
Feb. 16 – Feb. 20	ELECTIVE	SURGERY Selective	INT. MEDICINE Selective	ELECTIVE	ELECTIVE	ELECTIVE
Feb. 23 – Feb. 27	ELECTIVE	SURGERY Selective	INT. MEDICINE Selective	ELECTIVE	ELECTIVE	ELECTIVE
Mar. 2 – Mar. 6	ELECTIVE	ELECTIVE	SURGERY Selective	INT. MEDICINE Selective	ELECTIVE	ELECTIVE
Mar. 9 – Mar. 13	ELECTIVE	ELECTIVE	SURGERY Selective	INT. MEDICINE Selective	ELECTIVE	ELECTIVE
Back to Basics / MCCQE Part 1 Preparation: March 16 - April 10, 2015 (4 weeks)						

Again, like the tracks in third year, you will be ranking your group preference and will be placed in one group after the lottery. Students are allowed to switch groups with one another after the lottery results are sent out.

Some things to consider when picking a track:

- Are you interested in applying to Internal Medicine? If so, groups 1, 5 and 6 provide an extra two weeks of time spent in a medicine subspecialty in Ottawa before CaRMs interviews. The same goes for students interested in surgical subspecialties; groups 4, 5, and 6 provide an extra two weeks before interviews.
- If you are unable to secure a pre-CaRMS elective in a specialty or at a school that you are interested in, ranking groups 1 – 4 will allow you to have four to six more weeks of electives before CaRMs interviews. As such, you can still show interest in other institutions/programs before they send out their interview invites.
- If you are considering an international elective, keep in mind that students are required to be in Canada on Match Day. Therefore, choosing a group with elective time before the December holidays will allow you to plan international electives of four to five weeks duration.
- If you are interested in completing the two week Art and Science of Clinical Teaching elective (started in Jan. 2015), students will be eligible to do so in groups 3, 5 and 6.

CONCLUDING THOUGHTS

We hope that you have found this guide useful as you progress through your core clerkship year, and wish you every success in the future. Our thanks and acknowledgements go out to all of the individuals involved in making this guide possible, as well as the University Of Ottawa Faculty Of Medicine for supporting us.

Sincerely,

Gemma and Stephanie, MD class of 2015