Our Special Thanks

To Alex Morang, the Director of the Office of Student Affairs – for providing this opportunity, answering endless questions, and being a source of guidance through this process.

To Janice Viticonte, Donna Arruda, and Linda Bozzario – for answering oddball queries, providing guidance for this handbook, and being the best support group a medical student could ever wish for.

To Dr. Mark Fagan, Dr. Julie Taylor, Dr. William Metheny, Dr. Randy Rockney, Dr. Robert Boland, Dr. Michael Mello, Dr. Edward Feller, Dr. Patricia Nolan, Pat Gemma, Pam Richardson, Helen DaSilva, Helene Felici, Jane Shaw and Joann Barao – for your timely feedback, great suggestions, and kind corrections to gratuitous errors.

To Steven Chan, Julie Chee, and Melisa Lai – for your work on previous editions and invaluable guidance through the third and fourth years of medical school.

FOREWARD

After nearly eight years at Brown, it still continues to amaze me what Brown students can do and how much they have invested in not only their own future, but the future of others as well. The creation and perpetual update of the Guide to the Core Clerkships is a testament to that spirit.

This handbook is a tremendous resource for the novice medical student, but as with all things, the details need updating and additions made to address changes that have arisen since the previous edition. Nonetheless, I did not want to take away from the voices of Melisa, Julie, and Steven from previous editions and have done my best to be true to the original voice, but also remain focused on progress that will help future medical students.

Be prepared, but relax. The latter two years of your medical school career will be challenging, but it will also be among the best years you will ever have. This handbook is meant to ease you into the perpetual motion machine of the medical world in spite of new residents, new interns, and of course, new medical students every year. The faster you learn where you need to be, where you need to go, what you need to do, and whom you should be with, the sooner you can start learning the art of medicine, help out your team, and begin making a difference in the lives of patients since you decided way back when: “I want to be a doctor.”

Also, JMS returns with even more helpful hints on getting by on the wards, so be on the lookout for him again.

Finally, don’t worry. This is your time to shine and show people how bright and brilliant you are. Just be yourself, and you’ll do great.

Cheers,
Grant Chu, M.D.’06 (April 2006)
FOREWARD FROM THE FOURTH EDITION

Third year is a big transition from second year. But what you’ve heard is correct: third year is better than second year, and fourth year is better than third year….in fact, fourth year is the best!!! But to enjoy your clinical years, you should be prepared.

First of all – don’t panic! Everything contained in this handbook will be old hat to you within a week of starting each clerkship. Things are always new (and maybe confusing) during the first couple of days of any new clerkship or at any new site. However, the learning curve is steep – by the end of the first week, you will be in the swing of things.

The purpose of this handbook is to minimize the amount of time you do spend at the beginning of each clerkship wondering what the heck is going on. Hopefully, you’ll be prepared for what the clerkship is like and learn the ropes sooner – and you’ll have more time to shine and show your residents and attendings how amazing the Brown Medical students really are!

Also….be on the lookout for JMS, a.k.a. “Joe Medical Student.” He has some sage tips to give to you that are scattered throughout this guide. These tips are ones that are often not told to medical students, but things that are figured out by all as the clerkship unfolds…..and then wished were known earlier on. Or he sometimes provides advice that people don’t outright tell you, but expect you to know….that kind of subtle, implicit advice that you may have missed.

Following are forwards from the first and third editions – Julie and Melisa sum things up so well, that I wanted their thoughts and sentiments printed for all to read. Julie would be disappointed that I didn’t investigate why medical students are cut off of residency food budgets…but this is something that I pass on to someone else to investigate (those volunteer meal cards just don’t cut it). Thanks to Julie and Melisa, too, for doing such great jobs with this guide that I found very little to change.

And now my tidbits of advice: like with your first two years of medical school, the third and fourth years are about balance. That’s the only way that you’ll be happy enough to be your spry, bright self on the wards – and this enthusiasm is infectious (not in the Pseudomonas kind of way, but in the contagious-happy kind of way). If you are determined to learn, to help, and to enjoy, these next two years will be among some of the best in your life.

Best of luck!
Steven Chan, BMS-IV (M.D.’04) (January 2004)

FOREWARD FROM THE THIRD EDITION

Two years ago, upon receiving the previous edition of the Clinical Clerkships Guide, I was so impressed by Melisa’s effort that I knew immediately that I wanted to write the revision before I graduated. “Don’t drop the ball” she said in that second edition’s forward, and I was so moved that I decided I was not going to drop the ball, and sure enough, Alex gave me the chance to update Melisa Lai’s pet project. In re-reading these pages, so much of her insights and information have held true, even three years after she herself started the clinical portion of her medical education.

As a result, there was really very little work left to be done. Some minor tweaking, some editorial and anecdotal comments, and some revisions of the community health and surgery rotations, but everything
else pretty much holds true. A lot of my time has been spent in researching and reconfirming technicalities of the clerkships, such as when the lectures are held, what the call schedule is like, and where to scrounge food now that we are cut off of residency food budgets (grrrr... someone should get on that one ASAP).

As a result, most of this book is still Melisa’s voice, in part because I agree with her, and in part because I couldn’t have said it better.

So to you, future classes of BMS-3s, I offer Melisa’s challenge to continue to better our medical school through working hard and working together. I hope that someone will look to add their voice to mine and Melisa’s by making it a tradition that this guide gets updated regularly.

Sincerely,
Julie Chee, M.D.’01 (May 2001)

---

**FOREWARD FROM THE ORIGINAL EDITION**

To our newest clerks:

Congratulations! You made it. The proverbial light at the end of the tunnel which leads out of the Purple Palace is upon you. It can be glaring at times but as you have no doubt been assured by tens of students who went before you, it’s worth it – even if you don’t own polarized sunglasses.

What you’re holding in your hands (or reading on your kitchen table or using to fan yourself during orientation…) is the pre-first edition of the soon-to-be official *Brown University School of Medicine Clerkship Handbook*.

While a “First Aid for the Wards”-type handbook isn’t my brainchild, this specifically Brown-oriented publication is my independent study (yep, Melisa’s earning a little research credit here – isn’t Brown wonderful?). It’s pre-first edition because I’m waiting for your feedback about what else should be put into it – so be sure to send your commentary and critiques my way so that the real first edition will be good to go for the class of 2001!

(The plan is that this handbook will be the BUMS Digest equivalent for the second two years, maintained and revised each year by a willing group of rising-fourth-years. But that’s two years away and I digress.)

**And now for my message to you,** ’cause that’s what people write in forwards: I hope that the very fact that this handbook exists, even in this premature form, serves as a reminder of how we all have to help each other in order to get through and succeed in medical school. Whenever you see a need of your fellow classmates, I hope that you strive to fill it. Share information, give pointers to the clerks who are to follow you, REALLY TAKE THE TIME TO FILL OUT EVALUATIONS so that people after you can benefit from your suggestions, reach out and pull each other up the medical hierarchy ladder – and never step on someone’s back while climbing up it because it’s not only contrary to being a team player, it’s plain old mean.

Always remember: we’re in this together. Just as you should be there for your classmates, they should be there to help you.

And now a final note about this handbook: anything that resembles editorializing represents the opinions of only one medical student and/or the opinions of other med students filtered through this one little brain of mine. The opinions represented herein are not those of the School of Medicine or its administration (even if we think it should be). 😊

Welcome to the Wards! You’re going to be great.

Good Luck,
# CONTENTS

## The Basics
- The Affiliated Hospitals (and Directions) ........................................... 6
- Food ........................................................................................................... 11
- The Players ............................................................................................... 11
- Teaching vs. Non-Teaching ...................................................................... 13
- Teams vs. Services vs. Subspecialties ..................................................... 14
- ACLS & ATLS ......................................................................................... 14
- Codes ......................................................................................................... 15

## On the Wards
- Scutwork & Pimping .............................................................................. 15
- Glossary of Common Abbreviations ..................................................... 17
- Notewriting
  - SOAP Note ............................................................................................ 18
  - What Color Pen to Use .......................................................................... 20
  - How to Erase a Mistake in a Note .......................................................... 20
  - How to Sign Your Name ........................................................................ 20
  - Co-Signatures ......................................................................................... 21
- Patient Presentation
  - Pre-Rounding ....................................................................................... 21
  - Presenting ................................................................................................ 22
  - Resident/Attending Short-Term Memory ................................................. 22
- Dictating .................................................................................................... 24

## Your Gear
- What Do I Wear? / White Coats .............................................................. 24
- Importance of Nametag/ID Badge ............................................................ 26
- General Good Things to Carry ................................................................. 27
- Do I Need a PDA? .................................................................................... 27
- Programs for Your PDA .......................................................................... 28
- Pocket Text Recommendations
  - General Reading Recommendations ..................................................... 30
- Where Do I Study? ................................................................................... 30

## Cardinal Rules of Being a Good Student ........................................... 31
## Cardinal Rules of Being a Good Classmate ....................................... 32

## Clerkships
- Community Health .................................................................................. 33
- Family Medicine ....................................................................................... 36
- Medicine .................................................................................................... 40
- Obstetrics & Gynecology .......................................................................... 49
- Pediatrics ................................................................................................... 54
- Psychiatry .................................................................................................. 59
- Surgery ....................................................................................................... 65

## USMLE Step 2 ....................................................................................... 75
## ERAS and the Match ............................................................................. 82
## A Few Final Words ................................................................................. 82
There are several teaching hospitals affiliated with The Warren Alpert Medical School of Brown University that you may rotate through. These include Rhode Island Hospital (RIH), Hasbro Children’s Hospital, Women and Infants’ Hospital (W&I), The Miriam Hospital (TMH), Memorial Hospital of Rhode Island (MHRI), The Providence Veterans Administration (VA) Medical Center, Butler Hospital, and Bradley Hospital.

Now, on how to get there and where to park…(courtesy of map.google.com)

**Rhode Island Hospital / Hasbro Children’s Hospital**

593 Eddy Street, Providence, RI 02903

Rhode Island Hospital is the site for rotations in Medicine, Surgery, and Psychiatry. Hasbro Children’s Hospital is the site of your rotation in Pediatrics.

**Directions:**

*From the Brown University campus,* drive down College St. and turn left onto Benefit St. Continue on Benefit St until you reach the traffic light at Benefit St./Wickenden St. There will be a Shell gas station across the intersection on your left. Turn right onto Wickenden St., pass under I-195, and cross over the Point Street Bridge until you reach the traffic light at Point St./Eddy St. (there is a 5-second window to turn left on the green before the opposing traffic has a green light). Turn left onto Eddy St., remain in the right lane, and pass under I-95. Continue past the RIH main entrance on your right to the traffic light at Eddy St./Dudley St. Hasbro will be on your right. Turn right onto Dudley St. and pass under the Bridge Building, which holds the Emergency Department (ED) and surgical suites.

*From I-95 heading south,* take exit 19, Eddy St. At the end of the exit, you will be at the Eddy St./Dudley St. intersection in the direction of Dudley St. Across the intersection to your right will be Hasbro, to your left will be the Cooperative Care Building (COOP), and ahead of you will be the Bridge Building. Continue on Dudley St. and pass under the Bridge Building.

*From I-95 heading north,* take exit 18, Thurbers Avenue. Bear left onto the ramp to Eddy St., pass under I-95, then move into the right lane after the traffic light. Turn right at the second traffic light at Thurbers Ave./Eddy St. onto Eddy St. Continue on Eddy St. as you pass a Burger King and Jack In The Box on your left and a Dunkin Donuts on your right until you reach the traffic light at Eddy St./Dudley St. The COOP will be on your left and Hasbro will be across the intersection on your left. Turn left onto Dudley St. and pass under the Bridge Building.

**Parking:**

You will need a RIH badge to park at RIH, which can be obtained at the Security Office. You will be assigned a parking.
Women and Infants’ Hospital
101 Dudley Street, Providence, RI 02903

Women and Infants’ Hospital is the site of your rotation in Obstetrics and Gynecology (OB/Gyn) and the neonatal portion of your Pediatrics rotation.

Directions:
Same as Rhode Island Hospital.

Parking:
You will only be allowed to park in the W&I parking lot during your OB/Gyn rotation. The W&I parking lot is located on the right on Dudley St. after you pass under the RIH Bridge Building and cross the Dudley St./Gay St. intersection.

The Miriam Hospital
164 Summit Avenue, Providence, RI 02906

The Miriam Hospital is the site for rotations in Medicine, the general surgery portion in Surgery, and Psychiatry.

Directions:
From the Brown University campus, drive north on Hope St. towards Pawtucket. Turn left onto 5th, 6th, or 7th St. and continue for a few blocks until you reach the hospital.

From I-95 heading south, take exit 25, Smithfield Ave./North Main St. Turn left onto Foch St. Follow the hospital signs. Turn right onto Nashua St., then turn left onto Frost St. At the traffic light, turn left onto North Main St. Continue on North Main St. Turn right onto 5th, 6th, or 7th street and continue for a block until you reach the hospital.

From I-95 heading north, take exit 24, Branch Ave. Bear right onto Branch Ave. Continue on Branch Ave. until you reach the traffic light at Branch Ave./North Main St. Turn left onto North Main St. Continue on North Main St. Turn right onto 5th, 6th, or 7th street and continue for a block until you reach the hospital.

Parking:
Park in the Sears lot off of Main St. There is a shuttle that will take you back and forth to the hospital. On the weekends, you may park in the employee lot between 7th and 8th St.
Memorial Hospital of Rhode Island
111 Brewster Street, Pawtucket, RI 02860

Memorial Hospital is the site for rotations in Medicine and Family Medicine.

Directions:
From the Brown University campus, drive north on Hope St. towards Pawtucket. Continue on Hope St. as it turns into East Ave. Stay to the right as the street splits to George St. on the left. Turn right onto James St. Turn left onto Pleasant St. At the traffic light at Pleasant St./Division St., turn right onto Division St. and cross the Division Street Bridge. Bear right onto Water St. and you will merge onto School St. Continue on School St. and move into the left lane and follow the hospital signs. Turn left on Beechwood Ave. Memorial Hospital will come up on your left.

From I-95 heading south, take exit 29, Downtown Pawtucket. Bear right onto Broadway then bear left onto Underwood St. Turn right onto Walcott St. Turn left onto Summit St. Turn left onto Division St. Turn right onto Brewer St. Memorial Hospital will come up on your right.

From I-95 heading north, take exit 28, School St. Turn right onto School St. Continue on School St. and follow the hospital signs.

Parking:
There is a hospital employee parking lot on 555 Prospect St., located a half-mile away. From there you take the shuttle service, which picks people up every 10-15 minutes. To reach the parking lot, do not turn left on Beechwood Ave. as noted in the directions above. Instead, continue on School St. and you will see the fenced-in parking lot on your left three-quarters of a mile down the street as you round the left curve in the road.

The parking lot in front of the hospital is reserved for patients and visitors, but you can park there on the weekends as a student.

Avoid parking in the surrounding four blocks of the hospital where there are signs displaying “permit parking only.” These areas are strictly enforced. Many medical students before you have received many parking tickets for failing to obey these signs.

JMS says: Beware! The speed limits in Pawtucket are strictly enforced, especially around the hospital. The cops will pull you over for speeding even if you are only going 26 MPH in a 25 MPH zone.
Providence Veterans Administration Medical Center

830 Chalkstone Avenue, Providence, RI 02908

The VA is the site for rotations in Medicine, the general surgery portion of Surgery, and Psychiatry.

Directions:
From the Brown University campus, drive down College St. Turn right onto North Main St. Turn Left onto Smith St. (a.k.a. Route 44) as if you were visiting the State Capitol. Remain on Smith St. for a while until you come to a nasty little intersection with a 7-Eleven. Bear left onto Chalkstone Ave. and the VA will come up on your left.

Parking:
Park in the surrounding parking lots. No problem.

Note: Davis Softball Park is right next to the VA. Many veterans refer to the hospital as “Davis Park.” So when you are doing the mini-mental status exam and the patient replies to “where are we?” with “Davis Park,” he’s right! Do not think that he is not oriented to place.

Butler Hospital

345 Blackstone Boulevard, Providence, RI 02906

Butler Hospital is the home of the Psychiatry clerkship and is a potential site for your rotation in Psychiatry.
Directions:
*From the Brown University campus*, drive north on Hope St. towards Pawtucket. Turn right onto Lloyd Ave. Continue east on Lloyd Ave., until it ends at Blackstone Blvd (the big street everyone jogs on). Turn left onto Blackstone Blvd. Drive north on Blackstone Blvd. and the entrance to the Butler Hospital campus will come up on your right. Turn into the campus and follow the main road, which leads to the hospital.

Parking:
Park in the surrounding parking lots. No problem.

---

**Emma Pendleton Bradley Hospital**

1011 Veterans Memorial Parkway, East Providence, RI 02915

Bradley Hospital is a potential site for your rotation in Psychiatry.

Directions:
*From I-195/US-44 heading east*, take exit 4 to Riverside. Take the ramp to Riverside and bear right onto Veterans Memorial Parkway. Continue on Veterans Memorial Parkway for a while (through some really nice scenery) and Bradley Hospital will come up on your right.

Parking:
Park in the surrounding parking lots. No problem.
FOOD

Eat when you can. Simple enough. Given the responsibilities, obligations, and commitments you have in the hospital though, you soon realize how much you take for granted normal mealtimes. That being said, there is no reason for you to starve and there are ways to help keep yourself fed... most of the time.

Rhode Island Hospital / Hasbro Children’s Hospital
Lunch is also provided at noon conferences during your Medicine rotation. Otherwise you are on your own.

Women and Infants’ Hospital
You are on your own. The food at W&I is pretty good and relatively inexpensive considering its quality.

The Miriam Hospital
You are on your own here also. The sandwiches are good, but pricey. Lunch is also provided at noon conferences during your Medicine rotation.

Memorial Hospital
Arguably some of the best food among the hospitals. Lunch is also provided at noon conferences during your Medicine rotation. The rest of the time, you are on your own.

VA Medical Center
Lunch is provided at noon conferences three times a week during your Medicine rotation. Breakfast is provided and sometimes lunch during your on-call rotation.

Butler Hospital
The controversy continues on the quality of food here. It has definitely improved and is worth trying.

Bradley Hospital
Arguably some of the best food in the hospital system, you are unfortunately on your own here.

THE PLAYERS

The players – nurses, attendings, residents, interns, ancillary services, and clerks (i.e. you) – are all important members of the healthcare team. Treat all of them with respect, and hopefully they will do the same to you.

Nurse (RN)
This includes operating room nurses, emergency nurses, intensive care nurses, and floor nurses. They are listed first because without them, none of us could be a doctor. Remember, they have been doing their job longer than you have known how to perform long division. Listen to them, ask them for help, and learn from them. They can teach you a lot.

Nurse Practitioner (NP)
You will often see NPs in the outpatient setting working with doctors. You may also see them in the hospitals as well. She is similar to a doctor in that she sees patients, does histories and physicals (H&P), and prescribes medications. However, she will also consult physicians for medical guidance, or even transfer patient care to the doctor if the patient’s medical problems become too complex to manage.
Certified Registered Nurse Anesthetist (CRNA)
Th CRNA is a nurse that has received a degree in nursing, and then completes an additional two years of training in anesthesia. The CRNA assists the attending anesthesiologist.

Physician Assistant (PA)
These are medical personnel trained to assist physicians. PAs began as a natural extension of military medics who, after extensive training and experience, found themselves with a lot of skills, but no nursing or medical degree to use them. Instead, they are somewhere in between. The PA position has been a natural springboard for these highly trained folks, and now PAs are trained through the military and many universities with a two-year basic science and clinical curriculum resulting in a PA degree. They may do H&Ps, prescribe medications, perform bedside procedures (placing central lines, performing lumbar punctures), and treat or assist in a diverse range of medical applications.

You will mostly see PAs working with doctors in outpatient settings. In the hospital, they often work in intensive care units (ICU) (managing patients in the neurosurgical ICU, while the residents perform surgeries), the emergency department, or see consults for physicians. PAs have been described as perpetual residents who actually get to go home at night. They do a lot and can teach you a great deal.

Attending
This person is the doctor with whom the buck stops. She has completed all the necessary training to call the shots, be that residency, residency plus fellowship, residency plus fellowship plus research or what have you. To you, she is the last word on patient management… unless your resident or the nurse questions the decisions being made, in which case you are just caught in the middle until management parameters are worked out (such is the way of medicine in the HMO age…). The attending is a great source of medical information (for obvious reasons), advice on future career decisions, and the person whom you will eventually ask for a letter of recommendation.

Fellow
This person is the doctor who has already completed residency, but is pursuing additional training in a subspecialty fellowship. You will often see her on a consult service or running a surgical case with the attending supervising. She knows as much as your resident and more and can be a great source for medical information and career advice.

Resident (PGY-2+, R2+, a.k.a. house officer / housestaff)
This person is the doctor-in-training who has more responsibility than you want to think about right now. He is in charge of your team and is the person with all the answers. He is also the person who may inadvertently pimp you simply from thinking aloud. Forgive him. He is sleep-deprived. He is also the person often considered responsible for your education. They are more experienced and have less scutwork to do (see “intern”), so you should hang out with the resident and learn from him.

Intern (PGY-1, R1, a.k.a. house officer / housestaff)
This doctor-in-training is the first-year resident who is dumped upon to do everything, learn everything, and on top of all that – teach you. They are often even more sleep-deprived than the resident, but they will teach you how to be a good intern, and if you stick with them during Quarter One you will learn many procedures. After Quarter One, however, you may discover that many procedures are ultimately scutwork, and that your intern, as great a guy as he is, will not have much time to teach. Thus, hang out with your resident after you feel comfortable with intern work.

Cardinal Rule: Always ask your intern if he needs help, because he probably does and will appreciate it. Also, always offer help to your intern before your resident, otherwise you look like you are not only brown-nosing, but also do not provide much help to your team.

Ancillary services / Support staff
This includes, among others, physical and occupational therapists, case managers, respiratory therapists, central transport, and phlebotomists. You will spend little to no time with them, but they are invaluable to patient care in terms of rehabilitation, arranging for discharge, and dealing with acute care issues (you will become familiar with some alarm bells ringing, and then a voice over the hospital address system: “Respiratory therapy, stat, <room number>”).

**Sub-Intern (a.k.a. Sub-I, Extern, Acting Intern, A-I)**
This person is a fourth-year (sometimes a third-year) medical student, usually your classmate although sometimes someone from a different medical school. She is knowledgeable and is gearing up to be <gulp> a real doctor. In fact, the residents on your team will expect your sub-I (pronounced “sub-eye”) to perform at the level of an intern.

Depending on the rotation you are on, your sub-I may be “auditioning” in hopes of earning a residency position in the program you are rotating through or simply to check out the city. If such is the case, forgive her for any blatantly obvious statements meant to be seen as teaching points by the rest of the team. She is trying to demonstrate her competency, impress the team, and add to the overall goal of patient care. Help your sub-I, and your sub-I will help you.

**Clerk**

This is you! Woo hoo! You are the third-year medical student… the clinical clerk. For all the questions that are answered with, “Why don’t you present that to the team tomorrow morning?” and all the scutwork that somehow seems to fall upon you, you are in an enviable position. For the last time in the rest of your medical career, you have the freedom to ask any question you want and to say, “I don’t know” without the icy stare of an attending trained on you. You are not expected to have all the answers. You should be learning as you help the team. Anything you do know can only be considered as a contribution to your team.

*Note: A little disclaimer about the use of gender-specific pronouns: No, not every attending is a woman and not every resident is a man, but wouldn’t you find it annoying reading “s/he” and “him/her” 238 times? Course, practically every patient at the VA is a man... ;-)*

---

**TEACHING VS NON-TEACHING**

I am almost tempted to write, “The hospitals we go to are teaching hospitals, while the other ones are not, so don’t worry about the difference,” and leave it at that. But you should know that there are two main types of hospitals in this country and know what the difference is between them.

Teaching hospitals are hospitals that teach (obviously). Not all of them are affiliated with medical schools (although it helps). All of them train residents at various stages in the medical education pipeline. The greatest distinction that a teaching hospital has is that the primary, day-to-day care of patients is carried out by residents. Because of this arrangement, many hospitals divide large services into teaching and private (read: non-teaching) services, allowing doctors with admitting privileges to decide whether they or the residents will oversee their admitted patients. For example, IMIS is a hospitalist group at either RIH or TMH and may manage patients admitted to their name with residents providing physician coverage (hence, teaching service) or provide patient care without residents (hence, non-teaching).
Non-teaching hospitals do not have residents. They probably should not have medical students either (well, not a clerkship at any rate). Doctors who admit to non-teaching hospitals round on their patients themselves and do not go through the “middle-man” of the resident.

There are, of course, variations on these two broad characterizations, but in general that is what you should know about teaching versus non-teaching hospitals.

**TEAMS VS. SERVICES VS. SUBSPECIALTIES**

**Teams**
Until you have completed your training, you will work with colleagues and peers as part of a team taking care of your patients (and even after you complete training it is rare that anyone in our generation will open a solo practice). Knowing whether you are on a team that is part of a general service or a subspecialty service team can be a little confusing. After a few weeks (or months), you may come to understand the general organization of the Brown-affiliated system—but you will make sense of it all more quickly if you remember the following: almost everything runs in teams. Also, teams have a hierarchy and for a team to be effective there has to be communication between the levels of the hierarchy. Whatever you do, every level of the hierarchy should know about it.

**Services**
Services are broken down into one or more teams, depending on which hospital and which service you are on. It is important to know that a service is more or less a medical department and can be divided into more than one team, so you can understand how to navigate consults and work efficiently within the hospital.

For example, the Medicine service at RIH is divided into eight teaching teams (subdivided into four teams on Medicine Team A for private, teaching patients and four teams on Medicine Team B for non-private, teaching patients), a non-teaching team (for patients who are not considered to offer much to resident medical education and are cared for by hospitalists), and a private team (which is really a private service for community-based attendings who prefer or whose patients prefer not to be teaching patients).

**Subspecialties**
Like general services, subspecialties are their own little departments within each hospital. They are usually comprised of only one team. For example, the Neurosurgery team is synonymous with the Neurosurgery service (the service has only one team).

**ACLS & ATLS**

**ACLS (Advanced Cardiac Life Support)**
You have the opportunity and are required (by the medical school, although not by the hospitals) to become ACLS-certified before you start working on the wards.

The ACLS course is taught over the first few days of orientation before Quarter One. The days are spent in lecture, practicing intubation on mannequins, and watching videos. You will review Basic Life Support (CPR, choking), learn the ABCs (airway, breathing, circulation) of the ACLS algorithm, learn how to use an Automatic External Defibrillator (AED) – like what the airlines are carry now, and learn the ACLS algorithms for administering electrical shocks and medications to a patient with an arrhythmia or in cardiac arrest.
Do not get too flustered by the lectures and the gobs of numbers and ratios and drug names thrown at you. Your head will swim with how many parts per million of epinephrine to give through what route but in the end it is more important to memorize the basic algorithms. The dosing of medications will become second nature when you are a doctor and you have to run codes. For now, just get a general sense of how things run, and you can always refer to your handy-dandy reference cards for more information.

Regardless, the ACLS course is overall a lot of fun. You get to run several mock codes with your classmates, and for those who are not Emergency Medical Technicians (EMT) or who are new to the wards, it is nice to figure out what your role as a medical student could be in a code. There is a fifty-question multiple-choice exam at the end of the course that you must pass in order to be certified. Certification lasts two years.

ATLS (Advanced Trauma Life Support)
There is currently no ATLS course requirement at Brown. Many of us will take this class as part of our residency orientations. You will have a chance to review the ATLS algorithms during your Surgery clerkship if you are assigned to a trauma rotation. There is a rotating ATLS book, which you should at least skim and of course, while on trauma, you will see ATLS in action.

Codes
These are hospital emergencies for various situations. Some you will hear during your rotations, while others you hope you will never hear. Below are two you will likely hear on the wards.

Cardiac arrest/medical emergency. All medical personnel in the area and the Code Team should respond. Usually, this is the surgical and/or on call medical team. The first person there starts with the ABCs of the ACLS algorithm. The doctor running the code does not actually do anything except call the shots and delegate duties. No medical student is expected to run a code, but you should do whatever you are told and whatever you can to help.

Code Red (formerly Code Drill)
Fire. In case there is a fire or suspected fire, patient and unit doors are closed to keep the area isolated and the patients safe, while the Fire Department responds to the call to address the situation.

SCUTWORK & PIMPING

Scutwork
Scutwork is as scutwork sounds: It’s all the jobs of patient management that just have to get done and don’t get much glory. These tend to be jobs you are expected to do as an intern, so the wards is an excellent place to perfect your “scut skills.” Scutwork can encompass procedures (IV insertions, arterial blood gases, inserting nasogastric tubes, removing staples and sutures) as well as paperwork (getting the morning labs) and miscellaneous jobs (e.g., “bird-dogging” an x-ray, meaning you follow the technician,
wait for the film to be developed, then run it back to your resident; or running an arterial blood gas to the lab).

Three things to know about scut work:

1. It’s actually not that bad.
2. It’s actually pretty important.
3. It’s not scut unless you are being used as a scut monkey.

In fact, during your first quarter, you should jump at the chance to be scutted because you need to know how to do all these things and more by the time you are a doctor, and there is no better time to learn than now! Plus, you do not want to be a second-year resident asked to put in a Foley catheter because no one else can get it in and then realize that you have inserted a Foley only once before.

As long as you are learning and refining your skills, scutwork is not scutwork. It’s about your mentality and goals.

It is the scut monkey kind of scut that you have to be on the lookout for and stop before you get stuck with more. If you are supposed to be at a conference, or if you are reading for an exam later in the week, or if you are supposed to be asleep – that is, if you are being taken advantage of by your seniors simply because you are the junior-most person around, then you are being scut monkey–scutted and you should not be. At the same time, scutwork can be a powerful bartering chip in exchange for teaching later on (as in: “I’ll be happy to go look up the labs for you if we can sit down later for 20 minutes and talk about COPD.” – this usually works). It can also earn you respect and gratitude from your team from helping them out.

Learn to recognize when you are being used as a scut monkey so that you can remove yourself from the situation and get to work! Try to identify a senior early on to discuss your concerns and/or step in if needed. It can make all the difference in how much you get out of a rotation, which is the bottom line for you as a medical student.

Pimping
You’ve heard about it. You’ll have it done to you. You’ll do it to someone else, too. And so it goes on.

Pimping, in its purest form, is a sort of tortuous Socratic method of teaching in which some senior person (who can be anyone, but most commonly an attending, chief resident, or an overzealous junior resident) asks you questions until you no longer know an answer. The worst part about true pimping, and the part which we all hate, is that it is done publicly and without regard to what you actually know (e.g. it’s almost guaranteed that if you spent last night reading about atrial fibrillation that in the morning you’ll be asked about compartment syndrome).

Fortunately, pimping in our medical school is kinder and gentler than the stories would have it be, and generally does not happen that often.

For the person getting pimped, it is important to remember that:

♦ You are smart.
♦ You are smart enough to say, “I don’t know” when you do not know something rather than try to B.S. your way through an answer.
♦ You are a member of the team and you have something to contribute, even if it is acknowledging that you do not know something so that everyone else on the team who was afraid to ask (or answer) a question can benefit from hearing the answer.
◆ You have the right – **and the obligation** – to tell someone when his pimping has crossed the line into condescension and triviality.

**If that person dismisses your constructive criticism, you should feel comfortable letting Alex Morang or Dean Gruppuso know what you have experienced.**

◆ You are here for an education and unless you hear an answer after being pimped, you should ask for one.

Even more important to remember is that with few exceptions, your residents also hated getting pimped when they were in medical school (many will, in fact, apologize before asking you whether you know something), and that quite often they do not even realize that they are pimping you.

The evolution of the pimp is usually innocuous and starts with a question the resident has, is translated into thinking aloud, which is then transformed into a question to the medical student because it will not only answer the resident’s question, but will also teach the medical student something.

As long as you are learning, that’s what matters.

Beware of the rare but nasty trap of being too successful during a pimping session – especially if you happen to end up knowing more than your seniors on a particular topic. The medical hierarchy matters a lot, even at Brown. In this case, the only thing to do is to try to be humble without playing dumb, and by all means try to get out of the situation as soon as possible. That being said, if you know about something that may contribute to the knowledge of the team, you should share it. Just share it in a humble sort of “I was reading about such and such, and it talked about such and such.” (if you are wrong or contradicted, at least you can blame the book, but also show your seniors that you at least invested some time into reading)

---

**GLOSSARY OF COMMON ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Unacceptable</th>
<th>Description</th>
<th>Acceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dig</td>
<td>Digitalis/Digoxin</td>
<td>Write &quot;Digoxin&quot;</td>
</tr>
<tr>
<td>IU</td>
<td>International Unit</td>
<td>Write &quot;international unit&quot;</td>
</tr>
<tr>
<td>Lack of leading zero (.X mg)</td>
<td></td>
<td>Always use a zero before a decimal point (e.g., 0.3 mg is acceptable)</td>
</tr>
<tr>
<td>Trailing Zero (X.0 mg)</td>
<td></td>
<td>Never write a zero by itself or after a decimal point (e.g., 3 mg is acceptable)</td>
</tr>
<tr>
<td>MS or MSO₄</td>
<td>Morphine Sulfate</td>
<td>Write &quot;Morphine&quot;</td>
</tr>
<tr>
<td>MgSO₄</td>
<td>Magnesium Sulfate</td>
<td>Write &quot;Magnesium&quot;</td>
</tr>
<tr>
<td>Nitro</td>
<td>Nitroglycerine or Nitroprusside</td>
<td>Write &quot;Nitroglycerine&quot; or &quot;Nitroprusside&quot;</td>
</tr>
<tr>
<td>Qd or QD</td>
<td>Daily</td>
<td>Write &quot;Daily&quot;</td>
</tr>
<tr>
<td>QID</td>
<td>Four times daily</td>
<td>Write &quot;Four Times Daily&quot;</td>
</tr>
<tr>
<td>QOD</td>
<td>Every other day</td>
<td>Write &quot;Every other day&quot;</td>
</tr>
<tr>
<td>U</td>
<td>Unit</td>
<td>Write &quot;units&quot;</td>
</tr>
<tr>
<td>Microgram</td>
<td></td>
<td>Write &quot;microgram&quot;</td>
</tr>
</tbody>
</table>
SOAP Note
Basically a daily progress note on the patient. The details of the SOAP format are as follows:

S = Subjective (overnight events, what the patient tells you about how they are feeling) – Usually includes a brief chief complaint, brief history of present illness, medications. May include pertinent past medical, surgical, family, and social history.

O = Objective (what you find on the vital signs, physical exam, labs, tests) – Objective information.

A = Assessment (briefly recap the clinical situation in a few lines) – Usually a one-line, run-on sentence.

P = Plan (what we are going to do about each and every issue) – Organized either by system (usually used in the ICUs) or by problem (usually used on the floors).

Some attendings / residents like it if you outline the plan by system, i.e. running through neurologic, cardiovascular, pulmonary, renal, heme, GI, GU, musculoskeletal, infectious disease, etc. and describing any problems if it exists or do not exist, then formulating a plan for any problems. This method of running through systems ensures that you do not forget any problems, and it is a very thorough technique.

However, other attendings / residents do not want to hear every system if it is not involved in the current plan of care. Hence, they prefer a problem-based presentation, where you talk about the current medical issues (i.e. a patient with congestive heart failure might also have issues such as coronary artery disease, hypertension, COPD, diabetes, etc.). For each problem, there needs to be a formulated plan for how to address that problem.

The Assessment and Plan are often written together as A/P.

The length and style of a SOAP note varies with each clerkship (shorter notes in Surgery, longer ones in Medicine), but the idea is the same. Look in the patient charts to see the type of notes expected of you. Get used to writing one and feel confident telling your resident you can write the SOAP note on a patient.

An example of a SOAP note in Surgery:

S: Pt doing well. c/o minimal abdominal pain. No F/C. No CP. No SOB. No N/V. Tolerating PO. +flatus. No BM.

O: Tm 98.9 HR 60-70 BP 100-120/50-60 R 16-20 96% RA
I/O: 2200/1800 LR@100cc/hr UOP: 1450
RRR, no M
CTAB
Soft, NT, ND, dressing c/d/i
No edema

A/P: 46 yo F POD # 2 s/p open CCY doing well.
D/C IVF
D/C foley
Amb/OOB
Adv diet as tolerated
Start home meds

An example of a SOAP note in Medicine:

S:  Mr. Chan is a 25-year-old Asian male with PMH of asthma who presented with shortness of breath for one week. Patient also complained of wheezing, cough with yellow-brown sputum, and chest tightness secondary to cough. These symptoms began suddenly 7 days ago. No improvement with repeated use of albuterol inhaler. Pt denies fever/chills/sick contacts. Patient never hospitalized nor intubated for asthma. Started on oxygen, prednisone, respiratory protocol.

Pt reports feeling better this AM compared with admission. No fevers/chills. No CP this AM. Pt continues to complain of SOB, cough, and wheezing. Tolerating PO well.

PMH: asthma FHx: DM all: NKDA home meds: Advair qday
SocHx: nonsmoker, occ. EtOH, denies rec. drug use Albuterol PRN
lives with parents, who both smoke
has 2 cats and 2 dogs, since childhood
baker x5 years

O:  T 99 HR 75 RR 20 BP 110/60 91% 2L NC
General well-groomed (good looking), young male sitting upright in bed; no signs of respiratory distress
HEENT NC/AT PERRLA EOMI sclerae anicteric
neck supple no LAD no JCD
CV RRR nl S1/S2 no m/r/g
Pulm CTA left wheezes right lung base
Abd soft NT ND +BS no HSM
Ext warm no c/c/e
Skin no rashes/lesions
GU/rectal deferred (thank goodness)
Neuro A+Ox3
motor 5/5 BUE, BLE
reflexes 2+ throughout
sensory grossly intact
gait normal

labs: pending
CXR: normal
EKG: normal

A/P:  25- year-old Asian male with PMH of asthma who presents with dyspnea & cough for seven days feeling better with continued dyspnea, cough, and wheezing.
1. Dyspnea – SOB episodes resemble prior asthma attacks. No known acute triggers, although pt is constantly exposed to irritants such as cigarette smoke (home), pets (home), and flour (baker). Unlikely PE, as pt has no FHx nor PMH of hypercoagulable state; no recent hx of stasis. Most likely acute exacerbation of asthma, perhaps due to underlying respiratory infection as trigger (bronchitis). Continue treatment with prednisone, respiratory protocol.
2. Chest pain – Normal EKG. Chest tightness likely secondary to labored breathing x 7 days.
3. Prophylaxis – Continue Protonix 40 mg PO daily. Heparin SQ TID
4. Dispo – Full code, continue respiratory protocol
You should always date your notes. Also, make it a habit to time your notes, as it can be helpful to folks who visit your note later.

What Color Pen to Use

Black. *Always* use a black pen.

Yes, you will see residents and some attendings use blue. Do **not** follow their example. It’s similar to those residents and attendings who don’t wash their hands or wipe their stethoscopes between patients. Just because they have a bad habit doesn’t mean you should pick it up. Some people think that it’s the attendings’ or residents’ desire to be distinctive.

Anyway, use black ink. *Always.* Why? I don’t really know, but some people get really sensitive about it and you just don’t need to risk incurring that kind of wrath.

And of course, **never** use pencil.

How to “Erase” a Mistake in a Note

You don’t.

A patient’s record is a medical and legal document, and you should never “erase” any mistakes or scratch them out so that they are illegible. Instead, draw one line through the words you do not want to use anymore, followed by the word “omit” or “error.” Sign your initials next to it.

Example:

58 yo M with **CAD, AF, <error GC> DM** presents to RIH ED with 3 day h/o abdominal pain.

How to Sign Your Name

Like this:

First name/initial Last name, BMS-III <pager number>

*BMS=Brown Medical Student or “Best Medical School” if you’ve read The House of God, III=third-year*

And yes, **always** write your pager number!

You will discover that many doctors’ signatures are so illegible that no one knows who wrote a set of orders. *Don’t you become one of those doctors!*

Example signature:
Be responsible for your actions and take responsibility for your patients by legibly writing your name and pager number so that nurses and other housestaff can contact you with questions. Once you do, you will soon discover how important the medical student note is. Staff will even compliment you on the neatness of your handwriting, and it always helps to get on the good side of the nurses. I cannot tell you how many times I have been paged from the pharmacy or the floor to be asked about a set of orders either I, my intern, my resident – or sometimes even my attending – has written!

Co-Signatures

Yeah, yeah – you’ve been signing your John Hancock all your life, attesting that you did fill out your taxes yourself, that you’re old enough to drive, that you’ll pay the amount shown on your next credit card bill (though this last issue is often iffy) – what’s the big deal?

Everything.

For perhaps the first time in your life, your signature will mean more than “<insert your name> was here.” Every time you sign your name to a piece of paper that is part of a patient’s medical record, you are attesting to the fact that you did order or do whatever it is you wrote. Your signature carries a lot of power and RESPONSIBILITY. Use it wisely – sign only what you have written, and after you write something, always sign it!

Until you become an MD in your own right, however, there is one signature more important that yours: that of the MD or DO supervising you. That person could be your attending, a resident, your intern, or your preceptor. Whoever it is, it is imperative that that person co-sign everything that you sign!

Now while medicolegal experts will tell you that it is your supervisor’s responsibility to read what you have written and to co-sign your notes, you in good conscience, as not only a medical student but as a member of a healthcare team, need to take responsibility to have your notes co-signed. You should also take responsibility and make sure as much as you can that your supervisor reads what you’ve written. Often our senior doctors will sign reflexively without reading your note – it’s their sign of confidence in you and because they are often too busy to read your beautifully crafted work.

True, if you make a mistake in a note and your supervisor co-signs it, it will be your supervisor’s ass that gets strung up and not yours. However, you are just as responsible for making sure that you don’t get your supervisor into trouble that way.

Be a team player. Reread your notes, make sure your notes are co-signed, and ask whether your co-signatory actually read what you wrote.

PATIENT PRESENTATION

Pre-Rounding

Pre-rounding is the time before rounds when you can gather information on the patient, including what happened to him overnight and how he is feeling, as well as a focused physical exam. For example, if your team meets at 8am for morning rounds, most students will arrive at the hospital around 7am to pre-round on the two to three patients they are following. You do not have to have the notes written by the time rounds start (if you do, the better), but you should have a good general sense of what the pertinent issues are and what course of treatment should be pursued so you can present the patient to your team during rounds.
Things to find out while pre-rounding:

- **Vital signs:** They are called “vital” signs for a reason! These are the first things you should check before entering a patient’s room. Vital signs include the maximum and/or current temperature (was the patient febrile overnight?), heart rate, blood pressure, respiratory rate, and oxygen saturation. A current movement in medicine is to include “pain” as the “fifth vital sign” i.e. assessing what level of pain (scale of 0-10) the patient is currently in. You should also check ins and outs (I/Os), which you can find on the patient’s flow sheet to learn if the patient is eating/drinking and urinating enough.

- **How the patient fared overnight:** Ask her how she is feeling, ask relatives who are in the room what they think of the patient’s progress, read the chart for nurses notes or notes from consulting services, ask the third shift nurse before he takes off or ask the nurse who just came on for a quick recap of the sign out (it is always helpful to check with the nurses).

- **Labs:** Record any early morning labs that were drawn or labs from the previous night and make note of any labs pending.

- **Management:** Look in the chart for any new orders written overnight (i.e., if the patient spiked a fever overnight, did the night float service write for blood cultures or to start any antibiotics?).

- **Medications:** Look in the medication chart (a.k.a. MedBook, a.k.a. Cardex) for what the patient received (e.g., did this patient complaining of pain end up asking for and receive 4 doses of Tylenol #3 last night?). It is important to make sure that even though a medication has been ordered that it actually has been taken. If there is a date with initials, then the patient took the medication. If there is a date and initial circled, then either the patient refused (why?) or the medication was held (again, why?).

- **Physical exam:** Perform a pertinent physical exam (i.e., does this patient with CHF still have wet-sounding lungs this morning after receiving Lasix (furosemide) last night?)

---

**Presenting a Patient**

Presenting a patient – be it during work rounds, at noon conference, at morning report, to your intern, to your team, or to your classmate – is one of the most important skills of medicine you will learn this year. If you know your patient well enough that you can present him to anyone, then you have done half your job already.

Presenting a patient involves explaining the patient’s chief complaint, the history of the present illness, past medical history, current medications, allergies, findings on physical exam, and other pertinent issues.

One frustrating part of presenting a patient is that the format is very resident/attending-dependent. Some attendings only want you to present positive findings on physical exam. Others want you to describe everything you did on the physical exam to make sure that you performed all possible maneuvers (including rectal exam). Some attendings want all possible details, including if the patient has any pets at home. Others roll their eyes when you mention the patient’s pet turtle (potentially relevant with *Salmonella* toxicity!). Residents
and attendings are often very picky about their ways of presentation – probably because they were taught certain methods that they found useful and helpful, and now they want to pass their knowledge on to you.

Perhaps the most important thing about your H&P is that you collect all the information, and have it available in case you are asked about it, but did not necessarily include it in your formal presentation (unless it was relevant). As time goes on, you will get a better sense of what is relevant, but it is safer at the beginning to err on the side of more information rather than less. Some attendings do not mind if you refer to your notes to check on some details while presenting, while others want you to have all details memorized (except for nit-picky lab data).

A general way of presenting this information on the morning following the patient’s admission (basically, reciting aloud the H&P):

1. Chief complaint
2. HPI (what happened? why is the patient here?)
3. Past Medical History, Past Surgical History, Birth History if relevant (pediatrics), Obstetric History if relevant (obviously just in women)
4. Medications, Allergies
5. Social and Family Hx
6. What has been done since admission into the ED, including lab results
7. How the patient did overnight
8. Vital signs and physical exam
9. Assessment (one run-on sentence summary of who the patient is, why he is here, what has been done): “Steven is a 25 year-old male with a history of asthma presenting with 3 days of shortness of breath, admitted with asthma exacerbation now being treated with prednisone.”
10. Plan (what are you going to order, what studies are being done, who is being consulted) either by system or by problem. Some attendings/residents like it if you outline the plan by system, i.e. running through neurologic, cardiovascular, pulmonary, renal, GI, heme, musculoskeletal, infectious disease, etc. and describing any problems if it exists or does not exist. This method of running through systems ensures that you do not forget any problems – it is a very thorough technique. However, other residents/attendings do not want to hear every system if it is not involved in the current plan of care – they prefer a problem-based presentation, where you talk about the current issues (i.e., a patient with HIV might have issues such as pneumonia, rash, joint pain, headache, etc.).

Order of presentation on subsequent mornings:

1. Brief reminder of the patient and his problems (similar to the Assessment, #9 above)
2. Pertinent events from the day before
3. Events overnight
4. This morning: vital signs, pertinent physical exam findings, labs
5. The plan for today

---

Resident/Attending Short-term Memory

A note about senior resident amnesia during morning rounds: Do not get discouraged or flustered when the following happens:
Medical student Steve: last night, Mr. Kim was comfortable, this morning he has no complaints. Vital signs were – he was afebrile with T99, pulse 60s to 70s, BP 110s over 80s to 90s, Pulse Ox 96 to 99 percent, Ins 590, Outs 400 plus 2 bowel movements. On physical exam...

Senior resident Kevin: Wait! You forgot to mention his temperature. Was he afebrile?

Medical student Steve: He was afebrile with a Tmax of 99. On physical exam his belly remains soft, nontender, nondistended... There's a consult from GI in the chart in which they say...

Senior resident Kevin: Oh, wait! Was he afebrile last night?

This is just “senior resident short-term memory loss.” It most often occurs when your team is post-call, but can happen during any episode of rounding. Do not take it personally – certainly try not to think that your resident has completely lost it or was not listening. They were listening, but they have a bazillion other things to worry about and are tired, so sometimes they will repeat themselves. Be kind to them (like you are to animals in a zoo) – you are going to be one someday, too.

DICTATIONS

On your sub-internship and psychiatry clerkships, you may do some dictating. Basically, that means audiotaping (or typing, at some psychiatry sites) the clinical hospital course of a patient after discharge. The dictations are transcribed by some magical transcription people someplace else and formatted into the DISCHARGE SUMMARY.

You will notice your interns dictating, dictating, dictating...and dictating. You will also notice that whoops of joy over a patient’s discharge are often followed with groans of disappointment upon realization that the chart has not yet been dictated.

You will be required to dictate charts when you are an intern. So the question arises – when do you learn to dictate?

Most everyone learns how to during their sub-I because then, as an acting intern, you take full responsibility for your patients from admission to discharge, including dictating the discharge summaries. Others learn during their Psychiatry rotations, when students dictate their patients either over the phone (like at Butler) or are typed and saved on disk (like at RIH).

That said, if you would like the practice and if you like your intern and would like to help him out, offer to try dictating a patient or two while you are a clerk. Be sure to state your name (spell it) and say that you are dictating on behalf of <your intern’s name> on behalf of <your attending’s name>.

YOUR GEAR

As a general rule, while there are places to leave your gear, there is no secure locker other than on your OB/Gyn clerkship for it. Avoid bringing valuables to the hospital. Otherwise keep it on your person.

Clothes
Knowing what to wear is a combination of common sense, courtesy, and comfort. Basically, unless you are wearing scrubs, you should dress professionally. What constitutes professional attire varies from practice to practice and site to site. A good rule of thumb is to dress how your preceptor and residents dress: most outpatient pediatricians do not wear white coats so you probably will not need to either; most
medicine residents wear scrubs when they are on call so you may, too; most surgeons change into nice clothing for grand rounds, even when they are post-call and so should you.

I know, scrubs are really comfortable, but if the situation dictates professional wear, you should follow suit. How do you know what the situation dictates? Again – dress how your preceptors/residents dress.

For **men**: shirt, slacks, and tie.

For **women**: shirt or blouse, slacks or dress.

Note to women regarding skirt lengths: Again, use common sense. While our short white coats are short enough that any skirt/dress you wear should show from underneath (otherwise you may have forgotten half of your wardrobe that day!), you probably should not wear any hems higher than what you see the residents wear. I remember one medical student who wore a tight, short skirt – something you wear to a club or bar – and while no one directly broached the subject with her, most people agreed that it was unprofessional and hence, inappropriate.

**Footwear**
You will be walking miles upon miles throughout the hospital. A friend of mine wore a pedometer and found out that she walked a few miles already before lunch. Thus, it is a good idea to have comfortable shoes, but also those that look appropriate with both scrubs and your professional clothes.

Lucky for you, there are shoes where form meets function: Clogs. I invested in a pair of black clogs (brand: Merrell’s) from “Jamiel’s Shoe World” at the beginning of my third year. While my feet initially hurt while breaking them in during my surgery rotation, they have since given me months and months of podiatric bliss. I have slipped them off many times during surgeries, wriggling my toes to regain circulation – no fuss with laces. They provide the comfort of tennis shoes, the slip-on and no-lace ease of slippers, and the professional appearance of basic dress shoes. Common brands include Merrell’s, Birkenstock, and Dansko.

Although you have already purchased a lot of things including professional wear, pocket texts, diagnostic equipment, study materials, etc., purchasing a new pair of $70 shoes can be hard to swallow. However, if you can swing it, your feet will thank you.

**White Coats**
So, you should all have received a short white coat during the first-year White Coat Ceremony. They are probably still white, clean, and pristine. Oh, how that will change. Common stains include: blood, saliva, chocolate, barbeque sauce, ketchup, and “other stuff.” There are many purposes to the short white coat:

1. It is part of the medical student uniform.
2. It identifies you to patients as part of the medical team.
3. Its short length identifies you to medical staff as a medical student.
4. It has extra pockets!
5. It protects your professional wear from all of the above stains.
6. Plus, a white coat is fantastic for making almost any outfit that does not include blue jeans look acceptable for being in the hospitals.

About the short length of the white coat… this is part of the medical hierarchy. Medical students, physician assistants, and pharmacy students all wear white coats that end at the hip. This distinguishes you from residents and attendings, who wear the longer white coats that end near the knees. Personally, I cannot wait to get the longer white coats – when the shorter white coat pockets are stuffed with books and tools, they flare out and make my hips look kind of fat.
Of note: even residents at hospitals affiliated with a well-known medical school in Boston have traditionally continued to wear short white coats through residency, while students at a well-known medical school in California receive long white coats from the start (lucky!).

You can get an extra white coat in the basement of RIH (ask for directions to the window once you are down there) and paying the cashier a $10 deposit. She will then direct you to the laundry area where you can try on a coat. Also, during your OB/Gyn rotation, you will be offered a Women & Infants long white coat to use during the clerkship (the kind with the pink and blue W&I patch on the shoulder).

Importance of Nametag/ID Badge

Years ago, Brown mailed the same memo to first- and second-year medical students, asking them to “please wear your nametags in class” so that the professors recognize you. The response back then entailed people tossing the memo into the recycling bins, everyone laughing, and no one wearing their little nametag.

It is much different for third- and fourth-years. Wear your nametag in a visible location at all times. Reasons to wear your nametag/badge:

1. **Parking!** The best reason to wear your nametag. Your ID badge gives you access to your assigned RIH/W&I parking lot, and it is free! Granted, the location is not the closest to the hospital, and you are paying $40,000 for the privilege of working in the hospital, but at least you get parking privileges. Students at other medical schools are not as fortunate, such as Boston, NY, and San Francisco.

2. **Security.** There is a “code amber” (formerly “code pink”) at Women & Infants for infant abduction. When my classmates and I were first notified of the code’s existence, we were both amused and impressed that there was such a drill. I tell you this because it emphasizes the importance of security at our hospitals. It is dreadful that a “code amber” exists, but I am glad it does, just in case. **You should ALWAYS wear your name badge while on hospital property,** especially when you are not wearing your white coat. Not because someone may accuse you of being a baby-snatcher, but because you have a duty to keep our hospitals safe and secure. Do not make the security guards chase you for an ID and do not give people cause to question who you are in a patient’s room. Wear your ID so that the guards can focus on the important issues of protecting our patients and staff and YOU. With all the heightened awareness and security measures in our nation, it is important to have yourself easily identifiable as a hospital worker.

3. **Courtesy.** Don’t you hate meeting someone new and either not being introduced, or introducing yourself and not having them return the introduction? Well, it happens a lot in hospitals. As a courtesy to patients and hospital staff, prominently display your name badge so they know who you are. Relating back to security, people have to know that you are a medical student and not some person off the street who is interviewing and examining patients. You also do not want to misrepresent yourself as a resident or physician, and wearing your name badge will remind patients and nurses that you are a student (and thus they may be less disappointed when you do not know the answers to their questions).

Note: A common ID tool used is the round, clip-on device that attaches to your ID badge via a retractable string. It adds some convenience when you have to swipe your badge into a card reader to gain access to places like the ED, psychiatry unit, or cafeteria from outside – you can tug on your badge, swipe your card, and the string snaps the badge back into place without you having to actually unclip your nametag. However, this device also lets your badge rotate around, so that the front of your nametag is hidden, showing the back of your nametag to everyone, which is extremely unhelpful. A clever solution is to use your hospital ID (e.g. for RIH) and attach a second ID (e.g. your Brown ID or for TMH) back-to-back with the first. This way, when it flips, some version of your picture ID will remain visible.
**General Good Things to Carry**

This applies to most clerkships although each clerkship will also have its own special things to carry (such as a pregnancy wheel in Ob/Gyn), but those are elicited in each respective clerkship section later on in this guide.

- Pens, pens, pens (black ink, of course).
- Notecards/notebook/clipboard, or your own note-taking system
- Diagnostic instruments: stethoscope, reflex hammer, penlight are the basics. Whip out a tuning fork to look like a superstar.
- List of important phone numbers – for example, when I started my Medicine rotation at Miriam, I received an index card with phone numbers for the various floors, labs, and radiology; pager numbers of residents; etc. Very helpful when managing your patients, when you need microbiology lab results, or want to meet up with your team.
- Any clerkship-specific pocket reference (e.g. *The Washington Manual*) and/or pocket texts (e.g. *Sanford*).

**Do I Need a PDA?**

Yes. No. It’s up to you.

Personal Digital Assistants (PDAs, a.k.a. Palm Pilots or Pocket PCs) can be extremely helpful for the clerkship years. Many students use them. That being said, there are students who do well during their third- and fourth-years without having PDAs – the pocket text guides work just as well. However, it is nice to be able to condense a lot of the pocket texts into a small, handheld device – along with being able to store my address book, to-do lists, and calendar in the same gadget (along with some games, for those lulls during rounds or lectures). Also, searching for medications or topics can be easier in contrast to searching the index and pages.

It can be difficult and bulky to carry around many different pocket texts and it is much easier to cram programs like *Epocrates* (similar to a pocket pharmacopoeia), *MedMath* (a quick program that computes many different medical equations and formulas), an immunization schedule, a pregnancy wheel, a medical dictionary, a *DSM-IV*, and a pocket *Cecil’s Guide to Medicine*, and *5-Minute Clinical Consult* (like *UpToDate*, except condensed for the PDA) into a small handheld device.

So… do you need a PDA for the clerkship years? **Definitely NOT.** Is it helpful to have? **Definitely YES.**

Note: With the advent of PDAs, there is also the development of an unwritten “PDA etiquette.”

If someone is directly asking you a question during rounds, it is inappropriate for you to whip out your PDA and look up the answer – the purpose of the question is to test your knowledge base, not how quickly you can find the answer in your little gizmo. If someone asks your intern or resident a question, it is also inappropriate for you to look up the answer in your PDA and then offer it up as your own knowledge. Appropriate times to use your PDA include if the entire team is stumped and wants an answer, or if you want to supplement your own knowledge of a disease and then share this knowledge with the team in a non-ostentatious manner.
Programs for Your PDA
So, you have decided to purchase a PDA, and you have entered all your friends’ contact information in the address book and filled in important dates in the calendar. Now, what medical programs do you need?

Epocrates
An extremely helpful (and free!) program is Epocrates. Available for free download at www.epocrates.com, this is like Tarascon’s Pocket Pharmacopoeia (see below), but with more! Not only does it have drug names and dosages, but it also contains lists of side effects, mechanisms of action, and allows you to determine if a certain drug interacts with another drug. It also has a notes section for you to enter any additional information about each drug.

MedMath
A free program that has formulas for common problems. For example, do you remember how to calculate the ever-important FeNa? Simply type in the lab values into the MedMath program, and the program spits out the numbers to tell you if your patient has prerenal azotemia! Available online, but you can also beam it from one palm device to another.

Any basic medical guide (such as 5 Minute Clinical Consult, The Washington Manual, Cecil’s Guide to Medicine) is like carrying around a pocket Ferri’s or pocket Washington Manual. When you are rounding with your team and forget the details about HUS-TTP, simply whip out your PDA (at an appropriate time – see the section on PDA etiquette) and read blurbs about the features, differential diagnosis, complications, and treatment of this disease. Any one of these programs can be invaluable in supplementing your learning. They are also available on-line, through providers like Skyscape.com.

Below is a list of additional popular free PDA programs and their respective URL, obtained from the Medical College of Wisconsin.

Asthma Treatment Guidelines (http://hp2010.nhlbihin.net/as_palm.htm)
Treatment guidelines by the National Asthma Education and Prevention Program. Includes: Diagnosis, control of contributing factors, pharmacologic treatment, treatment of exacerbations, medication dosages.

Diagnosaurus (http://books.mcgrawhill.com/medical/diagnosaurus/index.html)
Differential diagnostic tool that allows you to browse by organ system, symptoms, or diseases.

Geriatrics At Your Fingertips (http://www.geriatricsatyourfingertips.org/)
Comprehensive reference to clinical geriatrics that provides up-to-date, practical information on the evaluation and management of diseases and disorders most common to elderly people.

Johns Hopkins Antibiotic Guide (http://www.hopkinsabxguide.org/)
Provides diagnostic criteria, treatment regimens, and literature references. Includes clinical relevance, sites of infection, and treatment regimens for pathogens, as well as indications, dosing, adverse reactions, and drug interaction information for antibiotics.

Med Rules (http://pbrain.hypermart.net/medrules.html)
Application featuring useful clinical prediction rules taken from the medical literature.

MedCalc (http://www.med-ia.ch/medcalc/)
Contains 81 formulas and clinical scores including pregnancy calc, BMI, Apgar.

Medical Mneumonics (http://www.medicalmnemonics.com)
This database of mnemonics allows you to browse by discipline, system, body part or search by keyword.
MentStat (http://goldenratiodesign.com/)
Mini Mental State Exam Calculator application for administering and scoring the standard MMSE.

Obesity Guidelines and Treatment Recommendations (http://hin.nhlbi.nih.gov/obgdpalm.htm)
Use this resource to calculate body mass index, assess risk factors for cardiovascular disease and more.

Pregnancy Calculator (http://www.medicaltoolbox.com/products/)
The industry standard pregnancy calculator for Palm OS based handheld devices.

Shots 2005 (http://www.immunizationed.org)

STAT Cardiac Clearance (http://www.statcoder.com/cardiac1.htm)
Application that contains complex algorithms established by the American College of Cardiology/AHA Task Force on Practice Guidelines and the ACP for evaluating patients prior to noncardiac surgery.

StatGrowth Chart BP (www.statcoder.com/growthcharts.htm)
This program calculates growth percentiles based on the June 2000 revision of the CDC Growth Charts for the United States. It includes new body mass index-for-age charts

USDA National Nutrition Database (http://www.nal.usda.gov/fnic/foodcomp)
Calculates calories, carbohydrates, protein and fat, cholesterol, sodium, and vitamins for foods.

USPSTF Preventive Services Guidelines (http://www.acponline.org/annalspsdaservices/collections/index.html)
Common screening and immunization services in the U.S. Preventive Services Task Force guidelines.

Pocket Text Recommendations
These are small reference manuals, which will be handy in every clerkship:

The Tarascon Pocket Pharmacopoeia
A mini-PDR (Physician’s Desk Reference) that fits in your pocket! A helpful guide to look up common drugs, their generic and formulary names, and dosages. A drawback of this is that it does not list mechanisms of action nor common side effects.

Maxwell Quick Medical Reference
A must-have! A spiral-bound guide that lists everything that you need to know and commonly forget – such as normal lab values, how to write a note, a mini-mental status exam, the dermatome man, etc.

The Sanford Guide to Antimicrobial Therapy
The guide for infectious diseases, it is how everyone figures out the antibiotic dosing for practically every antibiotic-treatable ailment. It lists common infections and their most probable microbial etiologies, spectrum of coverage by antibiotics, etc.

The Clinician’s Pocket Reference
A handy “first how-to-do-everything” pocket book. It is like training wheels for The Washington Manual or Ferri’s Guide to the Practical Care of the Medical Patient. The Clinician’s Pocket Reference is particularly useful during Quarter One or your first ward rotation (and especially for your Medicine rotation). It contains notes on how to write notes, how to do a complete H&P, what various procedures are and how to go about doing them, what various lab values mean, and contains a list of commonly prescribed drugs.
General Reading Recommendations

Everyone is different. Some people read only *NMS* texts. Others think that reading *NMS* is like reading a phonebook. Some people always buy an actual textbook from the bookstore – they like having a clerkship-approved reference book, or something that fleshes out the details more than the *NMS* outline format.

Like *NMS*, there are some series that have books for each specialty and clerkship. These include *First Aid*, *PreTest*, and *Blueprints*. *PreTest* is a question book with Shelf-like questions and good explanations of answers.

Some students swear by just doing questions in *PreTest* for the clerkships that have Shelf exams (Medicine, Surgery, OB/Gyn, Pediatrics, Psychiatry). Others really like the basic, easy-to-read format of *Blueprints* – the *Blueprints* series is a good introductory overview for each specialty. Meanwhile, others like *NMS* for a comprehensive text, although not really meant to sit down and read page-to-page. There are sections that corresponding to scheduled lectures and it also has practice questions similar to those on the Shelf.

*UpToDate* is a great, quick-reference resource on most every existing medical topic (pathology, evaluation, diagnosis, differential diagnosis, and treatment of various diseases; uses of various drugs; etc.). It is available through Lifelinks (the Lifespan hospitals’ computer system for accessing patient labs and data). Many students like to use *UpToDate* to quickly read up on topics mentioned during rounds, especially when there are only random 10-15 minutes to spare at a time. Other students like to use *eMedicine*, another web-based resource like *UpToDate*.

Read whatever works for you, but always read WHENEVER you can, WHEREVER you can. Because you will have even less time to read when you are an intern.

*Note: Some people use the readings and journal articles handed out during a clerkship – these are the folks who begin to file and categorize articles so that they have their own personal library to which to refer. If you do this, now is the time to go to STAPLES (no, I do not own stock in them) and buy an accordion file or file box in which to collect the HUNDREDS of articles you will be handed over these next two years. At the end of each clerkship go through your articles – keep only the ones you actually read or intend to read, recycle everything else. By the time you are an intern you will have a quick reference resource for the presentations you will have to do and the research you want to look up.*

Where Do I Study?

Real estate is at a premium in the hospitals and study areas for residents – let alone medical students – can be hard to find. That being said, there are ways to get by at the different hospitals.

**Rhode Island Hospital / Hasbro Children’s Hospital**

The Peters Health Science Library on the first floor of the Nursing Arts building (across from Jane Brown) is a great place to study if you have the time to walk over there. Quiet, plenty of desks, as well as a number of computers. The conference rooms on the fourth and fifth floors in the Ambulatory Patient Care (APC) building are also places to sit down and study for Surgery and Medicine, respectively (avoid mixing the two up), but be aware that they are often used for conferences in the mornings. The Medicine Residents Lounge, when not filled with residents, also works while on Medicine, but you will need a key to enter. There are also a number of computers there so chances are at least one will be available (please give up your spot for an intern or resident if computers are short as they have work that needs to be done). During Pediatrics, the Residents Lounge and dining area are good places to study. There is a code to enter the Residents’ Lounge, but the dining area is open to all. On Psychiatry, there is a small staff work
area on Jane Brown 5 South for you and your residents. It is cramped, but is convenient during your
downtime given the fact that the floor is a locked ward.

Women and Infants’ Hospital
During their OB/Gyn clerkship, you will receive a code for the staff elevator and library on the third floor.
The library is connected to the computer room and has nice comfy chairs with ambient lighting. Beware! The chairs are so comfy that you may fall asleep reading in them. In the afternoons, the cafeteria is a fair place to study and relatively empty with nice obscure corners and booth seats to hide away and read.

The Miriam Hospital
There is a library in the basement that you can get to by walking through the cafeteria. It is not the most impressive study space, but it does have books, journals, and a copy machine. There are also conference rooms on the second floor between the ICU and Coronary Care Unit (CCU), as well as a conference room on the third floor. Both of these rooms may see use throughout the day for assorted meetings. Some people find the Medicine Residents’ Lounge to be a fair place, but lacking in desk space and often filled with busy (and noisy) residents and interns while on Medicine. There is also a dining area behind the computers on the third floor 3B. It is usually empty, but is out of the way and very nice. The cafeteria may also serve as a decent study area when it is empty during non-mealtimes.

Memorial Hospital
There is a library in the Primary Care Center building, but you may also find the conference rooms on the fourth, fifth, and sixth floors to be sufficient for studying.

VA Medical Center
There is a library on the second floor that you can get to by walking away from Radiology. There are also conference rooms on the fifth floor, but the library is the most popular place to sit down and read.

Butler Hospital
There are plenty of empty conference rooms throughout the hospital. That being said, you will unlikely have to be at the hospital for that long on a given day. Go home after all the work is done.

Bradley Hospital
You will unlikely have to be at the hospital long enough to need to find a place to study. Nonetheless, get creative or just go home after everything for the day is finished.

CARDINAL RULES OF BEING A GOOD STUDENT

You have a lot to memorize already, such as how to calculate the fractional excretion of sodium in the urine (and other extremely helpful bits of pathophysiology and physiology), and it is tough to try and learn more.

However, the following rules are here to make you a more conscientious, courteous person. Knowing these guidelines will help you not just in medicine, but also in your non-medical, daily interactions with people. Hopefully you will follow these tips enough that they will become intuitive.

The basic message here: Be courteous and use common sense. That is the essence of the rules below. Some cardinal rules on being a good student (and person) in medical school:

Cardinal Rule #1: Know your patients really well. The patients that you follow on your service will be your best learning tools. It is difficult to remember all the sequelae and treatments of cirrhosis, but if Mr.
Q has cirrhosis and you have to treat him with lactulose and beta-blockers and treat his varices and perform a paracentesis on his ascites and work up the etiology of his hepatitis, the information sticks in your brain much better. Trust me.

Not only does knowing your patients really well help you in the learning process, but it helps the team, too. The sister of one of the editors, a neurology resident, wrote this advice:

*If you can know your patient really well...you will be an incredible help. I remember there was one med student in particular this past year who was especially outstanding. He knew his patient very well and understood his pathophysiology, etc. Ours was a very busy service but since he practically functioned at the level of an intern he was extremely helpful. I didn’t have to do as much for the patient he was following since he was so on top of things. This saved me time. This student was very reliable so I could trust his info, etc. If you can do the same I can guarantee that interns and residents will notice and not forget that.*

Other medical residents agree.

**Cardinal Rule #2: Remember your goals.** Your goal as a medical student should be (in no particular order): to learn, to help your team, and to advance the overall health of your patients. All of your actions should be directed towards one or all of these goals.

**Cardinal Rule #3: Be mindful of your manners.** Common courtesy rules! Although others (attendings, residents, nurses) may not be particularly polite or courteous all the time, do not mimic their bad behavior. For example, some intuitive tips:

- Address patients as “Mr.” or “Ms.” unless they tell you otherwise
- Do not sit on the patient’s bed
- *Never* eat in front of the patient. Some may not have eaten for days and may be very hungry.
- Do not sit down unless those above you (attendings, residents) have sat down and have seats available. The attending may want to deliver some news to the patient, and it is always delivered in a more comforting manner if she is seated. Do not hog the only seat in the patient’s room.

It just makes sense. In addition to making sure that you are a good medical student, there are some other unwritten rules on being a good classmate and helping others...

**CARDINAL RULES OF BEING A GOOD CLASSMATE**

You could become a doctor on your own—but why? A large part of your education is the journey towards becoming a doctor and then some. Your classmates are invaluable resources. Depend on one another, look out for one another, and prove that you can count on one another and earn each other’s respect and trust. Without each other, you will still become doctors, but it just won’t be the same.

When you are first starting out, help each other and ask questions whenever they occur to you. Trust your elders when we tell you that no one else knows the answer either and they are all relieved that someone had the courage to ask. After you learn the ropes, take the time to show others what is going on.

When you start thinking about residencies, do not waste time engaging in the same petty putdowns about other specialties that you will hear your residents partake in. We are all going to be doctors and we will be better ones for having helped each other.
COMMUNITY HEALTH

What is the Community Health Clerkship?

The Community Health Clerkship is an applied learning experience designed to help develop in Brown University medical students the knowledge, skills and perspectives of community health that are necessary to become a complete, highly competent physician. The specific educational objectives of the clerkship focus on developing the ability of clinicians to utilize population-level information in the treatment of individuals, incorporating population-based data, as well as an understanding of the community context of health, illness, and health care. These objectives also lead to an appreciation of the public health and resource implications of caring for individual patients. Consistent with the Mission Statement of the Warren Alpert Medical School of Brown University, it is hoped that the clerkship will help foster in students an informed sense of social responsibility and help students develop the skills needed to become strong patient advocates and community leaders in areas important to the public’s health.

The general approach of the clerkship is to present the major themes in core curriculum sessions. In addition, students will participate in one of a variety of six-week field experiences where they can focus on a single community health issue to help them understand and apply the material presented in the core curriculum. The MyCourses site for this course (BI0540) provides an overview of the clerkship; specific educational objectives; detailed core sessions; and reading materials, which augment the assigned texts. More information is also available on the clerkship website http://bms.brown.edu/commhealth/chc/website/.

Main Contacts / Sites

The Community Health Clerkship Co-Directors are: Patricia Nolan, MD, MPH (Patricia_Nolan@Brown.edu; 863-6416); Edward Feller, MD (Edward_Feller@Brown.edu; 863-6149); and Michael Mello, MD, MPH (MJMello@lifespan.org; 444-2685). The Community Health Clerkship Coordinator is Joann Barao (Joann_Barao@Brown.edu; 863-3699).

The Clerkship offices, as well as the conference rooms where most core sessions are held, are located on the second floor of 121 South Main St. (building with Hemenway’s Restaurant on the first floor – just down the hill from the main campus).

Overall Clerkship Schedule

The clerkship is a continuous six-week block with each student receiving an individualized schedule at the clerkship orientation. About 25% of the clerkship encompasses core curriculum sessions, generally held twice per week. The other 75% the clerkship time is spent participating in a hands-on fieldwork experience/project time, which is scheduled around the lectures/seminars either during weekdays, evenings, and/or on weekends.

Core Curriculum Sessions

There are fifteen core sessions throughout the six weeks, consisting
of seminars, journal clubs and small group discussion meetings. The topics include public/community health issues, researching population data, basic methodologies in studying populations, epidemiology, biostatistics, health care systems, health insurance, global healthcare, medical ethics, and evaluating medical literature.

Field Experience

Each student participates in a field experience that allows her/him to focus on a specific public health issue and culminates in a final project. The goals of this field experience include:

- develop an understanding of the community context of the specific health issue
- investigate how population-level factors such as community systems affect the delivery of health care to the individual
- appreciate how choices of treatment at the individual level create health consequences for populations
- work in a real world setting to apply the central concepts of what you learn during the Community Health Clerkship

The field experiences must be set up with the Clerkship Coordinator or one of the Clerkship Co-Directors well in advance of the start of a student’s clerkship rotation. There are numerous options for established field experiences and project ideas. However, motivated, pro-active students, who contact one of the clerkship co-directors at least eight weeks before the start of their respective rotations, can propose a field experience arrangement that is outside of the established sites. This arrangement must be approved by the clerkship co-directors.

Final project

The field experience culminates in a final product (health education/promotion brochure, IRB proposal, survey design/data collection instrument and analysis, extensive literature review, documentary film, website design, manuscript draft, etc.). In addition, students present their projects in a poster and oral presentation during the final week of the clerkship.

Although there is great variety in the types of projects that can be done, an ideal project not only serves to synthesize the learning done in the clerkship, but also can make a contribution to education, patient care, or research in the area of the field experience. The oral presentation (usually PowerPoint) is a maximum of 15 minutes, with 5 minutes for questions and answers. The poster is created as a PowerPoint slide and is printed on a poster printer by clerkship staff. Students receive help and support from the clerkship co-directors, field experience preceptors, and clerkship staff in formulating their projects and in designing their posters and oral presentations.

Required Texts and Readings

The clerkship has two required texts which are loaned to students at the start of the clerkship:

- Epidemiology, 3rd edition (Leon Gordis)
  This is probably one of the best introductory epidemiology books.
- The Strategy of Preventive Medicine (Geoffrey Rose)
  This book presents an interesting view of preventive medicine.

JMS says: The Gordis Epidemiology book clearly explains many public health topics and terms and is a good resource for the epidemiology questions that will be included in Step 2 of the boards. There is also a session on how to conduct electronic searches of population data that is extremely helpful in locating articles for students’ specific topic areas.
Students are also required to read specific articles related to the respective core curriculum sessions and to a student’s specific field experience topic. In preparation for the weekly small group discussion meetings, students must submit a 1-2 page essay that incorporates the readings and addresses the assigned topic of the week within the context of a student’s specific field experience.

Student Evaluation

The overall student evaluation is a composite of student performance in all aspects of the clerkship – input from the core curriculum faculty; evaluations from the field experience preceptors; the poster, oral presentation and final project; and the direct observations of the clerkship co-directors, of whom students have extensive contact throughout the clerkship.
FAMILY MEDICINE

What is Family Medicine?
Family medicine is the medical specialty of general primary care. As such, family physicians aim to provide high quality continual and comprehensive health care for individual patients and their families, and strive to care for the surrounding communities from which their patients come. It is a specialty with breadth that integrates the biological, clinical and behavioral sciences. The scope of family medicine encompasses all ages, both sexes, each organ system and most disease entities.

The mission of the family medicine clerkship is to teach students to provide comprehensive, evidence-based, cost-effective primary care in the context of a patient’s family and social unit. The clerkship’s goals include helping you to 1) improve your clinical skills, 2) practice evidence-based medicine, and 3) understand the specialty of family medicine.

By seeing a high volume of patients of varying ages and sexes with a range of presenting complaints, students will have an excellent opportunity to hone their history taking, physical exam, and clinical reasoning skills. As this is the most comprehensive ambulatory experience during medical school, students also have the experience of broadening their differential diagnoses to the out-patient setting.

Main Contacts and Sites
The clerkship director is Dr. David Anthony (729-2308, David_Anthony@brown.edu). The assistant clerkship director is Dr. Kim Zeller (729-2753, Kimberly_zeller@brown.edu). Your primary contact person is the clerkship coordinator, Jane Shaw (729-2763, Jane_Shaw@mhri.org). The clerkship secretary is Marian Lee (729-2753, Marian_Lee@mhri.org).

Your home base for all lectures, discussions, and exams is Memorial Hospital of Rhode Island (refer to the earlier pages of this guide for directions and parking information). Each student is also assigned to a single family medicine outpatient practice with somewhere from one to ten attending preceptors. These sites are scattered across various towns in Massachusetts and Rhode Island and Connecticut (which is secretly not that far away).

Matching to Sites…
…is done very carefully. A few weeks before the start of the clerkship, Jane Shaw sends everyone a fairly detailed survey about your learning objectives, your strengths and weaknesses, what career path you are currently interested, and what you would like to see during your clinical experience (varying emphasis on pediatrics, OB/Gyn, geriatrics, sports medicine, procedures, different types of patient populations, etc.).

How much information you give ahead of time will help Jane match you with the best site for your interests. Dr. Anthony and Jane work very hard to make this match possible – a difficult task, given the various requests – and they most often succeed! Even when your clinical site is not exactly what you were hoping for, you may find that it works out nonetheless.

Clerkship Schedule
Family Medicine is a six-week rotation taken as one block. This involves spending seven “half-days” (typically Monday afternoons and all day on Tuesday, Thursday and Friday) at your clinical site although there are creative variations on this theme that involve evening or weekend sessions in exchange for the more typical Monday to Friday, 9am to 5pm times. The extra “half-day” is intended for students to work on their Social and Community Context of Care (SACC) proposals. Students who have an ongoing longitudinal experience do six half-day sessions, so your longitudinal counts as one of your weekly clinical sessions.
The one exception to this is Wednesday – there are mandatory didactics on Wednesday that preclude doing a longitudinal those days. Although you have a tremendous amount of independence with your schedule, please know that you will be held to the number of sessions per week that are expected of you. The faculty are generally flexible with creative scheduling if you include them in your plans for say, family emergencies or interviewing crises.

Didactic sessions at Memorial Hospital are all-day on Wednesday and mandatory. Thus, the typical weekly schedule involves:

The typical weekly schedule looks like this:

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM: SACC Proposal time</td>
<td>AM: Preceptor’s Office</td>
<td>AM: Lectures Group Discussions</td>
<td>AM: Preceptor’s Office</td>
<td>AM: Preceptor’s Office</td>
</tr>
<tr>
<td>PM: Preceptor’s Office</td>
<td>PM: Preceptor’s Office</td>
<td>PM: Workshops</td>
<td>PM: Preceptor’s Office</td>
<td>PM: Preceptor’s Office</td>
</tr>
</tbody>
</table>

Other things you will do include:

1. A Social and Community Context Project. The goal of this project is to teach students to appreciate the impact of a patient’s community and social context in his/her health and illness. This project is paired with a ½-day session early in the rotation. During that session, students are led on a community assessment of either the town of Central Falls, RI or the community surrounding the International Institute of Rhode Island. This half-day experience serves as a model for what students are asked to do in their preceptor site communities. Basically, you are supposed to perform a community assessment involving investigating available state databases, interviewing two people who know the community (one patient and one community figure), and literally walking or driving around the town. Based on that assessment, you are to identify some health need in the community and then devise concrete ideas on how to address that need at a community level (making sure that existing community resources do not already address that issue). You do not need to actually carry out the project; you are evaluated on the appropriateness of your intervention at addressing the health issue in the community at hand. For example, I created a project around care of the lower back – how businesses and occupations that require heavy lifting or other maneuvers that involve the lower back should have back-healthy stretching and strengthening programs.

You will deliver a seven-minute PowerPoint presentation (seriously, seven, no more) about your project at the end of the clerkship. It’s actually difficult to cram all of your work and research into 7 minutes, but the evaluators are fairly strict about keeping your presentation within these time limits (there are a lot of presentations to listen to). It is a good lesson in condensing your presentation to the bare essential facts.

2. Attend an Alcoholics Anonymous meeting. The goal of this session is to experience an open AA meeting (open meetings are those for the public; closed meetings are for members only). You are purposefully not provided with any other information – thus students experience first-hand the difficulties involved in finding the locations and times of meetings, when no advance information is provided.

On Call
There is none. Yes! However, there is an optional Maternal-Child Health (Family Medicine-speak for OB) on call experience where you can work with the family medicine residents on the Maternal-Child
Health (MCH) service. If you have any interest in family medicine, obstetrics or pediatrics, it is a great experience. Some students have called it the “absolute highlight” of the clerkship. Again, strictly optional.

**Didactics**
Didactic sessions occur all day every Wednesday. The Wednesday didactic sessions are where the faculty teach you various bread-and-butter topics. Half-day workshops include orthopedics, health care maintenance, diabetes and cholesterol management, geriatric assessment, maternal-child health, and dermatology.

Wednesday mornings include a one-hour lecture followed by small group, community faculty facilitated discussions of individual appointment for members of the 4-generation Wilson family. There are two cases each week with learning objectives, readings and questions. The discussions are guided by the facilitator and are entirely student-driven so that the cases can be made simpler at the beginning of the year or more advanced for those further into clinical rotations. This works well for students starting with Family Medicine and for others in their last rotation.

**Wilson who?**

The Wilson family is a virtual family whose members you will become intimately familiar with over the six-week clerkship. Each family member has different issues following their stages of life: grandpa Henry Wilson had dementia that progresses to the point that he needs nursing home care; mother Judy smokes and has headaches and depression issues; father Joe has problems with hypertension, insomnia, and alcohol; daughter Melissa has questions about dysuria and contraception (too late apparently because she receives prenatal care and gives birth during the rotation); little Michael has issues revolving around well child care and ADHD; and baby Adam (via his teen parents) opts for circumcision and short-term breastfeeding. You know… your average American family.

The goal of this virtual family, per the Family Medicine syllabus, is to “display many of the unique characteristics of our discipline, namely: continuity of care, care of the family and family dynamics, preventive medicine, the biopsychosocial model and the patient-centered clinical method, in a short outpatient experience.” It is a really good experience to discuss these issues with your classmates, as you will likely encounter patients like the Wilsons during your clerkships.

**Working at Your Preceptor’s Office**
You will generally start out by shadowing your preceptor, especially if this is one of your first rotations. Very quickly, you will meet and examine patients on your own, present them to your preceptor, formulate a plan, and then go in with your preceptor to see how she interacts with this patient. You can think of each patient as a little quiz to see how well you would do if this were really your practice and your patient. It can be lots of fun, especially since family physicians tend to see a wide range of patients and pathology.

Depending on your site, you may get the chance to participate in different office procedures like IUD insertion, endometrial biopsy, toenail removal, colposcopy, casting, suturing, skin tag removal, punch biopsy, and cyst and lipoma removal (yup, in the office under local anesthesia).

Make sure that you sit down for a formal feedback session during week three or four of the rotation. Jane will send the form to your preceptor to prompt him or her, but you can also step up to the plate. It can be a little painful, but can also be invaluable to improving your performance.
A quick recommendation: If it interests you and if your site allows it, you should try to learn how to draw blood for labwork. It is an invaluable skill that is becoming increasingly lost in medical education as ancillary services in hospitals begin to take over the former scutwork that medical students used to do. I guarantee that there will come a point in your career that you will be looked at as the doctor to get the blood that the phlebotomist (the professional, most-experienced blood-sucker of them all) could not get.

What to Bring and Wear
The first day of Family Medicine involves orientation in the morning followed by your first visit to your preceptor site. Given that you may be asked to see patients on that first afternoon, you should dress in clinical clothes on day one (lab coat, stethoscope, etc.). Jane, Marian, Drs. Anthony and Zeller will supply you with binders full of schedules, articles, and expectations. Wednesday’s at Memorial Hospital are casual dress.

When you travel to your preceptor’s office, bring your white coat, pens, reflex hammer, stethoscope, PDA, and any pocket texts (pharmacopoeia, Sanford’s antimicrobial guide, Maxwells) for your first day. You will probably drop the white coat, depending on your practice. Just follow along with how your preceptor dresses. Introduce yourself to all staff members and befriend the nurses and nurse managers – they are some of your best education allies.

Clerkship Grading
Honors are awarded to those students who score 92-100; high pass to 88-91; and pass to 70-87.

Preceptor Evaluation (50 points)
Your lead preceptor will complete evaluations for you as supplied by the department. Do not worry about having to hand deliver one to him/her. This is a heavily-weighted component of your final grade.

Didactic Participation (20 points)
This is assessed by your small group leader in the didactic sessions and the core faculty.

Social and Community Context Project Presentation (15 points)
You are evaluated primarily on your overall project (including your community assessment, your proposed intervention and how it benefits the community). Your presentation style is considered, but is only worth 2 of the 15 points, so most of the points are intended to come from the work and thought you put into the project.

Final exam (15 points)
This is a written exam consisting of multiple choice and short answer questions. Questions are generated from the textbook and didactic sessions. FYI: There is a web-site that goes with the textbook that has 75 sample multiple choice questions on it. It is good practice for the test.

Recommended Texts
The Family Medicine Clerkship will supply you with a textbook (Essentials of Family Medicine, 5th ed. by Sloane et al) and a binder’s worth of reading (mostly recent journal articles) as well as a Bright Futures Guide to Pediatric Care and a RI Breastfeeding Resources Booklet. This is all you really need for the clerkship. Anything else is a bonus.
What is Medicine?

Medicine refers to “Internal Medicine.” As Dr. Harlan Rich likes to say, this is where “the bulk of Pathophysiology comes to life.” In the grander scheme of things, Internal Medicine is the basis of all medical subspecialties similar to the way Surgery is the basis of all surgical subspecialties. At Brown, you should complete Medicine by Quarter 3 because this clerkship teaches you how to manage the “average” medical patient.

Goals of the Medicine clerkship include:

- Improving your ability to obtain a history and physical examination
- Developing skills in utilizing appropriate tests and procedures to meet patient needs
- Developing a problem-based approach to clinical situations
- Learning how to critically evaluate and utilize clinical literature

Hospital Sites and Contacts

There are four main hospital sites for your Medicine rotation: Rhode Island Hospital (RIH), The Miriam Hospital (TMH), the Veterans Affairs (VA) Medical Center, and Memorial Hospital.

The clerkship directors vary with each of the hospitals. They are:

- RIH Dr. Mark Fagan (overall Medicine clerkship director)
- TMH Dr. Edward Wittels
- VA Dr. Amos Charles
- Memorial Dr. Joseph Rabatin

The clerkship directors, however, may not be the main contact person during your Medicine clerkship. At The Miriam, Pat Gemma is the clerkship coordinator and the person to ask regarding your daily schedule, team assignments, conference schedules, testing schedules, appointments with the clerkship director, etc. She can be reached by phone at 793-4001 or by e-mail at pgemma@lifespan.org. At RIH, Lucy Kwiek is the clerkship administrator and can be reached by phone at 444-5344 or e-mail at LKwiek@lifespan.org. Paula Goncalves is the clerkship coordinator at Memorial and can be reached by phone at 729-3609 or e-mail at Paula_Goncalves@mhri.org. Dr. Charles at the VA can be reached by phone at 457-3603 or e-mail at amos.charles@med.va.gov.

Clerkship Schedule

The Medicine clerkship is twelve weeks long, and is divided into three four-week blocks. A total of eight weeks are spent as part of an inpatient ward team and may or may not be consecutive blocks. Students at TMH spend one of their inpatient weeks in the Coronary Care Unit (CCU). Four weeks are spent in an outpatient clinic that may be a general medicine clinic, a private physician’s office, home visits with physical and occupational therapy, hospice care experience, time spent with a social worker, etc.

The clerkship generally begins on a Monday with orientation and usually ends on a Friday with the National Board of Medical Examiners (NBME) exam for Medicine, also known as “the Shelf.”

Sample Medicine clerkship schedule:

<table>
<thead>
<tr>
<th>Block One (4 weeks)</th>
<th>Block Two (4 weeks)</th>
<th>Block Three (4 weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient ward team</td>
<td>AM: Outpatient clinic</td>
<td>Inpatient ward team</td>
</tr>
</tbody>
</table>
Outpatient experiences vary based on site. RIH outpatient is spent working at the clinics in the Medical Primary Care Unit, while Miriam outpatient is spent at a private practitioner’s office – these are two vastly different experiences. Subspecialty outpatient experiences including hospice may also be available. The VA outpatient month takes place in the primary care clinic at the VA, and Memorial uses both hospital-based and community-based outpatient sites.

The Miriam also has Friday afternoons devoted to subspecialty experiences (dermatology, endocrine, gastroenterology, etc.). During The Miriam, the VA, and Memorial, outpatient weeks, several half-days are reserved for experiences in outpatient continuing care (i.e. physical therapy, social work, hospice home visits, etc.) Students at RIH are also scheduled for sessions in cardiology, gastroenterology, oncology, and rheumatology clinics.

**Daily Schedule**

For your *inpatient* block, a typical day includes:

- Pre-round on your patients (allow ~15-20 minutes per patient).
- Check morning labs, images, test results (if available)
- Attend morning report (if applicable – some hospital sites, such as TMH, have morning report only for the residents).
- Write daily SOAP notes. Think up original plans and do not rip off your interns.
- Do the things you put in each patient’s plan.
- Attend didactics and conferences with your team
- Attend lectures with your classmates (lecturers appreciate promptness).

During you *outpatient* block, a typical day will vary with each hospital site. A generic schedule includes:

- Go to your outpatient site (clinic, private office, etc.).
- See patients with your preceptor or on your own (after which you present the patient to your preceptor).
- In the afternoon, return to your hospital for more didactic teaching sessions. If there are no afternoon lectures that day, you may continue to work with your preceptor that afternoon or have the afternoon off (varies with different sites).

**On Call**

The rule of thumb is that you are on call when your team is on call.

The call schedule is a four-day cycle. You will be on long call every four days (“Q4”), with short call every second day after a long call. In other words, you are on call every other day in some form or another. A typical call schedule would run like this: Long call on Monday, post call on Tuesday, short call on Wednesday, and “good day” or pre call on Thursday, then the cycle repeats itself.

**What does it mean to be on call?**

Being on call means being the *admitting* team. That is, patients admitted to the hospital will be the responsibility of your team. Again, this occurs every other day (whether it is long or short call). Short call means your team admits all morning until the long call team takes over at 2pm or
until the short call team caps or reaches their maximum of four admissions, whichever comes first. Long call means your team admits after the short call team caps or after 2pm, whichever comes first. Most hospitals have a long call cap at 10 patients, with certain discretionary exceptions. With the 80-hour week regulations, most long call teams also go home by 10pm rather than spend the night in the hospital.

**What will I do long call?**

Hang out with your team, follow up on your current patients, and wait for admissions. Help admit patients. Do not run home. When a patient is admitted, your resident may ask you if you would like to follow the patient, or he may just assign the patient to you. You should pick up at least one new patient during each long call. Check with your resident before leaving.

**Do I spend the night?**

No. Because of the new American College of Graduate Medical Education (ACGME) 80-hour work week guidelines, most hospitals send the long call team home by 10pm. Early in the year when the interns are new and just starting off, the team may stay as late as 2am in the morning. Most teams will send you home once they feel things have quieted down, or once you have admitted your fill of patients. If you really want to stay overnight, you can (if there are extra beds in the call room). However, it is just plain nicer to sleep in your own bed and take a shower in your own bathroom.

**Do I get fed?**

Ah, yes, the most important question. Well, it depends. See the “Food” section for more on this very important matter.

**Didactics for Everyone (you and your team)**

You are special in that you get your own special medical student didactic sessions. However, residents and interns also need teaching. The good part is that you get to participate in these sessions, too.

Didactic sessions for your team include:

- **Grand Rounds** – Tuesdays at 8am, George Auditorium at RIH. If you are not at RIH, Grand Rounds is simulcast to your hospital.
- **Morbidity and Mortality (M&M) Conference** – Time varies with hospital site.
- **Noon Conference** – Occurs at noon (obviously) every weekday at each hospital site. This is a didactic session for residents and interns where an attending lectures on a pertinent topic. Worth attending for the educational experience and includes a free lunch.
- **Attending Rounds** – Usually three times a week. Each team is ultimately managed by an attending who reads your patients’ charts, writes an attending note, and conferences with you about the management of each patient. Attending rounds are a time for you and your team to review your patient load, talk about treatment strategies, and be taught – usually something relating to your attending’s specialty. Teaching quality varies with attending, and sometimes you may have such a high patient load that your attending will cut short the time to go over teaching points with your team. In general though, she is a good resource on patient management.
Didactics for Medical Students
Teaching sessions – afternoon conferences, lectures, and didactic sessions – are the dedicated teaching that you get as a third-year medical student while everyone else on your team is working. During these sessions, you will learn how to read chest X-rays, read EKGs, textbook manage common medical problems seen in adults (diabetes, MI, CHF, PUD, etc.), and learn how to think through a case.

Essentially, you will have (each week):

- **EKG Class**
- **Casebook Session** (problem-based learning exercises)
- **X-Ray Conference** – learn to read chest radiographs
- **Preceptor Session** – students are assigned in groups to a preceptor during each inpatient month. The preceptor’s job is to meet with students and review case presentations and write ups, discuss differential diagnosis and treatment, and assess how the students are faring on the wards.
- **Ethics Session** – usually two to three times over the course of the clerkship

Each hospital has its own special didactics, too. For example, at The Miriam you are lucky to have “Dr. Carpenter Rounds”, where every Friday morning (or not as he is often away at lectures), Dr. Charles Carpenter (of infectious disease and Cecil Essentials of Medicine fame) leads the medical students through a patient case. Those at RIH are fortunate to have special ABG practice sessions.

**Wow… that is a lot of stuff on my schedule!**
Yeah… but you will learn to manage it somehow. That is a skill you will acquire over the clerkship – how to balance patient management with didactic sessions and other commitments. You will also learn to prioritize things – for example, the general conferences (noon conference, grand rounds, etc.) should be secondary to patient care.

Below is a sample week for a third-year medical student at The Miriam. I did not include specific schedules for each hospital site since they are subject to change and scheduling around attendings’ schedules. During your orientation, you will be provided with the most up-to-date and accurate schedule.

Sample inpatient schedule at The Miriam:

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:15am Ward rounds</td>
<td>8:00am Grand Rounds</td>
<td>7:15am M&amp;M</td>
<td>9:15am Ward rounds</td>
<td>9:00am Ward rounds</td>
</tr>
<tr>
<td>10:30am Attending rounds</td>
<td>9:15am Ward rounds</td>
<td>9:00am</td>
<td>10:30am Attending rounds</td>
<td>9:30am Dr. Carpenter</td>
</tr>
<tr>
<td>12:00pm Noon conference</td>
<td>12:15pm Journal Club</td>
<td>10:30am Attending rounds</td>
<td>11:00am Physical Findings</td>
<td>10:30am Attending rounds</td>
</tr>
<tr>
<td>1:00pm Radiology conference</td>
<td>1:30pm PBL casebook</td>
<td>12:00pm Noon conference</td>
<td>12:00pm Noon conference</td>
<td>12:00pm Noon conference</td>
</tr>
<tr>
<td>2:15pm EKG conference</td>
<td></td>
<td></td>
<td></td>
<td>3:00pm Preceptor session</td>
</tr>
</tbody>
</table>
Team Structure
The Internal Medicine residency program is completely team-driven. Each hospital has either eight (RIH) or four (everyone else) medicine teams consisting of:

- One second- or third-year resident (PGY-2 or PGY-3)
- One or two interns (PGY-1)
- Possibly a sub-intern
- You (the third-year clerk) and possibly a classmate (another clerk)
- Possibly another student, such as a pharmacy student

Each team is overseen by an attending who reviews the notes your team has written on a patient and conferences with you regarding the management of each patient.

Your Role on the Team
As the junior junior junior member of the team, you may (especially at first) feel like you do not have much to contribute to the daily functioning of the team. **Stop that thought right now.** You will contribute far more than you realize.

**How many patients will I carry?**
Your resident will set the rules (and if she does not, you should ask), but most teams will have you carry **two to three** patients at a time, depending on how complicated their management is. In general, you should pick up **at least one new** patient during each long call.

**What are my responsibilities?**
1. Do your initial H&P.
2. Write admission orders with your intern or resident.
3. Write up the H&P with the initial A/P for the chart
4. Pre-round on your patients in the morning.
5. Present your patient to your team during rounds.
6. Formulate a plan for your patient, discuss the plan with your resident, then act on it!

**What to Bring and Wear**
- White coat with ID badge
- Stethoscope with adult-sized diaphragm
- Reflex hammer
- Penlight
- **Black** ink pens (bring cheap black pens alongside your good ones. Your interns and residents have a habit of “borrowing” them, then forgetting to return them to you)
- List of important hospital phone numbers (radiology, chemistry and microbiology labs, admitting, resident and intern pagers, etc.)
- Ruler and calipers if you have them (for reading EKGs)
- Pharmacopoeia, *Maxwell’s, Sanford Guide to Antimicrobial Therapy*, etc. (or similar programs on your PDA)
- Some pocket medicine guide, such as *Ferri’s, The Washington Manual* (see below under “Recommended Texts”)

JMS says: Superstar medical students know as much as they can about their patients – not only the patient’s H&P. If a patient has an interesting CBC, go to the lab and look at the blood smear under a microscope. Have the radiologist review films and images with you. You need to **personally** experience and learn as much about the patient as possible – it helps your team and your overall learning.
Clerkship Grading
There are plenty of opportunities to be evaluated (not necessarily to the degree that you want). Evaluations account for 50% of your grade, the NBME Shelf Exam for 25%, and the Objective Skills Clinical Exam (OSCE) for 25%.

Resident Evaluations
Your residents fill out evaluations (now done online using OASIS) on your performance during the time you spent on their team. They rate you on everything from your ability to collect and present an organized and informative H&P to whether you dress and behave professionally. If you did your job as best as you could, remained positive, and tried your best to learn and help the team, you should do fine.

Interns are not required to complete evaluations on you, however, students can ask their interns (and for that matter, anyone else they have worked with) to complete evaluations of them. Most students ask one or both interns to complete evaluation forms.

Attending Evaluations
Whichever attendings oversee your team are asked to (but are not required) complete evaluations on you to your clerkship coordinator. Do not worry about these evaluations. Again, just do your job as well as you can.

Faculty Preceptor Evaluations
Students are assigned two faculty preceptors during their inpatient months with whom they meet once or twice a week. You may be asked to present an interesting case, give a short presentation, or just come up with a topic you would like to discuss. In addition, each student is assigned to an outpatient site coordinator for the outpatient month. Evaluations are completed by both inpatient preceptors and outpatient site coordinator (whose evaluation represents a consensus of the attendings you worked with).

NBME Shelf Exam
The infamous NBME Shelf Exam is brought to you by the same people who brought you the USMLE. Tips on preparing for the exam:

- Read whenever you can. Find sources that suit your style, whether it be dedicated Medicine clerkship books, reference books (Cecil’s or Harrison’s), or review articles (like on UpToDate online).
- Do practice questions. You could use NMS Medicine, PreTest Medicine, MKSAP for Students (the questions in here are harder than the Shelf, but should prepare you pretty well), or other guides. JMS says: Be aware that the questions on the Shelf have long stems with LOTS of clinical information. Getting through the questions quickly is important for success. Many students have difficulty finishing the exam within the allotted time (2 hours 10 minutes).
- Ask your residents, interns, and fourth-year medical students/sub-Is to help you prepare. They want you to do well, too.

OSCE
The Objective Standardized Clinical Exam (OSCE), depending on whom you ask is “actually a lot of fun” or “so stressful that it gave me the runs the night before just thinking about it.” What third-year medical students do not realize is that – despite being told so by fourth-year medical students, their residents, their attendings, and their professors – you will do fine. So long as you were not completely asleep for much
of the clerkship, you will assimilate information whether you like it or not and pass the OSCE. You will. It is important for you to know that the OSCE stations are mostly based on the PBL and other (CXR, EKG and ethics) didactic sessions. This OSCE experience will also help prepare you for the Step 2 Clinical Skills (CS) exam (more on that in the “USMLE Step 2” section).

The OSCE is an exam that gauges your clinical skills. It is held sometime during the last two weeks of the Medicine clerkship, usually located in the fifth floor medicine clinic in the APC building at RIH. All students on the Medicine clerkship take the exam at the same time. This is a lot of people, so your Medicine group will be split into two groups of students. Both groups do the OSCE at the same time, but rotate through two sets of the same station. All students take the same exam in spite of having two different sets of standardized patients.

There are around ten to fourteen stations, each lasting ten minutes. At every station you will be asked to perform a task that you should have mastered to an acceptable third-year medical student level. Importantly, the clinical scenarios are closely tied to the casebook/problem-based learning sessions.

Examples of OSCE stations include:
- Read a chest x-ray
- Read an EKG
- Counsel a patient with a problem (such as high cholesterol or diabetes)
- Take a focused history related to a chief complaint
- Give a presentation of the history you have obtained
- Perform a focused physical exam and present your findings to a doctor
- Provide a differential diagnosis and treatment plan
- Write about an ethical issue

At the stations, you will be evaluated by a standardized patient (a hired actor or actress), or you will record your findings on paper (i.e., write down your interpretations of the EKG or chest x-ray). You cannot pass the clerkship if you do not pass the OSCE. A score below 60 and also below 2 standard deviations below the mean is a failing score. The OSCE is graded based on performance at each station, the scores are normalized across the quarters, and a rank score is developed for each student (to compare performance with one another across the quarters).

---

**Recommended Texts**

**For reference and reading:**

*Harrison’s Principles of Internal Medicine.*

The reference book. Obviously, not meant for you to sit down and read cover to cover, but is a great reference book for all medical issues that you will encounter on your clerkship. You do not need to own it, but you may want to eventually. You may also consider getting the pocket version to carry around with you (see below). There is also an online version through the Lifespan.

*Cecil Essentials of Medicine.*

Again, not for reading cover to cover (though I know one medical student who attempted this… such folly!). Instead, it is an excellent quick reference with short chapters, colorful diagrams, and plain language. One of the chief editors is The Miriam’s own Dr. Charles Carpenter!

*Blueprints in Medicine.*

The typical *Blueprints* text. Not a definitive reference source, but a nice basic, introductory overview to common medical problems and their treatments.
*Blueprints Clinical Cases in Medicine.*
Like the above *Blueprints* text, but this presents pathologies in a case presentation format. Some people find it easier and more applicable to the medicine clerkship. It also has 200 practice questions.

*Step Up to Medicine*
Increasing in popularity and presented in a similar format to its Step 1 counterpart. It provides comprehensive information, but unfortunately does not include questions.

*First Aid for Medicine*
A popular text with thorough coverage of high-yield topics and presented in an outline-based format. It has received great reviews for its format and can great for the Shelf when supplemented with a reference text.

*Internal Medicine Essentials for Clerkship Students.* Short text specifically aimed at clerkship students. Available as a package with the MKSAP for Students question book.

*UpToDate.*
The online reference guide available at all hospitals. You should also have received a username and password from The Warren Alpert Medical School of Brown University. It is a great quick reference source that provides all you need to know about most common illnesses and diseases. Whenever there is a free moment during rounds, you can pounce on a computer and quickly skim topics that have been discussed.

**For questions:**
*NMS Medicine.*
Reads like a telephone book in the typical *NMS* dry, outline format. However, it is fairly comprehensive and covers most topics you will encounter on the wards. More importantly, it has practice questions at the end of every section, and it has a couple comprehensive sample examinations.

*MKSAP for Students.*
MKSAP = Medical Knowledge Self-Assessment Program. This book comes highly regarded by some students (and many medicine clerkship directors), while downplayed by other students. It contains a series of clinical vignettes with questions. The standard major topics are covered. Mastery of these vignettes should ensure a good grade in a third-year rotation, but requires a fair amount of effort. The questions are reputed to be more difficult than those on the Shelf exam, but that should make you well-prepared, no? The explanations of correct/incorrect answers are particularly good.

*PreTest Medicine.*
The typical *PreTest* question book, it contains around 400 shelf-type multiple choice questions (including some matching). Considered by some to be slightly less challenging than the actual Shelf, it easily fits into your white coat pocket and is a good book for quick Q&As.

**For reading EKGs:**
*Rapid Interpretation of EKGs* (Dale Dubin).
The most popular and widely-read guide to EKGs for third year medical students. Behind its gaudy, loud orange cover, this book breaks down the gluttonous task of EKG interpretation into bite-size, digestible bits. Very helpful for your weekly EKG class.

*The Only EKG Book You’ll Ever Need*
An increasingly popular book on how to read EKGs. More thorough than Dubin and provides better more detailed explanations on reading EKGs. It may be a better long-term purchase that can remain useful beyond the medicine clerkship.

For your pocket:

*Pocket Medicine: The Massachusetts General Hospital Handbook of Internal Medicine*
You will see these carried around by almost every single intern. It provides a quick presentation of common and even uncommon diseases, recent research, and a quick run-through of disease management.

*Ferri’s Practical Guide to the Care of the Medical Patient.*
Written and edited by Brown’s own Dr. Fred Ferri. This book provides concise and reasonably up to date information on common ailments encountered. It is a quick and brief way to review the main points of disease (differential diagnosis, workup, treatment etc) on your way to morning report or before attending rounds. Some students find it easier to read than *The Washington Manual.*

*The Washington Manual of Medical Therapeutics*
What you may see your interns carrying around. More information and detail than you will need to carry out your responsibilities (some clerkship directors do not recommend this for third-year medical students; they feel it is geared more towards residents and therapy, which is not the main focus of the Shelf), but an investment to consider if you are able to read what is in it. If you think you are going into internal medicine, you may want to purchase a copy before your medicine sub-I.

*Harrison’s Manual of Medicine.*
An excellent resource for those questions who need quick, concise answers. The chapters for *Harrison’s Principles of Internal Medicine* are neatly summarized into quick two or three page summaries, with many helpful charts and management tips. Depth and underlying pathophysiology are not well covered, but that is what the larger book (*Principles*) is for. Recommended by many clerkship directors. A PDA version is available.

*Current Clinical Strategies: Medicine.*
For your ward months; contains templates of common orders for common admissions; if you use this book you should try to write your own orders first and then refer to the book to see if you forgot anything so that you don’t end up relying on it instead of your brain. It also reviews medical therapeutics and management for most medical problems.

**Summary**
Have fun, and learn, learn, learn! This clerkship forms the foundation of your future career in any specialty. Dr. Mark Fagan (clerkship director at RIH) provides this list of top ten things to do to succeed on the Medicine clerkship, obtained from the University of Washington Medicine website:

1. Be on time.
2. Ask questions.
3. Be proactive. Follow-up on patients recently discharged from your service or between clinic appointments.
4. Be prepared. Read ahead for planned lectures, pre-round, obtain outside records.
5. Practice your presentations.
6. Do not read your write-up when presenting.
7. Offer a plan.
8. Take advantage of opportunities to be taught. Ask to go over x-rays, physical exam, gram stains etc.
10. Have fun!
OBSTETRICS & GYNECOLOGY

What is OB/Gyn?
In the simplest of terms, OB/Gyns provide both primary health care and specialized health care for women of all ages. It is hoped that you will come away from this clerkship with an understanding and appreciation of the role of the obstetrician/gynecologist; the importance of the gynecologic history and physical examination in the overall assessment of the health of women; and the major significance of competent obstetrical and gynecologic care in public health and preventive medicine.

Main Contacts and Sites
Dr. Star Hampton is the clerkship director. She can be reached at 453-7560 or by e-mail at bhampton@wihri.org. The clerkship coordinator is Kristine Ricci. She can be contacted at 274-1122 x1805 or by e-mail at kricci@wihri.org.

Clerkship Schedule
OB/Gyn is a six-week clerkship divided into various blocks:
- 2 weeks of Labor & Delivery
- 2 weeks of Gynecologic Surgery
- 1 week of Night Float
- 1 week of Outpatient experience

The clerkship begins on a Monday and ends with two days of testing (the OSCE, the breast and pelvic exams on Tuesday, and the Shelf exam on Friday). Consequently, whichever block you do last will be truncated due to the examination time.

A sample schedule (may vary with each student):

<table>
<thead>
<tr>
<th>Weeks 1 &amp; 2</th>
<th>Weeks 3 &amp; 4</th>
<th>Week 5</th>
<th>Week 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor &amp; Delivery</td>
<td>Gynecologic Surgery</td>
<td>Night Float</td>
<td>Outpatient</td>
</tr>
</tbody>
</table>

Daily Schedule (during each block)

Labor & Delivery (a.k.a. L&D a.k.a. OB)
Here is where you will reach one of the most memorable rites of passage in your medical school career… delivering your first baby… and your second… and your third… and so forth. People’s experiences will vary – some will cry, while others only mildly moved – and, of course, the number of babies delivered is variable. Some students have delivered 28 new Rhode Islanders (including 5 sets of twins), while others come away having assisted in one Cesarean section and delivered one baby. Don’t sweat about the small stuff! What is important is that you learn how to follow a woman in labor and develop enough competency to deliver a baby (in the event you are the only medical personnel at a random restaurant in a random snowstorm).

A typical day:
- Meet at 5:00am to round on the postpartum women with your intern. Talk with the patients and write SOAP notes (you will be provided with an OB/Gyn-specific SOAP note template in your OB/Gyn orientation packet). Be sure to write notes on the patients whose babies you helped deliver.
- 7am (M,T,Th), 7:30am (M,F) Sign-out rounds in Resident Lounge (2nd floor)
- Introduce yourself to the patient and their families and to the nurse whenever entering any labor room.
- Follow these patients throughout the day, write regular progress notes (at least every 2 hours) on them to document their progress through labor. The residents and nurse midwives will teach you what important points to include in these notes.
- During downtime, you should read or learn from the nurse midwives (one of their jobs is to teach medical students), attendings and residents
- When your patient progresses far enough, help deliver her baby, or go to C-section with her.
- Deliver more babies, read, learn, etc.
- Go to afternoon lecture

_Gynecologic Surgery_ (a.k.a. Gyn/Surg)
This is surgery of the pelvis and the perineum in women. It is run like surgery – only it isn’t. Instead of rounding with a team every morning, you will split up the work of rounding between yourself and other students. Everyone writes SOAP notes, has them co-signed by the interns, then you head to breakfast rounds in the cafeteria. After breakfast you head to the OR to scrub in on your cases assigned by your chief resident.

A typical day:
- Meet at 6am (W,F), 6:30am (M,T,TH) to do post-op rounds, write daily SOAP notes with the residents and interns.
- 7am morning report in the cafeteria (M,T,Th). An attending reviews topics with you, the residents, and the interns or one of you will present a topic. A good learning session.
- Head to the OR
- Attend and assist in surgeries.
- Afternoon lecture

_Night Float_
This one-week (usually Sunday through Thursday) block has you working night shifts with the on call team. Report to the residents at 6pm on the L&D floor or in Triage, you work with them until sign-out in the morning at 6 PM, after which you have the day off until afternoon lectures.

Call involves all the basics of L&D and you are expected to rotate through Triage (basically the W&I ED), as well as follow patients to the L&D floor, attend C-sections, and help your residents on the postpartum/post-op floors.

_Outpatient Week_
This one-week block is essentially a potpourri week where you rotate through the Women’s Primary Care Clinic and different experiences and subspecialties including urogynecology, women’s oncology, and reproductive endocrinology and infertility (REI).

A typical day:
- 8am – Meet at your preceptor’s office or the WPCC (you will be told where you need to go by Kristine). He/She will introduce you to the workings of a typical day there and let you know what he/she expects.
- Return to clinic if you are also assigned there for the afternoon, or go to the other schedule subspecialty clinic you are assigned to for the afternoon.
- Afternoon lecture

JMS says: Like with the Surgery Clerkship, you will learn that certain attendings let you do more and teach you more than others (the same applies to residents). Find the attendings you get along well with, and try to help out with their cases.
Preceptor Clinic
You will be assigned to two or more preceptors in the Women’s Primary Care Center Clinic at 2 Dudley Street. You will work with a nurse practitioner one half of the day (e.g. morning) and a resident the other half of the day (e.g. afternoon) where you will see patients, present to your nurse practitioner or resident, then go back in to see the patient together.

Didactics
There are many types of conferences to attend:
- **Grand Rounds** – 7:30am on Thursdays. It is held in one of the auditoriums on level 0
- **Core Lectures** – 6:30am in the auditoriums if scheduled.
- **Medical Student Lectures** – Pretty much much happen everyday usually starting at 4pm and usually finish by 5:30pm. Lectures are considered to be very important and residents will actually kick you out of interesting procedures so you can attend. Throughout the rotation, you will take turns presenting cases to each other with your faculty preceptor – these case presentations will be scheduled during afternoon lecture time. There is also a minimum 85% attendance policy (you must sign in at each lecture).

Preceptors
Each student is assigned to a faculty, resident, and nurse practitioner (NP) preceptor. The faculty preceptor will help you prepare your case presentation and provide education and career guidance. You meet with them about three times. Your resident and NP preceptors teach you during your clinic blocks as you see patients, present them to your preceptors, then both go in and see the patient again together.

What to Bring and Wear
This depends on what portion of the clerkship you are on. For the most part…
- Your white coat
- Your stethoscope with adult-sized diaphragm
- Pens, pens, pens
- Notecards, notepad, or some notetaking system
- Pharmacopoeia, Maxwell’s, etc…
- List of useful numbers, such as different floors, Triage, labor and delivery, residents’ pagers, etc.
- Your Managing Contraception mini book that will be given to you during orientation (this book has color pictures and descriptions of all the OCPs, which is key for clinic and the W&I Triage).
- A pregnancy wheel (loaned to you during orientation).
- Any other OB/Gyn-related materials you think you might need, such as the card on how to do a prenatal screening exam (issued during orientation).

Clerkship Grading
Clinical evaluations account for 50% of your grade, the Shelf exam 20%, OSCEs 15%, case presentation 15%. Lecture attendance must be kept at 85% or higher to receive credit.

Evaluations
Evaluations will come from your faculty, nurse practitioner, and resident preceptors. They will automatically complete evaluations on you, which are done online using OASIS. You will also choose two residents (you can choose more, if you like) to complete evaluations for you. Remember to ask them first as they will receive e-mail reminders from OASIS once you select them to evaluate you.
**NBME Shelf Exam**
Read as much as you can when you can, but feel fairly confident knowing that during this clerkship, you have probably picked up a lot of what you are supposed to know. As with all Shelf exams, be aware of the time allotted to complete the 100 multiple-choice questions in 2 hours 10 minutes. There is a wonderful resource for multiple choice questions called uWise that you will have access to while on rotation.

**Ethics Assignment**
During your rotation, you will attend two lectures on ethics and be assigned a two page paper to discuss an ethical dilemma that you may have encountered on this rotation or on a previous rotation.

**Case Presentation**
Each student selects a case, reviews it with her faculty preceptor, and presents it to her fellow medical students. This patient presentation, like any case presentation, should include history, physical, lab data, and hospital course. The student then presents information about the pertinent topic covered. It is usually a straightforward, PowerPoint-based presentation.

**Surgical Report & Written OB H&P**
You will see many cases during your Gyn Surg block and will be asked to select a case, read the operative report, then present it to one of your faculty preceptors or residents. The operative report is available within 24 hours after the case. The presentation should indicate the reason the surgery was performed (include the patient’s presentation), what was exposed, clamp, cut, ligated, removed, etc. (they want to hear about the anatomy), and the post-operative course. The purpose of the surgical report is to familiarize you with pelvic anatomy and gain experience in “dictating” an operative note. Make sure the person you present it to signs off on the blue card that is given to you at the start of the clerkship.

Also, you will need a midwife, resident, or faculty preceptor to review one of your written OB H&Ps. All patients admitted to L&D require an H&P, so you will have the opportunity to write up many during your L&D block. Once you feel comfortable with them (don’t worry, you will be given a guide on how to write one) and feel ready to present it, seek out one of the above folks to review it, give you feedback, approve it, and sign off on your blue card.

**Attendance**
You must attend at least 85% of your lectures/case presentations during the clerkships (be sure to sign in on the attendance form for each lecture) and complete evaluation forms on each lecturer.

**Overall completion of assignments**
Basically, doing what you are told to do, like meeting with your various preceptors, presenting your surgical case, etc.

**OSCE**
The goals of the OSCE are for you to demonstrate the technical and communication skills you acquired during the clerkship. There are two parts to the OSCE:

**General Women’s Health.** You and your peers will congregate in one of the W&I auditoriums for this portion. Unlike the Medicine OSCE, there is no assigned order, and the stations are not timed. You will go from station to station as they free up, and as you feel ready and prepared. Stations are:
- Hand maneuvers in delivering a baby – Using a model
- Repair of episiotomy – Using a sponge as a model.
- Counsel a patient on contraception – This could be OCPs, emergency contraception, long-term contraception, or an IUD.
- Counsel a patient with vaginitis

**Breast and Pelvic Exam.** This OSCE is administered after the other OSCE stations. It is similar to what you were taught to do during orientation. There is a standardized patient, and you perform a breast and pelvic exam on her (making sure to explain what you are doing, and counseling her on how to properly perform a self-breast exam). You will be critiqued on your bedside manner, technique, and communication skills.

You will receive a packet detailing everything you need to know for the OSCE at the start of the rotation.

---

**Recommended Texts**

Again, there are different texts, each with its own pros and cons. You are also loaned textbooks at the start of the clerkship, including *Obstetrics and Gynecology* (Beckmann). This is a good reference text for looking up information and reading about topics encountered during the clerkship. Other helpful guides include:

*NMS Obstetrics and Gynecology.*
The good old telephone book, it will cover almost anything and everything you need to know. Do not forget about those great practice questions for the Shelf Exam.

*BRS Obstetrics and Gynecology.*
Remember the *BRS Physiology* and the *BRS Behavioral Science* books you used to study for the Boards? This version is just as good and in some ways better than *NMS.* It has the typical *BRS* outline format, with a 100-question exam at the end of the book. Find whatever format suits you best.

*Blueprints Obstetrics and Gynecology.*
A student favorite. It is easy to read, lightweight, has big margins, and has essentially everything you need to know in an introductory format. For more depth, refer to other reference books.

*PreTest Obstetrics and Gynecology.*
The typical *PreTest* book, it contains about 500 Shelf-like practice questions.
What is Pediatrics?
Well, this is a no-brainer, right? Kind of… not really. Pediatrics is “medicine for kids” – everyone under 18 (generally speaking). Pediatrics is not medicine for small adults! No matter what prior experience you have had with children, you must remember that children are not small adults.

The goal of the clerkship is to expose you the field of pediatrics. You will learn the bread-and-butter issues in pediatrics, as well as determine whether pediatrics (or any medical field involving child care) is suitable for you.

Main Contacts and Sites
The home base for Pediatrics is, obviously, Hasbro Children’s Hospital. Half of your clerkship (three weeks) is spent on the Hasbro inpatient floors. Lectures and discussions are held at Hasbro. The only time you will be outside of Hasbro is during your two weeks of outpatient pediatrics and your one newborn medicine week (newborn nursery at Women & Infants and subspecialty clinics).

Helene Felici is the clerkship administrative coordinator, and she can be reached at 444-3406. Dr. Randal Rockney is the clerkship director, and he is available at his office (444-7289) or via pager (350-5569). Dr. Brian Alverson is his associate and he is in charge of the sub-internships and the inpatient portion of the clerkship. The website for the Pediatrics clerkship is accessible at http://bms.brown.edu/curriculum/b1450/.

Clerkship Schedule
The Pediatrics clerkship is six weeks long, divided into two three-week blocks of inpatient and outpatient medicine. Dr. Rockney and Helene Felici do a great job of organizing the clerkship and soliciting feedback. They also provide their own handbook, which explains in great detail what you will see and what you should expect from the clerkship. The best thing you can do in preparation for the rest of the clerkship after orientation is to read that handbook!

A sample schedule:

<table>
<thead>
<tr>
<th>First three weeks (inpatient)</th>
<th>Second three weeks (outpatient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient at Hasbro Children’s Hospital as part of Team red, blue, yellow, or green</td>
<td>Two weeks of outpatient at a pediatrician’s office</td>
</tr>
<tr>
<td></td>
<td>One week of newborn medicine and pediatric subspecialties</td>
</tr>
</tbody>
</table>

Inpatient Schedule
Your experience will be very similar to Medicine, except for the kids part. Like the medical clerkship, you will be on an inpatient team consisting of an attending or hospitalist (a “graduated” pediatrician), senior resident (either PGY-2 or PGY-3), two to three interns (they could be from pediatrics, family medicine, med/peds, psychiatry, emergency medicine, or triple-boarders), maybe a sub-intern (the pediatric sub-I is extremely popular), and you. There are four teams at Hasbro and as many as six-eight third-year clerks rotating through at a time, so some teams may have more than one third-year student.
A typical (non-call) inpatient schedule:

- Pre-round on your patients in the morning.
- Round and present with your team.
- 8am – 9am Morning Report – Presentation of an interesting case by a resident or an intern.
- Radiology rounds (you see the X-rays and other studies of the previous day on your patients and you review them with a radiologist – a very nice feature of this clerkship).
- Teaching rounds are scheduled at the discretion of your attending, when one member of the team (you will have your turn) will present a topic for discussion, or the attending wants to discuss a topic, etc.
- Complete the daily SOAP notes (with original plans) and orders.
- Noon – 1pm: Noon Conference – Attendings present topics for residents. Unfortunately, no lunch is provided (unless it is during interview season, from November – January); bring your own lunch.

One afternoon a week:

- Teaching resident rounds – A senior resident (usually PGY-3) is assigned to teach medical students – this is a great resource for the exam! Usually occurs three times a week, for an hour each time.
- Teaching rounds/lectures with an attending (usually six hours each week)
- One afternoon hospitalist lecture on Wednesdays at 2:30
- Tuesdays 4pm – 5pm – Medical Student Conference series, where students present case-based conferences with an outpatient focus.
- Thursdays 3pm – 5pm – Clerkship lectures. Attendings talk to you about topics such as immunizations, fluid and electrolytes, basic pediatric skills, and clinical dilemmas.

Grand Rounds occur on Fridays at 8:30am in George Auditorium at RIH. Because Tuesday and Thursday afternoons are scheduled didactic sessions, it is recommended for you (if you have a longitudinal elective) to schedule your longitudinal clerkship for Monday, Wednesday, or Friday afternoon.

This general schedule is accurate as of this writing. Of course, didactics are subject to change due to the ever-changing schedules of attendings, and you should check with Helene during your rotation to make sure you have the most accurate schedule.

Looking at the lecture schedule, it begs the question – when do you get work done? A general good idea is to get your SOAP notes and orders written before your afternoon conferences (whether it is teaching resident rounds, clerkship lectures, or medical student conference series). Your interns/residents should co-sign your notes so you do not keep waiting around for you to finish your lectures (I think this sentence has a typo… not sure what it’s saying…).

**On Call**

You are on call only during your three-week inpatient rotation on a typical Q4 long-call schedule.

*What does that mean?*

Call schedules can be pretty complicated. Each medical system has its own call system, and this is something that you will learn during your residency program interviews. Some programs have buffers to lessen the amount of patients admitted during call; others vary in the amount of hours when you are on call, etc. etc. The recommended plan of action is to do whatever your team does.

In our pediatrics residency program, there is a “float” system. That means that residents take turns every month doing overnight shifts. However, there is one group of residents that stays late each day, to bridge the time between the daytime team and the nighttime team.
At Hasbro, 70% of patients are admitted overnight. As a result, students have requested overnight shifts. Every month, they still agree that the overnight experience is one of the most rewarding parts of the rotation. During the course of the pediatrics clerkship, each student will do two overnights, during the week. The next day, they are expected to go home early, after presenting their new patients to the team. During these overnight shifts, students can either pick up patients admitted to their team, to be presented the next day, or they can also work up patients not being admitted to their team, but who have interesting diagnoses or therapies that make them educational to admit to the hospital. The decision of which patients to admit is determined by the senior resident, however students should feel free to engage the residents and consider together what patients will be most educational. During the overnight shift, the medical students work closely with the admitting senior resident, but are allowed time to do a thorough evaluation of their patients.

Additionally, pediatrics students will do one weekend call during their inpatient rotation. On weekends, students arrive at the hospital at noon, and then work with the admitting senior resident again admitting patients. However, on weekends, students may go home after admitting a minimum of three patients. Some students elect to spend the night to increase their experience, but this is not mandated, as long as the student has admitted three patients. If it’s a slow day, the student should stay overnight to guarantee the educational experience of those admissions.

**Outpatient Schedule**

You will spend two weeks rotating at an outpatient pediatrician’s office.

A typical outpatient day:

- Go to your site
- Shadow your preceptor until you feel comfortable seeing patients on your own
- Let your preceptor know when you are eager and ready to see patients on your own first
- Ask whether you need to bring a lunch!
- Attend conferences/lectures in the afternoon

*What is newborn medicine week?*

During your three-week outpatient block, you will have one week of various rotations designed to expose you to neonatology, newborn medicine, and some pediatric subspecialties. You will typically spend two days in the Newborn Nursery at Women & Infants, two days at various specialty clinics, and one morning and/or afternoon in the Neonatal Intensive Care Unit (pronounced “nick-u”).

While in the Newborn Nursery at W&I, you will be under the guidance of Dr. Marcia Van Vleet (who receives rave reviews for her teaching), as well as pediatric residents. This is a great opportunity for you to observe and participate in the care and physical exams of newborns (especially learning their various reflexes). Please page the Newborn Nursery pager at 452-4630 and ask them where to meet. They will likely be on either the 5th or 6th floors in W&I.

One morning and afternoon are dedicated to learning about Neonatology. The goal of this is for you to gain some familiarity with the workings of the NICU and common problems with the premature or sick infant. In the morning, you should have a case assigned to you, then present this case to the attending neonatologist during the afternoon.

The remaining sessions vary, and you will be scheduled to various clinics and/or spend time in the Hasbro ED. If you are interested in a specific pediatric specialty, such as endocrinology, child development, urology, or heme/onc, let Helene Felici know and she will try her best to accommodate your choices (she and Dr. Rockney send out information forms to you a few weeks before the beginning of the clerkship that have more details). You will also be given a choice of experiencing a variety of clinics or focusing on one to two.
Didactics
As mentioned above, you have two dedicated sets of didactics: a Medical Student Conference series (usually Tuesday afternoons) and Clerkship lectures (usually Thursday afternoons).

During the Medical Student Conference series, you and your peers deliver a case presentation on a patient whom you have seen on your outpatient experiences. It is similar to the format of a case presentation during Morning Report or Noon Conference.

During the Clerkship lectures, attendings teach you about the bread-and-butter pediatric topics, including immunizations, fluid and electrolytes, basic pediatric skills, and clinical dilemmas.

What to Wear and Bring
On your first day, you will be loaned A Harriet Lane book. This is good because, unless you plan on pursuing Pediatrics, it would cost a lot. If you want to enter the specialty or Med/Peds, you might consider buying the book for yourself. A $50 cash deposit is required, which will be returned to you at the end of the clerkship.

On the first day, you should dress in the typical professional attire. Bring your materials in case you are starting on the inpatient wards that day. This includes:

- Your white coat
- Your stethoscope with pediatric-sized diaphragm if you have one
- Reflex hammer, penlight
- Pens, pens, pens
- Notecards, notepad, clipboard, or other notetaking system
- Pharmacopoeia, Maxwell’s, Sanford’s antimicrobial guide, etc.
- **CALCULATOR.** Very handy to have on this rotation as all drug-dosing and other calculations are weight-based.

IMS says: Check that the toys you have dangling from your stethoscope or coat are made of non-toxic substances and can be easily wiped down and cleaned off with an alcohol swab or in the sink. You do not want your toys being the fomites that spread gastroenteritis throughout Hasbro.
JMS says: Other potential OSCE stations include: Writing admission orders (and calculating fluids); a basic neurology exam on a standardized patient; counseling a teenager on drugs or contraception; and a postnatal well-child check, including advising the mother.

On the outpatient block, you will probably end up ditching the white coat (most kids have white coat phobia and associate it with painful immunizations). If that is the case, just bring your stethoscope and ID badge.

Clerkship Grading
Evaluations
As with all clerkships, your attendings, residents, interns, and other folks you interact with (outpatient pediatrician and folks from the newborn medicine week) fill out evaluation forms on your performance and their interactions with you. Be your usual eager, helpful little self, and you will be fine.

NBME Shelf Exam
The famed “Dr. Rockney exam” has now been replaced by the standardized Pediatrics Shelf Exam. Like other Shelf exams, it has 100 multiple-choice questions to be completed within 2 hours 10 minutes.

OSCE
Usually held on the last Wednesday night of the clerkship. The OSCE is an oral and performance evaluation of the skills you have learned during the clerkship. It has approximately six stations, one or two of which involve oral presentations of patients you have seen in the hospital of your choosing. Be prepared to present and discuss two to three of your patients. Be on top of their diagnoses, differentials, and anything else you can remember about them (one student got dinged because she told the attending that Crohn’s disease is presently considered to be idiopathic – which it is – rather than have a pathophysiologic differential for possible etiologies). Do not stress about it. As long as you attended the clerkship and paid attention to what is important, you will do fine. Bonus: Pizza and soda are provided!

Recommended Texts
Blueprints in Pediatrics
Considered by many to be the best Blueprints book there is and contains most of the information you will need for the clerkship. It is easy to read and provides a solid introduction to common pediatrics problems.

Nelson Textbook of Pediatrics and Oski’s Pediatrics: Principles and Practice
Both are excellent comprehensive reference texts (i.e., don’t sit down and try to read the entire tome).

Signs and Symptoms in Pediatrics
A great book for formulating differentials. You can find a copy in the Resident’s library.

NMS Pediatrics
It is comprehensive and has great practice questions, but is dry and reads like a phone book.

PreTest Pediatrics
The typical Pretest guide containing plenty of practice questions.
**Psychiatry**

Robert Boland, MD: Clerkship Director
Tracey Guthrie, MD: Associate Director
Jane Eisen, MD: Director, Medical Student Education in Psychiatry
Esther Escotto: Clerkship Coordinator

Administration location: Butler Hospital, Residency Training Office, 4th Floor, Center House rear. 455-6417.

**What is Psychiatry?**

Psychiatry is the medical specialty that deals with the diagnosis and treatment (including psychotherapy and pharmacotherapy) of mental illnesses. Yes, you already knew that, and yes, you may have already taken the semester-long course as a second-year. Now it’s time to apply what you’ve learned.

**Main contacts / sites**

There are five main sites for the Psychiatry clerkship, each with its own pros and cons: Butler Hospital, Rhode Island Hospital (RIH), Veterans Affairs Medical Center (the VA), Miriam Hospital and Bradley Hospital. Unlike claims in other clerkships that you’ll have essentially the same experience no matter which site you go to, psychiatry will vary from hospital to hospital and even service to service. Ultimately, you’ll learn the same knowledge base, but there is some difference in the patient population between hospitals.

**Butler Hospital**

As the state’s main psychiatric facility, Butler offers a wide range of services focused on different patient populations. The general treatment floor (GT4) admits patients needing acute care (i.e., patients needing immediate medication adjustment or who pose safety concerns). The intensive treatment unit (ITU) admits patients who are floridly psychotic, homicidal, or suicidal. The Lippit Unit is for geriatric patients, usually with dementia. The partial hospital (aka Day Hospital) sees patients who need daylong supervision and daily psychotherapy but are safe enough to return home at night. Butler Hospital also contains the Patient Assessment Service (PAS). Although PAS is known as the Butler Emergency room, no actual treatment occurs there; patients are admitted if needed, or are referred to outpatient programs. Medical students most typically work on GT4 and in the partial hospital.

**Bradley Hospital**

Between hospitals, the largest difference is between the Bradley experience and others. Butler, RIH and the VA are all inpatient adult psychiatric services, while Bradley is a child psychiatric hospital. It’s a good experience in learning about child psych and evaluating patients with Asperger’s, conduct disorder, etc., but students wanting to learn bread-and-butter adult psychiatry will be better served at a different site.
RIH
Rhode Island Hospital has two main areas for students to choose to work in:

1. The inpatient units are on Jane Brown 4 and 5. The patient population covers the spectrum of psychiatric illnesses, and you will be exposed to pharmacotherapy family meetings and group psychotherapy. Students working on the inpatient floor stay mainly on the unit.

2. The consult service with Dr. Harrington treats the various medical patients throughout RIH that have psychiatric issues (delirium, psychosis, etc.). Students evaluate and chart patients individually during the morning hours and then round during the afternoon.

The Miriam Hospital
The Miriam Hospital is like the RIH consult service as described above. Students are part of a team, including attending psychiatrists, residents, psychologists and psychiatric nurses, consulting on medical and surgical patients in the hospital, and patients in the emergency department.

The Veterans Administration Medical Center
The VAMC is like RIH and Butler in that it consists of adult psychiatric patients. Like at RIH, you will be exposed to pharmacotherapy and a variety of psychiatric diagnoses.

Overall schedule
At Brown, the clerkship is a 6-week clerkship that is not subdivided into any other blocks of time (at least not at the moment, this is always under discussion). It’s a straightforward set-up that gives ample opportunities to practice and learn a lot of psychiatry. You’ll be at one hospital site for the six weeks with anywhere from zero to five other students. You may shuttle between sites for lectures, didactics, and outpatient clinics, but you will spend the majority of time at your main hospital site. Reasons given for this include: time needed to acquire skills to effectively work in your service, and exposure to faculty for evaluation (i.e., grades). Essentially, the idea is to emphasize depth over breadth.

The typical day varies from hospital to hospital, but in general: in the morning you should pre-round on your patients, reviewing their chart for notes of incidents that may have happened overnight. Then you’ll have walking rounds (~8-8:30am), which are much like regular rounds on Medicine or Pediatrics, where you’ll stop by and see each of your patients with your attending. Some attendings do all of the interviewing, whereas others will let you interview patients once you gain more experience; in the former case, residents generally help out with observing interview.
After rounding on patients, you and your attending will write daily progress notes and orders on all of your service’s patients. These activities will usually occupy most of the morning. What happens after lunch varies according to your schedule and your priorities. Afternoon activities include:

1. lectures/didactics – one afternoon each week (see section below)
2. outpatient site – one afternoon each week. The purpose of working at an outpatient clinic for one afternoon each week is to gain a flavor for how outpatient psychiatry works (versus inpatient treatment). Students are assigned to sites with different patient populations than in their primary site. On full capacity months there may be a shortage of outpatient sites, however this is generally not the case.
3. interview practice session – an hour-long session during one afternoon each week. Each site has its own practice interview session. For example, at RIH, Dr. Nathan and your peers watch you interview a patient, then provide constructive feedback afterwards. Sounds nerve-wracking? It is, but also is a great learning experience. Interview sessions at the VA are with Dr. Smokler and at Butler are with Dr. Greer.
4. Morning Report. Most sites have some sort of case presentation, occurring either early or late morning. They are generally co-run by residents and an attending.
5. longitudinal site – if you have one set up already

If you don’t have lectures, an outpatient site, an interview practice session, or a longitudinal site to attend….you should spend your afternoon finishing your SOAP notes, discussing the plan for each patient with your attending, talking more with each of your patients, or just sitting around and reading. You may have to perform admission physicals for your service (as the only official non-psych person on your team you are considered the “medical expert,” believe it or not. Take advantage to hone your physical examination skills). Or, if your work is done and you don’t have anything else on your schedule, you may go home.

ECT
Everyone is required to observe the administration of electroconvulsant therapy (ECT) at least once during the clerkship. If you’ve seen One Flew Over the Cuckoo’s Nest or A Beautiful Mind (well, the latter was actually insulin shock therapy—that you hopefully won’t be seeing), You may think you know what it’s like. However, ECT has made great strides over the past decades – general anesthesia allows patients to sleep through the entire procedure, and muscle relaxants (such as succinylcholine) minimize the generalized tonic-clonic movements. People treated with ECT are usually those with depression that is refractory to medication. ECT remains the most efficacious treatment for depression, and, many believe, the safest. ECT procedures usually occur in the morning, though the exact time depends on which hospital you are working at. The number of procedures you observe will depend on the attending you work with – some perform many procedures, while others perform next to none.

Mental Health Court
Medical students also spend a morning observing mental health court. Essentially, these are trials in which, usually, a doctor petitions to keep a patient in the hospital against that patient’s wishes, and a judge rules whether to commit the patient. This takes place on Friday mornings, alternating between St. Joseph’s hospital and the Eleanor Slater hospital.

On-call
Residents do call at both the Butler Hospital and Rhode Island Hospital Emergency Services. The Frequency of this call varies somewhat depending on the number of students on a rotation with a maximum (and mode) of 4 nights per rotation
In addition, students may be expected to come in on a weekend day to round on patients; this is a site specific requirement and varies somewhat depending on site and time of year. The average here is one weekend day per rotation.

Students at Miriam Hospital or doing the RIH consult service do NOT have to take call (as their hours are somewhat longer during the week).

**Didactics: rounds, lectures**

**The psychiatry conferences include:**

- **Tuesday morning Grand Rounds (RIH only)** – from 8-9am on the first Tuesday of each month in the basement of the Nursing Arts building. Dr. Gabor Keitner interviews a patient, and afterwards, the audience analyzes the patient. RIH students should attend, but others are welcome, too.

- **Wednesday morning Grand Rounds** – from 11am-noon on the first Wednesday of each month in Ray Hall – a nationally-recognized speaker presents his/her current research. Not required, but very educational for all to attend.

- **Wednesday afternoon medical student lectures/didactics** – there is one medical student lecture series for the psychiatry clerkship, meaning that regardless of which site you are at, students will congregate at one location (usually Butler, but once at Bradley and once at RIH) for each lecture. That is, you’re all getting the same lectures instead of in-house variants at your own site. Each afternoon (1-5:00pm) has three to four lectures covering basic psychiatry with either a resident or an attending. Topics include psychosis, depression, mood disorders, ethics, and child psychiatry. Students are required to sign-in; attendance is recorded and factored into the final grade.

- **Morning reports.** These are patient presentations, usually by a student or resident, and are site specific.

**Team structure; your role on the team**

“I felt like I had more responsibility on the Psychiatry service than I did on most other clerkships. Consequently, I also learned a lot.” The student’s role can be like that of a sub-intern. Your exact role depends on the hospital site, but in general, you will work one-on-one with an attending psychiatrist (and sometimes with a psychiatry resident or a psychology intern) who will assign patients to you following their admission. Medical students are expected to carry up to five patients, following their progress and dictating their discharges/transfers. Medical students also are expected to perform admission physicals (at most sites, new patients to the psych unit are required to have a basic physical exam performed within 24 hours of admission).

**What to bring/wear**

The first day of Psychiatry begins with a general orientation for everyone in the clerkship (occurring at Butler Hospital, in the residency training office, Center House Rear, 4th floor) followed by hospital-specific orientations at your respective sites. The only sites where white coats are worn (because the attendings do) are RIH and Miriam Hospital. Whether you bring your coat to other sites is personal choice. Regardless, on the first day bring:
• pens, pens, and more pens
• notecards, notebook, or your own notetaking system
• pharmacopoeia or other guide (epocrates, etc.) that describes psychiatric medications and their effects
• DSM-IV (pocket-sized or actual guide) for reference
• a copy of how to do a Mini-Mental Status exam (Maxwell’s lists it on one of its pages), and a guide/your own reference on how to perform a Mental Status exam (categories, descriptive terms used, etc.)
• usual physical examination tools (such as stethoscope, penlight, and reflex hammer) for the initial physical exams on new patients

Tests, evaluations, OSCE
Your final grade depends on a combination of factors:

The Shelf – ah yes, the famous Shelf exam. Your favorite 100-question, multiple choice exam that you are given to complete within 2hours+10minutes. How to prepare? Some of the lectures and didactics are good. You will also get a lot of practice during your clerkship from working up, diagnosing, and treating patients. As with all Shelf exams, I also recommend doing practice questions – those from BRS Psychiatry or NMS Psychiatry are good. There is no OSCE – I don’t know how they would do an OSCE (would there be some person acting drunk or floridly psychotic?).

Evaluation forms – you will be evaluated by all of those whom you work with, including your attending, resident, intern, outpatient preceptor, and on-call resident. As always, you should do fine on your evaluation forms if you just act like yourself – be helpful, enthusiastic, and eager to learn.

Patient interview – you are expected to perform a patient interview in front of your supervisor (or the supervisor’s designee) that is rated as at least “passing.” This can be repeated during the clerkship as needed until a passing grade is achieved.

Lecture attendance – remember to sign in for each didactic session you attend.

Recommended texts
For your shelf exam:
• BRS Psychiatry – a manageable outline of important points in psychiatry with great question sections. Some students find the BRS series to be dull and dry – and I usually agree – but I actually found BRS Psychiatry to be the most helpful study guide, in terms of reference, reading, and practice questions. List price = $32.95.
• NMS Psychiatry seems to be a favorite (particularly of those who haven’t taken psychiatry before taking Boards part 2). It reads like a telephone book (albeit a small one) but it’s full of information you need to know and includes great question sections. List price = $32.95.
• High-Yield Behavioral Science – a slim, cliff-notes guide to psychiatry, as well as ethics, biostatistics, and epidemiology. Not very in-depth, but is a decent overview of the major psychiatric disorders. List price = $24.95.
• DSM-IV-TR – THE bible of psychiatry. Don’t read through the entire tome – use it as a reference guide. You can also get a smaller pocket version to carry around. List price (large version) = $59.95. Smaller pocket version = $29.00.
• Introductory Textbook of Psychiatry, Fourth Edition (Andreasen and Black) A good reference, a decent supplement to the DSM-IV; it takes the disorders and fleshes them out, adding more descriptors and case examples. List price (from Amazon) = $74 new, $49 old.
**Other Resources**
The clerkship maintains a MyCourses site, which includes a number of resources including lecture notes, reading, a few automated lectures and some links to patient videos.

Brown has some good electronic psychiatric resources as well, and links to this are found on the MyCourses site.
What is Surgery?
Surgery is practically everything that is not medicine-related. At Brown, Surgery is the chance to be “hands-on” (or “hands-in,” as the case may be) in patient management. It is also the chance to experience sleep deprivation, a la our residents, firsthand. It is a tough rotation, even if you are a morning person, but you will come out of it having seen a lot that most people will never see – even if they subscribe to the Discovery Channel.

Hospital Sites and Contacts
The home base for the Surgery rotation is Rhode Island Hospital. Some students may rotate at The Miriam Hospital and the VA for general/vascular surgery. However, the rest of the rotation is at RIH, as are the lectures and didactic sessions.

Dr. Dean Roye and Dr. Beth Ryder are the co-clerkship directors. They will orient you during your first day. Kim Sanzi is the surgical clerkship coordinator who is in charge of managing your surgery rotation. She can be reached by phone at 444-8393 or by e-mail at ksanzi@lifespan.org.

Clerkship Schedule
The Surgery clerkship is eight weeks long and is divided into 4 week blocks of general surgery at RIH, TMH, or VAMC and 4 weeks of sub-specialties (SICU, Pediatrics, Trauma, Vascular, Transplant) at 2 week intervals.

On your general and sub-specialty blocks, you will work Mondays through Fridays and come in one weekend day to round on patients. Student on-call happens 4-5 nights (go home by noon the next day) throughout your 8 weeks, with the exception of SICU rotation, which is short call every third night. VA and Transplant are home call and there is no call for Vascular. The med student call rooms are located in the Gerry House. When you are on call over the weekend, you come in during the day and stay through noon the next day.

Daily Schedule
The daily schedule varies depending on which service you are on. However, below is a sample schedule during general or vascular surgery:

- 4:45am – Pre-round, usually 45 minutes before your team rounds. Perform daily exams, write daily SOAP notes on the patients you are following.
- 5:30am – Rounds (beginning at 5:30am or 6:00am – find out the day before)
- 6:30am – “Running the list” (10-15 minutes, usually done over breakfast)
- 7:00am – Conferences (lasts an hour)
- 8:00am – Scrub in on surgeries or go to office hours with your mentor
- Lunch between cases (if you have time)
- Afternoon – Read, help your interns, go to clinic or attending office hours, or help out with more cases in the operating room (OR)
- Discuss with your team and/or each other the allocation of OR cases for the next day
- 4:00pm – Go to lecture at RIH (if a lecture day). Students should sign out with a member of their team prior to attending lecture and then go home after lecture.
- Sign out (essential to communicate the day’s events to the team)
- Go home (unless you are on call)
On Call

What is the call schedule?
As mentioned above, call is about 4–5 times during your eight weeks. Call entails showing up for a usual day, spending the night, and going home post-call the following day around noon (hopefully). Some of your classmates (and maybe you) will love Thursday night call because you go home Friday around noon and usually will have the weekend off as well, resulting in a two and a half day weekend. If you are on call on a weekend, you come in during the day and leave by noon the next day.

What do you do when you are on-call?
During your on call nights, you follow the consult resident. This will give you the opportunity to be one of the first to work up a potential surgical patient. If it is a quiet night (and believe it or not some nights are quiet), some residents will just send you off to read on your own or to sleep. Leave them your pager number and they will page you if anything interesting arises. Some residents want you with them at all times (some because they want your help, others because they love to teach), while others will forget about you and never page you during the night. In general, it a good idea to spend some time with the consult resident and see acute presentations of surgical conditions and follow them into the OR.

Where do I stay?
At RIH, the call room is on the fourth floor of the Gerry House. There are 7 call rooms and you can use whichever one is not occupied. At The Miriam, the call room is on the second floor.

How do I get up at such an ungodly hour?
Some people bring little travel alarm clocks. Some have pagers with alarm settings. You can also call the operator at the hospital you are at and ask for either a wake-up call (in which case she will call the call room if there is a telephone in it) or a wake-up page. Don’t feel bad about asking. She is working the third shift from midnight to 8am and writes down many wake-up page times and can include you on her list. The key to a wake-up page, of course, is to leave your pager on.

Didactics for Everyone
In the Surgery clerkship, there are a number of department conferences which you should be aware of:

- **Trauma Conference** – Mondays at 7am, located in the George Auditorium. An entertaining show. The entire Division of Trauma and Surgical Critical Care attends and question the residents (don’t worry, never medical students) about the work up, management and care of the trauma cases being presented. The last Monday of the month is Trauma M&M Conference which is where morbidity and mortality of trauma patients are discussed.
- **Grand Rounds** – Wednesdays at 7am from September to June, George Auditorium. The Grand Rounds presentation is typically on a current surgical topic.
- **Morbidity and Mortality (M&M) Conference at RIH** – Tuesdays at 7am, George Auditorium. Afterwards, residents have their own conferences at 8am.
- **M&M Conference at Miriam** – Thursdays at 7:30am.
- **Service conferences** (Surg 1, Surg 2, Surg 3, and Surg IV conference) – Friday mornings. Each service has its own conference, primarily for the education of students and residents on the service. The format is a case presentation to the team and various attendings, followed by
Pimping starts at the student level, then proceeds up the hierarchy until the question is answered. Usually, students alternate with presenting one patient each week. Preparation is the key to success in these conferences! Have the patient's presentation, H&P, labs, and imaging studies ready. Perhaps the best preparation for this conference is to find the pertinent chapters and management algorithms in surgical texts. See “Recommended Texts” below.

Didactics for Medical Students

Surgery lectures for medical students occur about 3-4 times a week at RIH. You should read on the topic prior to attending. Conferences are interactive so this enables you to get the most out of the lecture series. Common topics include surgical oncology, teaching rounds, hernia, abdominal pain, breast problems, lung cancer, jaundice, etc. Lectures occur at the end of the day (usually 4pm or 5pm in the APC 415 conference room) to minimize conflict with the OR schedule and allow traveling to and from The Miriam and the VA.

There are also Resident Teaching Conferences that covers topics not included in the Faculty Lectures and are led by PGY-2 and 3 residents and proctored by faculty. These are of variable format from lectures to case-based presentations to group discussion.

Sign out with a member of your team prior to attending lecture so they know where you are and may let you go home after the lecture is done (although some teams prefer you to return for sign out to follow up on the day’s events for the patients). Of note, lectures may be cancelled on a moment’s notice, especially if the speaker is stuck in OR on a case running over. Kim Sanzi will page you (yeah text pagers!) and shoot you an e-mail if any lectures are cancelled, postponed, or delayed.

Procedure workshops occur during the first week of the clerkship and introduce you to various topics and areas. For example, you will learn skills such as suturing, placing, the “proper” way to scrub, post-operative complications, surgical nutrition, fluid and electrolytes, etc.

Service Structure

Surgery is service-driven with various teams comprising each service. The main services you will be a part of include:

**General Surgery** – You will be scheduled to do four weeks of general surgery at RIH, The Miriam, or the VA. At RIH, it is organized as four weeks on a general surgery service.

General surgery essentially means “operations on the middle part of the body.” That is, a lot of abdominal surgery (colectomies, appendectomies), some thoracotomies (chest surgeries, which are not the same as cardiac surgeries), hemorrhoids, gall bladders, thyroid surgeries – you get the idea.

- At RIH, the general surgery services are called Surg I, Surg II, Surg III, and Surg IV.
- At The Miriam, the general surgery service is one large team.

**SICU** – Pronounced “sick-u.” SICU is an ICU rotation. In the SICU, you will admit patients in critical condition who are recovering from major surgery, write an H&P, write daily notes and orders, and present new patients to the attending the following morning. The SICU can be a great place to learn procedures depending on your resident (SICU was my first ever wards experience, and my resident let me float a central line – cool). It can be either very busy or very quiet so there can be a lot of down time for reading and teaching. The amount of teaching is resident-dependent, so if your resident is teaching-friendly, you could learn a lot.

**Trauma** – Trauma is the other 2-week ICU rotation. While on the Trauma service, you will see the Emergency Department/Trauma rooms in action for any injury that involves heat and/or force, e.g. motor
vehicle crash victims, gunshot wounds, stabblings, falls, burns, persons struck by lightening (in contrast to medical emergencies such as MIs). The Trauma service also runs the Burn Clinic (Mondays 9am), and Trauma Clinic (Thursdays 9am). It is also worthwhile (but often forgotten) to spend down-time (between the ED calls) in the TICU (pronounced “tick-u”), learning critical care skills and following the trauma patients your team has admitted. It is also worthwhile to hang out in the ED and offer to stitch up lacerations that come in.

**Vascular** – 2-week rotation.
Vascular surgery means “bypass bypass bypass” – but not cardiothoracic surgery. There is a lot of reconnecting vasculature in the human body with either human or synthetic grafts. Common operations include carotid endarterectomies (cleaning out the carotids to prevent ischemic strokes), fem-distal bypasses (creating vascular bypasses from the femoral artery to a distal location, to aid perfusion to extremities), and abdominal aortic aneurysm (AAA) repairs. The role of the medical students on rounds is to assist in the physical examination and wound care of vascular patients. Students are assigned patients to pre-round and present on morning and afternoon rounds. Students are expected to be familiar with the events of each assigned patient's day including laboratory and radiology studies. The vascular service at RIH also includes renal transplants, but you may have an opportunity to attend transplant cases on any service. These are great opportunities and should not be missed.

**Pediatrics** – 2-week rotation.
The role of the medical students on rounds is to assist in the physical examination and wound care of pediatric patients. Students are assigned patients to pre-round and present on morning and afternoon rounds. Students are expected to be familiar with the events of each assigned patient's day including laboratory and radiology studies.

**Transplant** – 2-week rotation.
The role of the medical students on rounds is to assist in the physical examination and wound care of transplant patients. Students are assigned patients to pre-round and present on morning and afternoon rounds. Students are expected to be familiar with the events of each assigned patient's day including laboratory and radiology studies.

---

**Who’s Who on the Surgical Team**

**The Chief Resident** – The senior resident. A fourth- or fifth-year resident responsible to the attendings for everything that happens to everyone (patients, residents, students) on the service. Also helps attendings with high profile/difficult cases in the OR.

**Mid-Level Resident** – A second- or third-year resident. The operative workhorse of the service who, when not in the OR, is responsible for seeing consults, admitting patients to the floors, and making sure the interns do their jobs. This is the best resident to hang out with to learn the diagnostic workup of surgical patients.

**Interns** – The first-year residents. They are the workhorses of the service on the floors and are responsible for the day-to-day post-op management of patients on the service. They are also the most overworked and most beaten down. Sometimes they cover the ORs, but usually just managing patients.

**Sub-Interns** – The third- or fourth-year medical student who is likely interested in surgery. Like a student doing a sub-I in Medicine or Pediatrics, the sub-I functions like an intern except instead of doing floor management all day, they will go to the OR and scrub in more often. Try to help out your sub-I, and they will return the favor.
Your Role on the Team
Being the junior junior junior member of the team is slightly different, because now you are one of several junior most members (including the interns). Spread between the students and interns during rounds, you are collectively responsible for:

1. Getting the most updated copy of the patient list (see the upcoming section, “The List”) from your intern and distributing it to team members.
2. Pulling charts before rounds and placing them outside patients’ rooms (if that’s what your chief resident wants).
3. Doing the quick physical exams during morning rounds (at the same time as the intern).
4. Obtaining the vital signs and starting on the daily SOAP notes (the A/P may be left for the senior resident to complete depending on what your chief resident wants).
5. Obtaining supplies for redressing wounds during morning rounds. On the Vascular service, you will carry a plastic bucket/basin (found in the supply rooms) filled with various dressings, bandages, tape, scissors, and extra order sheets and progress note sheets if your chief resident approves. Some chief residents could care less, but most will appreciate your helpfulness. One of your residents/interns will direct you as to the ideal “dressing bucket” for your team.

When all is said and done, that is how you can be most helpful to the team during rounds: Be a handy, helpful medical student. The truth of the matter is that by being prepared and trying to anticipate what the team needs as you round, you will be more valuable to the functioning and general pleasantness of the team.

JMS says: Does this all sound like a bunch of scutwork?
It is all in how you view things. Your overall goal as a medical student should be multifold: To learn, to advance patient care, and to help out the team. What you do during rounds, though it could be viewed as menial, furthers the last two goals.

But wait, what about teaching and learning during rounds?
While you are supposed to learn during rounds, do not expect formal didactic teaching. Due to the quick pace and necessity of completing rounds before conferences, efficiency is at a premium in the morning. It is best to write down any questions you may have and ask a resident later in the day when they have a free moment.

After rounds and morning conference, your duty is to attend surgical cases in the OR (ask your residents which are the best for you to watch or help out at) or go to clinic, office hours, read, prepare for presentations, help out other team members with floor work.

THE LIST
Ah, yes. THE LIST. On no other rotation will you have THE LIST. Although you do have a list on other clerkships and services, their lists will not have the same importance as THE LIST in Surgery.

THE LIST is the list of patients on your service (Surg I, Surg II, Surg III, Vascular Surg, VA Surg, Miriam, or Trauma), their age, diagnosis, surgery performed or to be performed, antibiotics they are on, etc. THE LIST is all-knowing and all-powerful. If it is not on the list, it is not happening or it is not important.

Each hospital/service/team will have a copy of their list on some computer or database. THE LIST must be ready for morning rounds with a copy for every member of the team (make an extra one or two just in case). Thus, THE LIST must be updated each morning and night by the intern (and student) on call. Your interns will teach you how to access the list, make and save changes, and print copies for everyone on your team.
You should help our intern with THE LIST. While the ultimate responsibility for the day’s list lies with your intern, you will either be delegated some list responsibility or you may help out with THE LIST just because you are being a nice medical student. Hence, you should stay on top of changes made to THE LIST. That means paying attention to everything being said while “running THE LIST,” making notes during sign-out rounds when you are on call, and compare notes with your intern.

**Running THE LIST**
This is the equivalent of super-lightening-turbo-fast-speed sit-down medicine rounds. After your team finishes rounding and before the workday starts, your team will sit down and go through THE LIST (usually over breakfast in the cafeteria). One of your interns or junior residents will go through the vitals of each patient and run through the plan for the day on each. Your interns, who are responsible for floor patient care while everyone else is in the OR, will be making little “to do” lists by each patient’s name. You should do the same so that you will know what is going on and be able to help.

**Folding THE LIST**
Just wanted to draw your attention to how your residents fold their lists. There are efficient and inefficient ways of folding that 8½”x11” piece of paper to maximize your patient-to-information ratio. You will see.

**Life in the Operating Room (OR)**
a.k.a., “This is the only time in your life that you’ll strive to be sterile.”

You will be oriented to the operating room during orientation and be taught how to scrub, gown and glove, and scrub out, etc. Some things to remember, though…

**Who are these people in the OR?**

**The Attending**
The surgeon ultimately responsible for the patient’s well being, the procedure at hand, and the education of the resident and the student (in that order). During a case, you will see him refer to the OR as his OR.

**The Resident**
The person (usually the chief resident or the mid-level resident) doing much of the operation and learning the attending’s technique.

**The Scrub Nurse**
The sterile or “clean nurse” on the operating field responsible for handing instruments to you and the surgeons. This nurse will probably be the most vigilant regarding maintenance of the sterile field. Learn her name (not her nickname – one scrub nurse is affectionately called “Peanut” by the surgeons, but you should not refer to her as that) because she will be your ally if you get pimped and will be sure that you get as many instruments in your hands as needed before you even think to ask.

**The Circulating Nurse**
The unsterile nurse who circulates in the background, fetching equipment, moving things, keeping track of the comings and goings of the room. Learn this nurse’s name as well because he will be a big help in getting you a step stool, answering your glove-size questions, adjusting your face mask.

Always introduce yourself to the scrub nurse and circulating nurse ahead of time and offer to hand them your gloves.

**The Anesthesiologist/CRNA**
JMS says: A lot of what you do during procedures is holding retractors. Retracting provides better views for the surgeons. Get used to holding retractors for hours and hours. Some surgeons call retractors “learning sticks” for medical students.

1. Stay hydrated, but do not guzzle a big bottle of vanilla Coke before going to the OR.
2. Use the bathroom before you go to the OR. Pretty self-explanatory.
3. Have some granola bars, raisins, or other snacks in your white coat pocket so you have something to munch on in between cases and/or in case you miss lunch. Hypoglycemia in the OR is not good.
4. Keep some thread, dental floss, or sutures with you, so you can practice your knot-tying during down-times.
5. Do not take things personally. Have a sense of humor.

What do I do in the OR?
Six simple words to live by. Whatever you do, **DO NOT BREAK THE STERILE FIELD!** Also, whenever someone (usually the scrub nurse or circulating nurse) tells you that you have broken the sterile field, and you will need to re-scrub, re-gown, and re-glove… do **NOT** argue or protest or question them. Just go re-scrub, re-gown, and re-glove or do whatever it is they want you to do.

Obviously, sterility is important because surgical procedures expose the vital organs of the patient and you do not want your germs, bacteria, or any other gunk, dirt, and oils from your body seeping into the patient’s open body cavities or into their bloodstream.

Simple rules regarding the sterile field:
- Anything that is blue is “sterile,” i.e., **DO NOT TOUCH** with any part of your body!
- Your own sterile field, after scrubbing and gowning and gloving, is just your chest and hands – **not** your back, **not** your face (**definitely** not your mask or face shield), or anything else. The sterile area on your chest is any part below your nipple line (no joke) and above your waist. Anything above your nipple line and below your waist is considered unsterile.”
- When you rest your hands, clasp them together over your chest. Do **not** fold your arms over each other (the position people assume when they are impatient). This places your hands away from the sterile part of your chest. **Do not** stand with arms akimbo (hands on hips). Your waistline is not sterile.
- **WARNING!** There are all kinds of obsessive-compulsive, scary-ass rules about sterility. Some of them border on voodoo with very little scientific basis. For example, you are never supposed to reach above your nipple line. But when inserting plastic covers over the light handles, it is perfectly fine to reach above your head.

**DO ONLY WHAT YOU ARE ASKED TO DO.** Hold retractors, cut sutures, staple wounds closed, sing (it’s true – students have been asked to sing in the OR before, and you may be, too, so have a song ready) as you are instructed to do so. **Do NOT** scratch or ask to go to the bathroom (read the section in *Surgical Recall* about being a “hammerhead”).

**DO ASK TO DO THINGS YOU WOULD LIKE TO TRY** like suturing or operating the electrocautery knife (a.k.a. bovie), but again, **DO ONLY WHAT YOU ARE INSTRUCTED TO DO.**

What else can I do in the OR?
You may get to a point during your Surgery clerkship when you wonder what you are doing at an operation, especially for those not interested in a surgical career. You may be at your tenth laparoscopic cholecystectomy and suddenly think, “Do they need me here?”

Most of the time, they probably do not. It is not necessary for three people to be at a hemorrhoidectomy, no matter how bad the hemorrhoids.
Do not underestimate your importance in the OR though. Sure, it may seem as if you are there just to be pimped, but when you are asked to hold something, it is because it needs to be held. Yes, retracting bowel loops for two hours is not greatest activity in the world, but your extra hands can be helpful when you least expect it.

Try to have fun! Unless you are going into General Surgery, this is the only opportunity you will ever have to see surgical cases like these.

What to Bring and Wear

- Your white coat
- Stethoscope, placed in one of your pockets (a Surgical fashion statement). A surgical attending gently chastised me for wearing a “flea collar” when I had my stethoscope draped around my neck in the typical Medicine fashion.
- Black ink pens (and extra cheap ones in case they are “borrowed”)
- Notecards or small notepad
- Pharmacopoeia, Maxwell’s, Sanford’s antimicrobial guide, etc…
- Trauma shears

When do I wear professional clothes and scrubs?
- **Scrubs**: Whenever you are in the OR throughout the workday, or on call.
- **Professional clothes**: When you are rounding on any day, at Grand Rounds, or at any conference.

You used to be able to wear scrubs post-call or whenever depending on the discretion of the chief resident, but the clerkship directors have made an effort to encourage professional clothes during morning rounds in general and at conferences. Just follow the lead of your chief resident and the team.

What should I not bring?
A clipboard. This is not Medicine or Pediatrics. The reason you do not need to keep extensive records on this clerkship is because there are none. **Everything** should be on THE LIST. Also, if you are like some of the interns, you will be so sleep-deprived that you will be constantly forgetting it and leaving it lying around on various floors (with important confidential patient information… not good). Also, you will need both hands free at all times (especially during rounds, when you are changing wound dressings).

Clerkship Grading
There are a few methods of evaluation for the Surgery clerkship. Evaluations account for 50% of your grade, the oral exam 25%, the Shelf 25%.

Team Evaluations
All resident levels on each team will complete evaluations on each student who rotates through the service. The evaluations are completed online using OASIS and are sent to assigned team members (faculty or residents) for completion. You may also request for additional evaluations to be sent to any resident or faculty you wish to evaluate you. For example, if all went well, you should request for evaluations for your office hours attending or an attending whom you participated in many OR cases with to fill them out on you. The input from additional evaluations will be added to the team evaluation and are valuable to the student file.
The evaluations are kept online and you may view them at any time. There are also hard copies in your file in Kim Sanzi's office during the clerkship and you are allowed to review your file any time between 7:30am and 4pm from Monday through Friday. Of course, you fill out evaluations on your residents, attendings, as well as an overall evaluation of the clerkship.

**NBME SHELF Exam**

There is an interesting dichotomy between what you do and learn on the Surgery clerkship and what is on the Surgery Shelf exam. During your clerkship, your duty is to attend, observe, and help out on surgical cases in the OR. Thus, you learn surgical techniques, names of surgical instruments, how to tie certain knots, etc. The Shelf exam, however, tests your knowledge of the common presentation of surgical cases, what to do, common complications, etc. – knowledge that is not easily garnered from the clerkship.

The Shelf is fairly difficult because many people feel that, aside from the lectures, the clerkship does not proactively teach much that you will be tested on for this exam. You are expected to pick up a lot of information by osmosis, observation, and reading on your own time and should not expect to be spoon-fed any information. There is also a fair amount of trauma, neurosurgery, urology, and orthopedics that you should review before the exam.

Studying is hard. You are sleep-deprived, hungry, and beaten down. One editor’s advice: *Do as many practice questions as you can.* Also, ask others how they are studying. *NMS Surgery* is popular because it has chapters on each topic and has practice questions at the end of each section. One of the editors started doing a load of *NMS Surgery* practice questions starting his seventh week.

**Logging Operative Cases**

You are given OR cards to record the minimum requirements of cases you have seen in the operating room throughout the surgical services. Easy enough. Students will hand in OR cards on a weekly basis, and the entries are logged so that the clerkship directors can review your cases.

**Oral Exam**

Not as scary as it sounds, but you should certainly prepare for it. The oral exam is a 20 minute session where you are questioned on two patient scenarios (10 minutes each). Essentially, a pimping session. One question is formulated from the list given to you at the start of the clerkship, and one from the *Manual of Surgical Objectives* (also given at the start of clerkship). The examiners are either Dr. Roye or Dr. Ryder and one senior resident. Students are graded on knowledge about the disease, diagnostic approach to the disease, and management approach to the disease, as well as verbal and non-verbal communication skills (dress well, smile, maintain eye contact, and speak clearly and confidently). A practice session may be scheduled for students to assist with preparation. You can also study with another student by running questions with each other from cases in your OR cards and from questions in the *Manual of Surgical Objectives*. Some students feel that *Surgical Attending Rounds* is good to use to prepare for the oral exam. The exam format is very formal.
**Case Presentation**
Students deliver formal case presentations at service conferences at least once over the course of the clerkship. The students are given immediate feedback by faculty and the senior resident.

**Recommended Texts**

**Case/lecture preparation:**
Surgical Attending Rounds (Dyke)
Essentials of General Surgery (Lawrence)
Sabiston Textbook of Surgery (available through MD Consult)
A surgical atlas is also available online through MD Consult.

**Exam preparation:**
Surgical Recall (Blackbourne)
NMS Surgery Casebook
Appleton & Lange Q & A Surgery

**For your pocket:**
*Surgical Recall*
Yes! Yes! Yes! Buy it, use it, love it. It is the perfect anti-pimp book. It is handy Q&A format that allows you to brush up on cases and prepare you for pimpering before going into the OR. Do not use it to study for the Shelf exam, however, as it does not provide the information you need in a format that prepares for the Shelf.

*Mont Reid Surgical Handbook*
A pocket-sized guide to common presentations, evaluations, medical and surgical treatment of surgical problems. It is a good combination of what you need for the wards and for the Shelf exam.

*Surgical Intern Pocket Survival Guide*
A handy little red-covered book for serious surgeons-to-be. If you do not think you will be applying into surgery, do not bother buying this book.

**ON-LINE VIDEO LIBRARY**
The SAGES Surgical Education Video Library is available to you as a resource to familiarize you with surgical procedures in the operating room.
Okay, this handbook is a clerkship handbook. I tried to cover as many questions and concerns about the clerkships. That said, new clerks fresh from taking USMLE Step 1 often have questions about Step 2. So the following are common questions about the exam. For more information, talk to fourth-years about when they took it, but remember that they may have taken it at different times for different reasons.

**What do you need to know for Step 2?**

Step 2 is divided into the Clinical Knowledge (CK) and Clinical Skills (CS) exams. These are two separate exams that you may or may not take around the same time.

Step 2 CK is similar to Step 1 in that demonstrated knowledge of several subject areas is expected of you that mirror the core clerkships: Medicine, Surgery, Family Medicine, OB/Gyn, Pediatrics, Psychiatry, and Community/Public health.

You will receive a very detailed outline on what you are expected to know, just like the one for Step 1, as part of your registration materials.

**Should I take all my cores before I take Step 2 CK then?**

You do not have to, although it is highly recommended.

**Are there any cores that I should take before Step 2 CK?**

Yes! You should absolutely complete Medicine, Surgery, OB/Gyn, and Pediatrics before taking Step 2 CK. There is also a fair amount of neurology on the exam, but most people are pretty well prepared from the amount of neurology you get in your preclinical years and on Medicine.

OB/Gyn is especially important as a lot of OB/Gyn is so foreign from other areas of medicine that it would be prudent to be familiar with it before Step 2. Learning OB/Gyn from scratch can be a daunting task. The same can also apply to Pediatrics. Both the OB/Gyn and Pediatrics clerkships do a pretty good job of exposing you to the general material you need to know in those areas. Naturally, most people will have taken Medicine before taking Step 2 CK since you need to complete it by Quarter 3.

**What is it like? Is it the same as Step 1?**

It is better than Step 1. Of course, almost anything is. The common saying is “four weeks [of study] for Step 1, four days for Step 2, and bring a #2 pencil for Step 3” (except nowadays a #2 pencil will do no good for the computerized format). The truth is actually something different, but you get the general picture.

Step 2 is more clinical. Almost none of that biochemical pathway nonsense (there is some Step 1 material that comes up, but certainly nothing to waste your time pouring over the material again). You are more in tune with what you have learned simply by having seen a lot of it first-hand on the wards, which is a pretty neat thing. You best teachers have been your patients. It is much cooler compared to Step 1 (that is, as cool as an eight hour exam can be). Speaking of which, it is about an hour longer (with 8 blocks) than Step 1 (which had 7 blocks) and hence, can be a bit more of tiring simply due to visual fatigue.

**How much time should I set aside to study for it?**

At least two weeks for sure, but probably no more than four. Really.
The reason for at least two weeks is because despite what the fourth-years who have taught your Step 1 review classes when you were a second-year may have told you, you have to study for Step 2 CK. You have to set aside time to study and review material from your first year on the wards.

The reason for not more than four weeks is because you will be able to answer questions based on your wards experiences. There is no need to torture yourself with more studying and memorization for longer than two weeks (especially when you can be a vacationing fourth-year).

**What books are helpful for studying?**

You should have some basic Step 2 CK review books:

A comprehensive review book, e.g. *First Aid for the USMLE Step 2 CK*. This used to be a very poor comprehensive review book (the authors of *First Aid for the USMLE Step 1* slacked on early editions of this Step 2 counterpart), but recently it has become the comprehensive review book to use. There are other comprehensive review books, although not quite as comprehensive as *First Aid*, but still good such as *Crush Step 2: The Ultimate USMLE Step 2 Review*.

One or two question resources. Instead of *Appleton & Lange* most students are using Case Files orBlueprints Cases *Appleton & Lange* has a question book divided by subject, which some students use with their core clerkships. Instead of *NMS during the last week most students are using world questions or the cases in Step 2 Secrets* has a sample test book that you can do during the week before the exam. Other popular question resources include *Q Bank*, the web-based question resource from Kaplan (similar to the format for Step 1), or a less expensive, but similar *Q Bank* alternative from USMLE World seems much better Alex (www.usmleworld.com).

One quick and fun overview book like *Crashing the Boards* for Step 1. The Step 2 version of the book can be quite useful.

Plus: **Your own books from each clerkship, but not to be used as studying material.** I recommend setting aside two or three days to skim through whatever materials you used while on your clerkships to see if there are any areas you felt weak in and review those. Then do NOT, I repeat, do NOT bring these with you to study. There are too many bits of minutiae you may get trapped into memorizing from these books. Review what you felt weak in, then leave them behind in your apartment or locker and use your dedicated Board review books for studying. Do not worry. The people who write the Board review books know what you need to know for the Boards. Leave the minutiae books behind. You will be happier for it. Trust me.

A prior editor of this guide also highly recommended *Pharm Cards*. “There’s lots of ‘what drug may have caused what side effect’ and ‘what drug for what organism’ on Step 2. Use them, love them.”

**What is Brown’s take on Step 2?**

You do not need to pass Step 2 to graduate, but you do need to sit for the exam.

**What are residencies’ takes on it?**

You need to pass all Steps (1, 2, and 3) in order to be a licensed physician, and I cannot think of a residency that would hire you knowing you have not passed Step 2. So, in the end, you need to have passed both Step 1 and 2 prior to entering residency.
When should I take it? Fall or Spring?

Depends.

Some people have to take it early because they are on an armed forces scholarship, so they have to take it by the end of the summer as a fourth-year.

For everyone else, there are several things to consider when scheduling your Step 2 CK exam.

Reasons for taking Step 2 CK in the Fall:

- You want to pass Step 2 CK ASAP so you can concentrate on more important things like applying to residency.
- You do not want to study for Step 2 when every other fourth-year is done and vacationing in Antigua.
- Because the information you need to pass and do well on it is freshest in your mind in the Fall.
- If you do even better on Step 2 CK than Step 1, then your competitiveness for a residency program will increase and you may receive more/better interview offers or be ranked higher on the final rank list.

Reasons for taking Step 2 CK in the Spring:

- Poor scheduling prevented you from taking one of the four more significant clerkships until Fall and/or Winter of your fourth-year.
- You did so well on Step 1 that it would be difficult to do as well or better on Step 2 CK.
- Along the same lines as the previous statement, you are afraid that if you will not do as well on Step 2 CK, residency programs will see it, and you may become a less competitive candidate.

There are a few important things to remember about taking Step 2 CK in the Fall. If you take it early in Fall or even late Summer, and you do very well, you have an opportunity to have the scores seen by residency programs resulting in more/better interviews. If you take Step 2 CK late in the Fall or even early Winter, it may not have an impact on interview offers, but residency programs that have already offered you an interview may see you as a more competitive candidate and rank you higher and will at the very least know that if they do rank you high, they do not have to worry about you passing Step 2 CK.

An important note about taking Step 2 CK in the Spring is to above all else take Step 2 CK before Match Day! After Match Day and you have a job lined up and everything, it’s all downhill from there. Your desire to work and study will plunge down to the depths of nowhere, and it becomes very, very difficult to concentrate for Step 2 CK.

Regardless of exactly when you plan to take Step 2 CK, try to at least register for it and get a scheduling permit relatively early in your fourth-year so you have the time and flexibility to schedule the exam so that it best fits your schedule.

Wait, you mentioned something about a Clinical Skills (CS) examination. What is that?

Step 2 CS is the Boards version of the OSCE. It is basically a section of Step 2 that assesses your ability to prove proficiency in English, exhibit good interpersonal skills, and take medical histories and perform physical exams on standardized patients. The test is composed of 12 encounters. You are given 15 minutes for the H&P and 10 minutes to write a patient note. You have the choice of either typing a SOAP note on a computer or writing a SOAP note on a paper (but not both at one station).
The SOAP note is simplified to four sections. The first is your HPI, ROS, and relevant PMH, Medications, Allergies, Family and Social history. The second section is your focused physical exam (which may be absent if there is no patient to exam). The third section asks you for a list of up to (but not necessarily) five differential diagnoses with the first being the most likely diagnosis (although the order of the rest does not matter). Finally, the fourth section asks for a list of up to (but not necessarily) five initial work up tests you would want to order or do (may include physical exam).

In addition to the standard patient encounter, you will have to do a third-party interview (a parent with a young child not there in the room) and a telephone interview.

Evaluation is based on three separate criteria:

1. Integrated Physical Encounter: Evaluates your skills at doing a history and physical as well as your ability to write a SOAP note.

2. Communication and Interpersonal Skills: Judges your ability to gather information and develop rapport with patients.

3. Spoken English Proficiency: Originally meant for Foreign/International Medical Graduates, but they include you as well for good measure.

Step 2 CS is pass/fail. You need to pass each of the three criteria to pass the exam. Only those who do not pass the exam will get a graphic representation of their performance for both remediation and further learning.

Step 2 CS is the NBME’s answer to the public clamor about testing medical students on competency in relating with patients (empathy, body language, etc.). Thus, you will have to:

1. Pay the $975 fee to take Step 2 CS. Rescheduling the exam is expensive at $400 if you do not show up on the day of the exam, $150 if you give less than 30 days notice, and $50 if you give more than 30 days notice.

2. Travel to Philadelphia on your own expense to take the exam (as of this point, Philly is the closest location that administers the exam). Some people have to schedule at other sites because Philly usually fills up very quickly. You may also choose to schedule at a site closer to home or while on the interview trail or simply because Philly is full (the other locations are Atlanta, Chicago, Houston, and Los Angeles).
ERAS & THE MATCH

Again, this is a clerkship handbook, and you are just starting out on your third year. But that is no reason not to address some questions about the Match, especially since I know that no matter what I write and no matter what anyone else says, you will wonder about it. There is also a popular residency guide Iserson’s “Getting into a Residency” that you may consider looking at.

What is “ERAS” and “NRMP”?  

ERAS (Electronic Residency Application Service)

This is the service that you use to apply to residency programs. You complete a basic application form online, upload your personal statement(s), and have Brown’s Medical Student Affairs Office upload your Dean’s Letter (a.k.a. MSPE or Medical Student Performance Evaluation) and letters of recommendation, transcript, photo. You then select the specialty and programs that you want to apply to, and your application materials are electronically sent to those programs. Thus, you only have to complete one application, which is sent to multiple programs. It makes life 10,000,000 times easier than for people who applied the old-fashioned way by mailing away for each application component.

NRMP (National Residency Match Program) a.k.a. “The Match”

This service matches you with (hopefully) your top choice residency program. Essentially, you rank the programs you want to be at (with #1 being your top choice, which you hope you get into; #2 = your second best choice, etc., etc.). The programs also rank candidates that they interviewed, from #1 to whatever. These Rank Order Lists (ROLs) are then submitted to some computer in some magical place, which then crunches out all the numbers and spits out the optimal pairings for every medical student and residency program, then on Match Day (some Thursday in mid-March), every medical student across the nation finds out where he or she is going to train for the next few years at exactly the same time.

Can I apply to every program in the United States using ERAS?

You could if you won the lottery. In order to encourage wise decision-making and discourage blitzing of applications, it costs money to apply to programs using ERAS and the scale used to determine what to charge you is exponentially based on the number of programs you apply to.

ERAS application fees are: $60 for the first 10 programs; $8 each for each additional 11-20 programs; $15 each for an additional 21-30 programs; and $25 each for greater than 30 programs. If you apply to 8 programs, it costs the same as 10 programs, $60. If you apply to 20 programs, it costs $60 + $80 for a total of $140. If you apply to 22 programs, it costs $60 + $80 + $30 for a total of $170.

If you are applying into a specialty that requires a preliminary internship year (prelim), then you will have to apply separately to programs that offer prelim positions with a separate set of application fees. For example, 10 residency programs and 10 preliminary programs would cost $60 + $60 = $120.

Hang on a second. I have no idea what I want to do with the rest of my life. When do I have to decide what kind of residency I want?

Considering that ERAS now opens September 1 and most residency applications are due by November, you will hopefully know what you want to do by July in order to have time to ask for letter of recommendations and work on your personal statement. There are also residency programs that participate in the Early Match and have earlier deadlines.
What is this Early Match?

Some fields participate in the Early Match, where you match in January, instead of March. These fields include Ophthalmology, and Urology. The timeline for applying to these programs is earlier than the others, and you should double check the exact dates.

How many letters of recommendation do I need? And from whom?

Most programs ask for three letters. Most medical students ask three to five people to write letters for them. Most of the time you should have them written by attendings you worked with who practice the specialty you are interested in. However, if you are applying to something like internal medicine, you may submit letters from specialists, such as cardiologists and gastroenterologists, since their training is based on internal medicine residencies. You should check with the programs you are applying to regarding their specific requirements and deadlines.

Should I do an away elective? When is the best time to do one?

Doing an away elective depends on your goal. Essentially, there are three reasons to do an away elective:

1. You want to audition at a particular hospital or residency program.
2. You want more letters of recommendation for the specialty to which you are applying.
3. You want to be in a particular city or country for a few weeks.

Let us go through each…

1. You want to audition at a particular hospital or residency program. It is worth it only if you know that you definitely want to match there or want to interview and rank the program high on your list. If that is your goal, be prepared to work your tail off and do not go away thinking you are going to be taking a vacation because if you are truly auditioning, you had better be a ★STAR★ and be better than their medical students.

2. You want more letters of recommendation. Similar to reason #1, so count on busting your butt and working on being a ★STAR★.

3. You want to be in a particular city or country for a couple of weeks. This is the antithesis of reasons #1 and #2. Experience the city or country, explore the region, but do not count on auditioning for this program.

Of course, it depends on the specialty you want to go into. If you are entering an ultra-competitive specialty like dermatology or ophthalmology, an audition elective may help you (plus some programs consider audition electives to be interviews, so you basically already have an interview in your pocket!).

Once you decide that you want to do an away elective, apply as early as possible. Each medical school has a limited numbers of spots for each rotation, and they may fill up quickly. Many are open to visiting student applications as early as six months prior to the elective start date. Also, you want to be able to find housing, transportation, etc. in the area. Plus, you have application materials that you need to complete, too, and some of these take a lot of time, such as obtaining a letter from Brown’s administration stating that you are in “good standing” in the
school; getting copies of your vaccination records, or updating your immunization status (PPD, anyone?). The earlier you get things done, the better.

**How many programs should I apply to?**

That depends on what you are applying in. The basic advising algorithm asks, “at how many places must I interview in order to be pretty well assured of matching?” Unfortunately, even with Iserson’s “Getting into a Residency” as a rough guide, the patterns for different specialties constantly change and are not necessarily predictable. The best way to get the answer to this question would be to talk to Alex Morang and your career advisors (assigned to you around halfway through your third-year)... early.

**Any other hints?**

Yes, three:

1. Residencies want to know that you are a happy and stable person whom they can count on to do the work that needs to done and whom they can train. They like to know that you have a good support network. At any place you apply and interview at, if you have friends or family (no matter how distant) in the area, tell that to the residency program! They love hearing that your mother will be able to bring you meals when you are on call and overworked, and that you will not have a nervous breakdown during your ICU months.

2. Your best source of advising is from within the department of your specialty. Also, ask fourth-years who have applied in specialties you are interested in about what they did and ask many different attendings what they recommend. Alex Morang is an invaluable resourse. **You can never get too much advice.** You can choose whether to follow certain pieces… but do not be bashful about asking for guidance. Sometimes the people you expect to have all the answers do not, and the ones you do not expect much from offer you a ton of helpful tips. Alex also has a list of alumni in different specialties that you can contact who would be happy to offer you advice on specialties and/or residency programs.

3. If you are applying into a specialty that requires a prelim, you must interview for two separate groups of programs: One for your residency and one for your prelim.
This final note appeared in the first edition, written by Melisa Lai. It sums up my sentiments so well that I found no need to change it.

You did it. You’re ready for the big time.

You’re gonna wear that white coat like you mean it, remember your stethoscope even when you forget your wallet, and you’re gonna show the world – and yourself! – just how good you are. Because you couldn’t have come this far already without being one of the best and brightest, and you know that – even when you’re being pimped like there’s no tomorrow.

‘Cuz there is always a tomorrow. Sure, you had to stay up all night to get there and you’ll have to stay awake through tomorrow, but there’s always something new to learn and there will always be something new to do. And before you know it, you’ll be co-signing for your medical student, thinking of what else you can teach and what else you can share.

These next two years are gonna be great. Whatever you do, you’ll do it with verve, you’ll do it with confidence (you will!), and most importantly: YOU’LL DO IT TOGETHER. Help each other, look out for one another, be there for your classmates – as they’ll be there for you.

And yes, even at 4:45 am on a Friday that you have two presentations and you haven’t yet started studying for the Shelf exam, you will remember (as difficult as it may be at the time), that it’s all worth it.

Good luck!