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To Grant Chu, 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.
FOREWORD FOR THE FIFTH EDITION

Congratulations! You’ve made it through the morass of preclinical medical education, and now you are entirely ready to jump into life on the wards. Right? If you’re anything like me, the answer to that was a resounding “no,” even after having gotten pretty comfortable with the way medical school works during first and second year.

However, true to form, other Brown medical students were there for me during that perplexing transition from the classroom to the hospital: this handbook, older friends, and my classmates all offered incredibly useful input. The final two years of medical school have been a blast, and I am incredibly thankful for all the “inside scoops” I’ve been given. You, too, will become adept at navigating through various EMRs, hitting the cafeteria just before it closes, or comforting the new clerks on your service who are overwhelmed and under-supported.

As it has been in past versions, this handbook is intended to serve as a guide for your third-year clinical clerkships. Many of the details will become second-nature to you throughout an individual rotation, and are merely a starting point for your learning. They will hopefully make you more comfortable on the wards so that you are able to sooner experience the real reason many of us came to medical school: the truly incredible experience of caring of patients and their families.

The spirit in which this handbook is prepared and passed down from class to class is the same as the way in which notes collectives, study groups, and all the other ways in which we support each other develop, and will only grow with the input of others. Take it, then; learn from it; make it your own; and then hand it off to the next group of students to benefit from. To that end, any revisions or suggestions for future versions can be submitted using this Google Doc: http://goo.gl/ok6ly.

Good luck!
Julia Heneghan, MD’13 (April 2013)

FOREWORD FROM THE FOURTH EDITION

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.

Good luck!
Julia Heneghan, MD’13 (April 2013)
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)

FOREWORD FROM THE THIRD 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 second 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)

FOREWORD FROM THE SECOND 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)

FOREWORD 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,
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Third Year: The 30,000 Foot View

Third year is awesome. Seriously. There are six different mandatory “core clerkships” (in addition to the Clinical Skills Clerkship) which are designed to give you an introduction to clinical medicine across a variety of specialties. Throughout the year, you will rotate at several different hospital sites and have the opportunity to see and learn things that most individuals could never even dream of. The world of medicine beyond the classrooms at 222 Richmond Street can be scary, exhilarating, and awe-inspiring all at once.

The Schedule
This academic year is the first year that all rotations will be multiples of six weeks, with medicine (clocking in at twelve weeks) being the only “double” rotation. The generic schedule for third year is twelve weeks on, one week off. This is an amazing luxury that doesn’t exist at most other medical schools, so make sure you take advantage of it! The twelve-week block which encompasses the winter holiday can be a bit disjointed, but the dates are all easily available through OASIS.

The Clerkship Lottery
Initial scheduling for the third year clerkships is done through a lottery system, with each person in your class ranking a set of “grids,” which basically detail all the possible permutations of your core clerkships based on the number of spots available at each site.

A good rule to remember for medical school is that if a decision would have a significant impact on your general clinical training, the administration probably wouldn’t let you have control over it. So, while you are hemming and hawing over which of your ridiculous number of grid choices to rank first, just remember that you will go through the same rotations as all of your classmates and be judged by similar standards.

You will get detailed information (likely from Eileen Palenchar or Lori Avallone) regarding the mechanics of the lottery process early in the spring semester of second year. However, there may be some things you wish to consider in ranking your grids:

- Many electives require that you fulfill specific pre-requisites prior to enrolling in them. While this typically includes the relevant core clerkship (e.g., the pediatrics clerkship prior to a pediatric emergency medicine month), some electives do not require any prior knowledge, and some may mandate more.
  - Consequently, if you know what you want to be when you grow up, it may be useful to try to have your elective time in third year scheduled after the respective core clerkship.
- Think about your own needs and desires. If you prioritize having weekends off during the summer to be outside or to need attend a gazillion different weddings, scheduling your surgery or medicine rotations during that time period might not be the most
prudent. However, if you need to see the sun every day, doing OB/GYN during the winter is probably not your best choice, either.

- Some clerkships have a reputation for being more difficult than others, either in terms of material or in the actual experience. You know yourself best, so consider how you would feel having several particularly demanding rotations back to back (that way you get them done) vs. spacing them out more throughout the year.

**Medicine Sites**

While you will be exposed to the basics of internal medicine regardless of the site you end up being assigned to, each has a slightly different atmosphere and overall experience. Here’s what some prior clerks have had to say about the benefits of each of the different experiences:

- **Rhode Island Hospital**: A relatively larger patient population here permits teams to usually only have one third-year student, meaning you’ll get more choice over your patient experiences. Students also have the option of doing one of their inpatient months on a specialty service (renal or heme/onc). There’s a substantial underserved population, and if you want to practice your Spanish, this is a great place to do it!

- **The Miriam Hospital**: Widely viewed as one of the best places for medical student education, this academic community hospital blends a small size with dedicated nurses and faculty to support medical students. Patients here are held by the residents to be sicker than at other Brown institutions, since many have good outpatient care and are only admitted to the hospital after failing prior management. Students here have the option of spending a week in the CCU, and the cafeteria’s blueberry pancakes are excellent!

- **The VA**: Perhaps the most obviously different site for your rotation, as the VA sees a majority male population with lots of bread and butter cases. Students routinely feel the teaching here is fantastic and “definitely a priority,” particularly due to the dedication of the site’s director, Dr. Charles. Teams are relatively small and medical students are typically given substantial amounts of autonomy and personalized attention. The VA has its own EMR which is easy to use.

- **Memorial Hospital**: Generally considered the most laid back place to do a medicine rotation, with an overall smaller census and more focus on “bread and butter” presentations of illnesses. In keeping with this, hours tend to be lighter. The IM residents are all foreign-trained and consequently exceedingly nice and very smart. There is no EMR, meaning you have a great deal of flexibility with your notes.

**Overall Requirements for Graduation**

You must satisfactorily complete all of your required clerkships during the third year. Then, between third and fourth year, you need to additionally complete at least thirty weeks of electives. These electives must include a longitudinal ambulatory clerkship (26 half-day sessions with a single provider), at least one sub-internship, a selective requirement of eight weeks (meaning that you’ve been under the direct, personal supervision of a Brown faculty member while completing those electives), and six weeks of surgery-related electives.
Obviously many of these requirements can be satisfied simultaneously by the same elective, so if you want to see how you’re stacking up in terms of your requirements, check out the Course Requirement Report (under Degree Progress on OASIS) to get a breakdown of each of the requirements and your progress towards fulfilling them.

**Methods of Evaluation**
As you’ve grown to expect in medical school, pretty much your every move will be scrutinized by others, and you will be tested through a variety of modalities. Although each clerkship has its own combination of evaluative mechanisms and assigns different weights to each, you will experience each of the following over the core rotations.

*Shelf Examinations*  
Brought to you by your good friends at the NBME (aka the group which produces the USMLE tests), these are standardized exams produced for each of the clerkships. They consist of 100 multiple choice questions administered over two and a half hours. Typically you will take them the morning of the final day of your rotation. They are traditionally paper-and-pencil examinations, although some clerkships have been experimenting with computer-based tests. Your score will be compared to a national sample of other third-year medical students to produce a scaled score; most rotations only consider the raw score in determining your grades.

*OSCE Examinations*  
Similar to what you’ve experienced in the Doctoring course, these experiences test your abilities in clinical situations specific to the practice scope of that specialty. In addition to working with standardized patients, you may also be asked to interpret specific imaging modalities or lab work, or write about an ethics situation. Some clerkships which do not have formal OSCE examinations will instead have required observation forms which your preceptors must complete during the duration of your rotation.

*Written Evaluations*  
In general, you will evaluate each person who evaluates you and you are able to ask for adjunctive evaluations from other individuals you’ve worked with who you feel can add meaningful input to the process. Typically the clerkship director will compile the evaluations completed by all of your evaluators into a summary evaluation, which will then be made available to you via OASIS and will likely be used in the composition of your Dean’s Letter. Additional comments may also be made in a manner that does not allow them to be used in your Dean’s Letter, but still provide you with valuable feedback.

*Additional Assignments*  
Some clerkships may have additional mandatory experiences (field trips, yay!) or expect you to complete other projects. For example, during the Family Medicine rotation you will complete a project to design a community-based intervention for the specific town where you are rotating.
The Internal Medicine and OB/GYN clerkships include an ethics assignment, and on Pediatrics you will be asked to write a reflective piece.

**Cardinal Rules for the Clerkship Years**
Just like your kindergarten teacher told you (most likely): being polite and playing nicely with others will get you far in this world. These guidelines may seem like common sense, but may be useful to return to as a reminder from time to time.

**Being a Good Medical Student**
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 perform a paracentesis on his ascites and work up the etiology of his hepatitis, the information will stick in your brain much more efficiently. Trust me. It will help your team, too.
2. **Remember your goals.** Your goals 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 at least one of these goals.
3. **Be mindful of your manners.** Common courtesy rules! Although others (attendings, residents, nurses, etc) may not be particularly polite or courteous at all times, do not mimic their bad behaviors. Some intuitive tips: address patients as “Mr.” or “Ms.” unless they instruct you otherwise; do not sit on the patient’s bed; **never** eat in front of patients; do not sit down unless those above you in the team hierarchy have sat down, particularly during a conversation with a patient; keep your patient’s nurses and other ancillary staff in the loop: tell them when you write an order, plan a procedure, etc.

**Being a Good Person and Classmate**
As you’ve learned in the preclinical years, 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 trust and respect. 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. No one else knows the answers either, and they are all relieved that someone had the courage to ask. Once you figure it out, take the time to show others the ropes, particularly as you become sub-i’s and fourth years. (Yes, it will happen!) If your classmate is struggling, a kind word or gesture may be all they need.

In addition to being good to your classmates, it’s important to remember that you have a life outside the hospital. As stressful as your rotations may be, your family and friends deserve the same care and concern (and arguably more) than your patients. Taking some time to invest in those relationships will make you a happier person and nourish your ability to care for patients.
THE BASICS

The Affiliated Hospitals
There are several teaching hospitals affiliated with The Warren Alpert Medical School of Brown University, many of which you will rotate through in your third-year adventures. 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 Medical Center (VAMC), Butler Hospital, and Bradley Hospital.

Now, on how to get there and where to park. You can access a map with each of the hospital sites and official parking areas (if applicable) for each of the clerkships here: http://goo.gl/maps/D8Yy5. Additional site-specific information is found below.

Rhode Island Hospital/Hasbro Children's Hospital
593 Eddy Street, Providence, RI 02903
Clerkships: Medicine, Surgery, Psychiatry, Pediatrics
Parking: Parking is available at the Coro Building (1 Hoppin Street). Shuttles run from the Coro Building to either the front of RIH or to the Physician’s Office Building near the APC. You could also walk, but this is typically a less popular option. You should have access to the parking garage via your Lifespan badge. If you have any issues with your badge, contact Scot Larue at 444-5223 or the RIH parking office at 444-4013. Many students choose to park on the surface streets surrounding the hospitals instead of dealing with the Coro lot and the shuttle. If you decide to do so, ask your friends for details on where to park and always check the street signs! Other Information: Rhode Island Hospital sits on a relatively large campus, and there are quite a few different buildings you may find yourself running between on different rotations. A map of the buildings and (public, aka not for you) parking lots can be found at: http://www.rhodeislandhospital.org/doc/Page.asp?PageID=DOC020530.

Women and Infants' Hospital
101 Dudley Street, Providence, RI 02903
Clerkships: OB/GYN, Pediatrics
Parking: You will be allowed to park in the W&I parking lot during your OB/GYN rotation. This parking lot is located on the right-hand side of Dudley Street after you pass under the RIH Bridge Building and cross the Dudley/Gay Street intersection. You should have access to the parking lot via your W&I badge.

The Miriam Hospital
164 Summit Avenue, Providence, RI 02906
Clerkships: Medicine, Surgery, Psychiatry
Parking: On normal days, medical student parking is in the Walker's Lot, which is entered via a driveway located next to the South entrance of the Sears Lot (see link to Google Maps above).
Like many things in Rhode Island, these lots are named after places that used to be there, so don't go looking for the stores to serve as your guideposts! There are shuttles running continuously between the Sears Lot and the hospital, although it is only a few short blocks up the hill so many people walk. Two exceptions: when you are on long call during the week, you may sign out a parking card the day before from Diane to have access to the Seventh Street parking lot. On the weekends, all lots are open and you may park wherever a space is available. If the Walker's Lot is full, you may park in the Sears Lot. Even though the street signs around the hospital indicate legal parking, the hospital forbids employees (and you are considered an employee during your clerkship) from on-street parking. The neighborhood is very sensitive to hospital traffic and they do not hesitate to call the hospital CEO when employees/visitors park in front of their homes. Security patrols a wide radius around the hospital issuing tickets to those who do not comply with their assigned parking.

Memorial Hospital of Rhode Island
111 Brewster Street, Pawtucket, RI 02860
Clerkships: Medicine, Family Medicine
Parking: There is a hospital employee parking lot located at 555 Prospect Street, approximately a half-mile from the hospital. From there, shuttle service is available to the employee entrance of the hospital approximately every 15 minutes. The parking lot in front of the hospital is reserved for patients and visitors, but medical students may park there on the weekend or more frequently if they can sweet-talk the security guard who mans the gate!

Providence Veterans' Administration Medical Center
830 Chalkstone Avenue, Providence, RI 02908
Clerkships: Medicine, Surgery, Psychiatry
Parking: Park in the surround lots. No problem.

Butler Hospital
345 Blackstone Boulevard, Providence, RI 02906
Clerkships: Psychiatry
Parking: Park in Lot B.

Emma Pendleton Bradley Hospital
1011 Veterans Memorial Parkway, East Providence, RI 02915
Clerkships: Psychiatry
Parking: Enter the driveway. Parking is available to the right of the school building in the B or C lots. If these lots are full, you may park in the visitor’s parking lot.

JMS Says: Avoid parking on the surface streets surrounding Memorial, where there are signs displaying “permit parking only.” These areas (as well as the speed limit around the hospital) are strictly enforced, and have been the source of many medical student tickets over the years!

JMS Says: 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.
Food
Eat when you can. Simple enough. Given the responsibilities, obligations, and commitments you have in the hospital, though, you may soon realize how much you take for granted normal meal times. That being said, there is no reason for you to starve, and there are ways to help keep yourself fed... most of the time. In general, you’re probably better off packing your own snacks and meals from home, if you can manage to overcome the weight of procrastination that sets in after too many weeks on the wards.

Rhode Island Hospital/Hasbro Children’s Hospital
The main hospital cafeteria is open 6:30am to 2:00am, seven days per week. A smaller café (The Dudley Cafe, such as it were) is located in the Co-op Building and is open on weekdays, 6:30am to 6:30pm; there is also a 24-hour ABP near George Auditorium. Lunch is provided at noon conference during your Medicine rotation. Otherwise, you are on your own. If you’re lucky, you’ll be rotating here during applicant season (roughly November through January) and will score some free lunches on days when residency applicants are in town.

Women and Infants’ Hospital
You are on your own. The food at W&I is pretty good and relatively inexpensive considering its quality. Plus, there’s a 24-hour Au Bon Pain in the lobby, so you’ll always be able to get something after catching a few babies. Maude’s Café (what W&I calls its cafeteria) is located in the basement and is open 6:30-10:15am, 11:00am-1:45pm, 4:30-7:30pm, and 2:30-5:00am.

The Miriam Hospital
Like at Rhode Island Hospital, lunch is provided at noon conference during your Medicine rotation. There are also frequently snacks (fruit, sandwiches, and chips) in the resident lounges for Internal Medicine and Surgery. As with most everywhere else, though, you’re on your own at other times, although ice cream is provided in the afternoon during interview season. Miriam’s cafeteria is renowned for its pancakes—they’ll even make blueberry chocolate chip if you ask nicely! The cafeteria is open 6:45-10:30am, 11:15am-7:00pm, and 1:00-6:45am. Additionally, the gift shop in the lobby has a “coffee shop” which sells a number of food items, with iced coffee being a medical student favorite.

Memorial Hospital of Rhode Island
Rumor has it that this is some of the best food among the hospitals. There is free coffee each morning at morning report, and lunch is provided at noon conferences during your Medicine rotation three days per week. The cafeteria is open 9:00-10:00am, 11:00am-1:30pm, and 4:30-7:00pm.

VA Medical Center
Lunch is provided at noon conferences three times a week during your Medicine rotation. The cafeteria is open 7:00am-1:30pm, so if you’re on call or planning to be in the hospital in the evening, make sure to bring your own food!
Butler Hospital
There are a number of dining options at Butler. Its main cafeteria is open 7:30-10:00am, 11:30am-1:30pm, and 5:30-6:30pm during the week. Additionally, the Blackstone Café in the arboretum is a nice place to get some sun as well as sandwiches and sushi. It is open 7:30am-4:30pm on weekdays.

Bradley Hospital
The cafeteria is located in the basement and is open on weekdays from 11:15am-3:15pm. The food is excellent and cheap.

The Players
The players — nurses, attendings, residents, interns, ancillary services, 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 for you.

Nurse (RN)
This includes operating room nurses, emergency room nurses, intensive care nurses, and floor nurses. They are listed first because without them, nothing would ever get done in the hospital, and we certainly would not be able to be doctors. Remember, they have probably 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, because they can teach you a lot.

Nurse Practitioner (NP)
You will often see NPs in the outpatient setting working with doctors, although there are many who also work in ICU settings or the emergency department. NPs see patients, do histories and physicals, and prescribe medications. However, NPs will also consult physicians for medical guidance or transfer patient care to the doctor if the patient’s medical problems become too complex to manage. In terms of training, most are RNs who have gone back to school for additional training at the master’s or doctoral level. Since those on the inpatient services tend to work in specialized settings, they are a wonderful resource for your questions.

Certified Registered Nurse Anesthetist (CRNA)
The CRNA is a nurse who has received a degree in nursing and then completed an additional two years of training in anesthesia. The CRNA assists the attending anesthesiologist, and will often be the person on the other side of the blue drapes in the OR.

Physician Assistant (PA)
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 in the civilian world. 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. Much like NPs, PAs frequently work in the outpatient setting or with specialized inpatient teams. You will interact with many of them on your surgery team. PAs have been described by prior medical students as perpetual residents who actually get to go home at night. They do a lot and are happy to teach you.

**Attending**
Where 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 (or another attending) questions the decisions being made, in which case you are just caught in the middle until those parameters are worked out. The attending is a great source of medical information, advice on future career decisions, and the person whom you will eventually ask for a letter of recommendation. Given these responsibilities, you will probably see her far less than you would expect.

**Fellow**
He has already completed residency, but is pursuing additional training in a subspecialty field. You will often see him on a consult service or running a surgical case with the attending supervising. He probably knows more than your resident, and can be a great source for medical information and career advice, as well as a sounding board for questions you’re too shy to ask the attending.

**Resident (PGY-2+, R2+, PL2+, a.k.a housestaff)**
This person is the doctor-in-training who has more responsibility than you want to think about right now. She is in charge of your team and is the person with all the answers. She is also the person who may pimp you simply by thinking aloud. Forgive her. She is sleep-deprived (yes, even with the new work hour restrictions). She is also the person often considered responsible for your education. Since she is more experienced and has less scutwork to do than the intern, you should hang out with the resident and learn from her.

**Intern (PGY-1, R1, PL1, a.k.a housestaff)**
This person is another doctor-in-training who has more responsibility than you want to think about right now, particularly since they’re a year closer to being in your shoes. The intern is frequently dumped upon to do everything, learn everything, and on top of all of that: teach you. He is often even more sleep-deprived than the resident, but will teach you how to be a good intern. If you’re interested in learning how to do procedures, it is generally a good bet to stick with the intern, although he may not have much time to teach.

JMS Says: Ask your intern if he needs help, because he probably does and will appreciate it. Also, always offer to help your intern before your resident (unless something unusual is happening), otherwise you look like you are not only brown-nosing, but also aren’t really providing 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 unless you make a specific effort, but they are invaluable to patient care. They are also frequently overworked but are typically happy to explain their work to interested medical students. Just try not to ask questions when the alarm bells ring and the overhead hospital address system is calling for “Respiratory therapy, stat, <room number>.”

Sub-Intern (Sub-I, Acting Intern, AI, Extern)
This person is typically a fourth-year (although sometimes a third-year) medical student. He is likely knowledgeable and gearing up to be <gulp> “a real doctor.” In fact, the residents and attendings on your team will expect your sub-I to perform at the level of an intern. Depending on the rotation that you are on, your sub-I may be a student from another medical school “auditioning” in hopes of earning a residency position in the program or simply to check out Providence. If such is the case, forgive him for any blatantly obvious statements meant to be seen as teaching points by the rest of the team. He is trying to demonstrate his 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 have finally made it to the wards, and are now the third-year medical student... the clinical clerk. For all the questions that are answered with, “Well, 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. Likely for the last time in your medical career, you have the freedom to ask any question (well, maybe not 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. That said, it’s probably poor form to continue to answer “I don’t know” to the same concepts day after day, so keep track of what people expect you to know and use some of those life-long learning competencies!

Teaching v. Non-Teaching
I’m 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 the United States 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 that typically 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 typically carried out by residents. Because of this
arrangement, many hospitals divide large services into teaching, non-teaching, and private 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 them 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 do not have medical students, either (or at least not an organized clerkship). 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, and you will also hear the terms “teaching” and “non-teaching” used to refer to services within our overall teaching hospitals.

**Teams v. Services v. Subspecialties**

*Services*

Services are more or less a medical division, and can be divided into more than one team. For example, the Medicine service at RIH is divided into eight teaching teams (further divided into four teams on Med A and four teams on Med B), a non-teaching team (for patients who are not considered to add much to resident medical education and are separately cared for by hospitalists), and a private team (which is really a private service for community-based attending who prefer, or whose patients prefer, not to be teaching patients). Additionally, “services” refer to who has primary responsibility for a patient. For example, if you are doing a neurology elective, there may be patients “on the service” (meaning your team has primary responsibility for all of their care) and other patients who are “on the consult list” (meaning your team is providing input to a different team but not making final management decisions).

*Teams*

Until you have completed your training (and probably long after that), you will work with colleagues and peers as part of a team taking care of your patients. In general, when people talk about your “team,” they are referring to an attending, possibly a fellow, the residents, and medical students caring for a specific set of patients. There are frequently multiple teams needed to cover all of the patients admitted to a specific service.

*Subspecialties*

Like general services, subspecialties are their own little departments within the hospital. They are usually comprised of just one team. For example, the Neurosurgery team is synonymous with the Neurosurgery service, since there is only one team caring for all the patients on the service. Confusing, but you’ll get used to it.
Codes
These are hospital emergencies for various situations. Some you will hear during your rotations, while others you hope you will never hear. They are standardized throughout the State of Rhode Island and Providence Plantations (yes, that really is its name), so you should know what’s going on regardless of the site you’re at.

- Code Blue: Cardiac arrest or other medical emergency
- Code Stroke: Pretty self-explanatory
- Code Grey: Need for security presence
- Code Orange: Hazardous material release
- Code Yellow: Trauma patient
- Code Green: Bomb threat
- Code Triage: Disaster plan in effect
- Code Amber: Infant/child abduction
- Code Silver: Hostile situation or person with a weapon
- Code Stork: Unexpected delivery/need for presence of OB/GYN team

JMS Says: In general, do not go to the scene of the code unless you are part of the appropriate response team. When you do go to codes, you may be pushed aside or asked to leave the room, or perhaps assist in chest compressions or obtain an arterial blood gas. Just do whatever you’re told.
ON THE WARDS

Pre-Rounding

Pre-rounding is the time prior to rounds (shocking!) when you can gather information on the patient, including what happened to him overnight and how he is feeling, as well as perform 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 or three patients that they are following. You should aim to have your notes written by the start of rounds, as well as having a good general sense of what the pertinent issues are and what course of treatment should be pursued so that you can present the patient to your team during rounds. Things you should find out while pre-rounding:

- **Vital Signs:** These are called “vital” signs for a reason! These are the first things you should check before entering a patient’s room. For the most part (unless your patient is in a critical care setting) they are found in the EMR, making them easy to check. Vital signs include the maximum and/or current temperature (was the patient febrile overnight?), heart rate, blood pressure, respiratory rate, and oxygen saturation. You should also check I&O’s, which can be variously found on a patient’s paper flow chart or in the EMR, to learn if the patient is eating/drinking and urinating enough.

- **How the Patient Fared Overnight and Management Decisions:** Just as it’s important for you to keep track of what goes on with your patient during the day, you should also know what happens when you’re not in the hospital. Ask her how she is feeling, ask relatives who are in the room what they think of her progress, read the chart for nurses’ notes or notes from consulting services, ask the overnight nurse for a quick recap of the night, talk to night float about any calls they got on your patients or new orders they started (as well as the reasoning behind them).

- **Labs and Radiographic Studies:** Jot down any early morning labs that were drawn or labs from the previous night and make note of any labs pending. Check to see if the patient had any imaging studies. Even if they are not final reads yet, you should look at the images for a “wet read” as well as trying to interpret them yourself.

- **Medications:** Look in the medication administration record for what the patient received, particularly in PRN medications (e.g., did this patient complaining of pain end up asking for and receiving four 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.

- **Physical Exam:** Perform a pertinent physical exam, with particular focus on any aspects which may have changed overnight or since the last time you examined the patient. For example, does a patient with CHF still have wet-sounding lungs this morning even though he received Lasix overnight? Depending on your service, you may also be expected to take down/change wound dressings, but ask your team first.
Scutwork

Scutwork is as scutwork sounds: it’s all the jobs of patient management that just have to get done and don’t get (or bring) much glory. These tend to be the jobs you are expected to do as intern, so the wards are an excellent place to perfect your scut skills. Scutwork can encompass procedures (IV insertions, arterial blood gases, inserting or removing nasogastric tubes, removing staples and sutures, etc) as well as paperwork, phone calls, and miscellaneous jobs.

Things to know about scutwork:
  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 few months on the wards, you should probably jump at the chance to be scutted because you need to know how to do all of 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 type 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 lecture or an educational 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 way to earn respect and gratitude from your team for 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’ve had it done to you. You’ll likely do it to someone else, too. And so it goes.

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 or intern) asks you questions until you no longer know the answers. 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. Plus, it’s almost guaranteed that if you spent last night reading about atrial fibrillation you’ll be asked about compartment syndrome.

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

If you’re being pimped, it is important to remember that:
1) You are smart.
2) You are smart enough to say “I don’t know” when you do not know something, rather than try to BS your way through an answer. However, you should at least attempt to reason and think through the question before going down that path...
3) You are a member of the team and 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.
4) You have the right, and the obligation, to tell someone when her pimping has crossed the line into condescension and triviality.
5) 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 are quite frequently attempting to use it as a teaching method. 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 you something.

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

Beware the rare (but nasty!) trap of being too successful during a pimping session—especially if you end up knowing more than your seniors about 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 just reading about such and such and it talked about...” way. (This also has the added benefit of being able to blame the book if you are wrong or contradicted, as well as showing your team that you’ve at least invested some time in reading!)

**Student Mistreatment**
Simply put, it shouldn’t happen. If it does, there are a number of resources available to you.
Each clerkship has an anonymous “mistreatment form” which you will be required to complete along with the other OASIS evaluation forms. These ask about public humiliation or belittlement; offensive remarks or name-calling; harassment on the basis of gender, race/ethnicity, or sexual orientation; and physical threats or assault. Additional information is gathered regarding the role of the perpetrator, any reporting which may have already happened, and any incidents of mistreatment that you may have witnessed. These should be filled out honestly and completely for each rotation.

In addition to the anonymous reporting mechanism, there are several avenues through which you can further pursue the issue. Departmental ombudsmen are available for every clerkship (and listed in their respective sections of this handbook). These individuals are typically not involved in other aspects of medical student education and can provide a specialty-specific perspective on the issue. Alex Morang and others in the Office of Medical Student Affairs, your Academy advisors, and the rest of the Medical Education Office are always available to talk to students. The Student Health Council provides student-run, confidential services to other medical students in need. You can contact them at studenthealthcouncil@brown.edu.

**Documentation & Presentations**

*Notewriting*

As you’ve learned in Doctoring, medical professionals have a very specific (and somewhat strange!) method of communicating regarding their thought processes and decision-making for patients. Now that you’re part of the clinical team, you will be expected to contribute to this documentation, usually through your own notes on the patients you are following each day.

In general, you should expect to perform and write the initial history and physical exams, including an assessment and plan. Your resident and attending will have to complete a separate H&P for medicolegal reasons, but medical student notes have a reputation of being more complete and accurate than those further up the hierarchy, so don’t despair. Then, each morning you should complete a SOAP note (basically a daily progress note) on each of your patients. Most of the documentation done in the Brown-affiliated hospitals now is electronic, and you will be oriented to the individual EMR at each clinical site. However, these can be confusing, so ask your residents or other medical students for help if you have questions!

Some attendings and services prefer that plans are outlined by **system** (i.e., running through neurologic, cardiovascular, pulmonary, renal, etc. and describing any problems that exist and then your plan for these problems). This typically ensures that you do not forget any problems and it is a very thorough technique. On the other hand, other services will not want to hear about systems not involved in the current plan of care. Hence, they prefer a **problem**-based presentation, where you talk about the current medical issues (e.g., a patient with congestive
heart failure might also have issues such as coronary artery disease, hypertension, COPD, and diabetes). For each problem, there needs to be a formulated plan for how to address that problem, even if it is just to continue the patient’s home medications.

The length and style of a note will vary widely with each clerkship (e.g., shorter notes in Surgery, longer ones in Medicine), but the idea remains the same. Look in the patient charts to see the type of notes expected of you. When in doubt, write more. If you’re looking for examples ahead of time, Tulane has a listing of sample SOAP notes by specialty at: http://tmedweb.tulane.edu/portal/jceuploads/files/courses/cdx/SampleSoapNote.pdf.

Once your note is finished, ask your residents if they prefer you to “finalize” or just “save” it. Finalizing it will mean that it will appear in the EMR under your name, while leaving it saved will permit your resident or attending to appropriate it to use as the basis for their own note for the day. If you finalize your note, either your resident or your attending will have to write their own note on the patient for the day, as well as co-sign your note.

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 the team, need to take responsibility to have your notes co-signed. You should also ensure as much as possible 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 their 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 they are co-signed, and make sure that your co-signatory has actually read what you’ve written.

**Signout**

In addition to daily notes, many teams you will be rotating on use a program called Signout to communicate updates on patients from the day team to the night team and back again. As a medical student, you should take the initiative to fill out the initial Signout form for your assigned patients and then modify the document as appropriate over the course of their hospital stay. Additionally, ask your residents if you can “sign out” your patient to the night float team in the evening; you’ll learn a lot about the information which is considered high-yield (e.g., is this patient sick? any expected complications?).

In conjunction with Signout, medical students can also be helpful by working on a patient’s Hospital Course and Discharge Summary. These documents attempt to summarize the patient’s time in the hospital and will be distributed to their primary care doctor and other involved providers following their hospital stay. Relevant information includes new medications that were started while the patient was in house (with indication), pertinent lab or
imaging results, pending test results, and plans for follow up appointments or studies. Ask your residents for feedback, as the goal is to be as concise and clear as possible to smooth the patient’s transition back to the world of outpatient care.

Presentations
Presenting a patient—be it during work rounds, at noon conference, at morning report, to your intern, to your team, or to your classmates—is one of the most important skills of medicine that you will learn this year. If you know your patient well enough that you can present him to anyone, then you have done half of your job already. Videos and transcripts of sample presentations from the CSC are available on Canvas.

As you learned in Doctoring, presenting a patient includes explaining the patient’s chief complaint, the history of present illness, past medical history, current medications and allergies, relevant lab or imaging studies, findings on physical exam, and your overall assessment and plan.

Perhaps the most frustrating part of presenting a patient is that the format tends to be very resident/attending-dependent. Some attendings only want you to present positive findings on physical exam, while others will want you to describe everything you did on the physical exam to make sure that you performed all the possible maneuvers (including rectal exam). Some attendings want to know every possible detail, including if the patient has any pets at home. Others will roll their eyes when you mention the patient’s pet turtle Buster—unless the patient possibly has Salmonella! 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 that knowledge on to you. Worry not. Everyone has their own individual style... you will develop one, too.

A note about senior resident or attending amnesia on morning rounds: the following is not an unusual situation. Try not to let it fluster or discourage you.

Medical Student Steve: ...last night, Mr. Kim was comfortable and he has no complaints this morning. Vital signs were—he was afebrile with Tmax 99, HR 60s to 70s, BP 110s over 80s to 90s, pulse ox 96 to 99 percent on room air, ins 590, outs 400 plus two 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, non-tender, and non-distended...
Senior Resident Kevin: Oh, wait! Was he afebrile last night?
This is just “senior resident short-term memory loss” (although you may not want to officially diagnose your residents with this…). 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 have a bazillion other things and are tired, so sometimes they will repeat themselves. You will too, someday.

Writing Orders
Once you’ve written your notes and presented your findings and thought processes to your team decisions will be made regarding the patient’s overall management. Often this will result in the need for further testing, the administration of medications, and other actions which require an order to occur. While medical students have no authority to unilaterally dictate what occurs to patients, you will in a few short years. Consequently, you should practice writing orders now while you have some oversight. The vast majority of orders are written through the EMR, so you should login, write the orders you’ve decided on, and then ask your resident to review them with you and co-sign them. You can feel reassured that the orders won’t be available to anyone other than your team until they are co-signed, so your patient won’t be getting whisked off to radiology just because you’ve ordered a full-body CT scan!
Common Abbreviations

1XD: once per day (you can infer 2XD, etc)
2/2: secondary to
AAA: abdominal aortic aneurysm
ABI: ankle-brachial index (difference in BP between the ankle and the arms)
ABG: arterial blood gas
AED: automated external defibrillator, or anti-epileptic drug (know the difference if you’re using it in your patient!)
A/VH: audio/visual hallucinations
BAL: bronchoalveolar lavage, blood alcohol level
BBB: bundle branch block, blood-brain barrier
BKA: below knee amputation
BM: bowel movement
BRBPR: bright red blood per rectum
BRP: bathroom privileges (aka why your patients may have no recorded UOP)
c (with bar above): complaining of
C/D: clean, dry, and intact (typically used to describe wounds)
CMO: comfort measures only
CTX: ceftriaxone
CXR: chest x-ray
DNR/DNI: do not resuscitate/do not intubate
ECMO: extracorporeal membrane oxygenation
ESBL: extended-spectrum beta lactamase
ESRD: end-stage renal disease
FEN: fluids, electrolytes, and nutrition
FENa (pronounced fee-na): fractional excretion of sodium
FNA: fine needle aspiration
GCS: Glasgow Coma Score
HA: headache
HAART: highly active anti-retroviral therapy
HD: hemodialysis
HLOC: hospital level of care
I&O: ins and outs

IDDM: insulin-dependent diabetes mellitus (aka type 1 diabetes)
IVDU: intravenous drug use
INT: intermittent needle therapy (basically, flushing of a patient’s IV every so often)
JP: Jackson-Pratt drain
LMP: last menstrual period
LOC: loss of consciousness
KVO: "keep vein open," ie, small amounts of IV fluid running to maintain the IV line
MIVF: maintenance IV fluids (D5-1/2NS with 20 mEq K+)
MRSA: methicillin-resistant staph aureus
NBNB: non-bilious, non-bloody
NGT: nasogastric tube
NKDA: no known drug allergies
NS: normal saline
NWB: non-weight bearing
OOB: out of bed
OSH: outside hospital
p/w: presents with
PICC: peripherally-inserted central catheter
PTA: prior to admission
PRN: as needed
s/p: status post
SCDs: sequential compression device (aka those things that go on patients’ legs and inflate/deflate to prevent clot formation)
SI/HI: suicidal ideation/homicidal ideation
SNF: skilled nursing facility
TEDS: knee-high stockings to prevent clots
TEE: transesophageal echocardiogram, not to be confused with TTE (transthoracic)
TPN: total parenteral nutrition
TVUS: transvaginal ultrasound
UA: urinalysis
UOP: urine output
USO(G)H: usual state of (good) health
VRE: vancomycin-resistant enterococcus
WNL: within normal limits
x (with bar above): without

Jablonski’s Dictionary of Medical Acronyms and Abbreviations (available online) is useful for the even more complicated!
**YOUR GEAR**

As a general rule, while there are places to stash your gear (you’re provided a locker on OB/GYN, surgery, and medicine), avoid bringing valuables to the hospital.

**Clothes**

Knowing what to wear is a combination of common sense, courtesy, comfort, and commando skills. 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 preceptors and residents dress. For example, most outpatient pediatricians do not wear white coats, so you probably will not either; 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, so you should too.

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**: shirts, slacks, and tie.

For **women**: shirt or blouse, slacks, or dress. Note to women regarding skirt length: again, use common sense. While our short white coats are sort enough that any skirt 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 your 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 an editor wore a pedometer and found out that she walked a few miles, just before lunch! Thus, it is a good idea to have comfortable shoes, which also look appropriate with both scrubs and your professional clothes.

While this might sound like a tall order, you are in luck. There are shoes where form meets function: clogs. Common brands include Merrell’s, Birkenstock, and Dansko. Once broken in, they provide the comfort of tennis shoes, the slip-on and no-lace ease of slippers, and the professional appearance of basic dress shoes. Plus, if you’re the adventurous type, they come in all sorts of crazy patterns! Given that you’ve already purchased a lot of things including professional wear, pocket texts, diagnostic equipment, study materials, etc., purchasing a new pair of $140 shoes can be hard to swallow. However, if you can swing it, your feet will thank you.
White Coats
So, you should have all received a short white coat during the White Coat Ceremony. They are probably still white, clean, and pristine. Oh, how that will change. Common stains include: blood, saliva, chocolate, barbeque sauce, coffee, and “other stuff.” You probably don’t want to know. 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 dressier than blue jeans look acceptable for being in the hospital.

Inevitably, you will want to get some of those aforementioned stains out of your coat. Tide to Go can be useful shortly after the fact. Using bleach will also do the trick, but may also discolor the patches and other stitching, so try soaking it in Oxiclean overnight before washing it. Alternatively, buy a second or third...

Nametag/ID Badge
Wear your ID badge in a visible location at all times. Important reasons to wear it:
1. Parking: Your Lifespan ID badge will give you access to the Coro parking garage, and it is free! Granted, the location is not the closest to the hospital, and you are paying $60,000 per year for the privilege of working in the hospital, but at least you get parking privileges, whether you choose to use them or not.
2. Security: There is a “code amber” for infant abduction. When my classmates and I were first notified of the code’s existence, we were 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 the hospitals safe and secure. Do not make the security guards chase you for an ID and do not give people cause to question why 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.
3. Courtesy: Don’t you hate meeting someone new and either not being introduced, or introducing yourself and not having them return the favor? 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. You also do not want to misrepresent yourself as a resident or attending, and wearing your 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 badge via a retractable string. It adds some convenience when you have to swipe your badge into a card reader—you can just tug on your badge without having to actually unclip your nametag. You can get one for free in the HR office, located in the basement of the Potter Building at RIH, or Staples sells a variety.

**Good Things to Carry**

Each clerkship section has its own discussion of specialty-specific items you may want to tote along with you. In general, you should always have your white coat and basic physical exam equipment (stethoscope, reflex hammer, penlight) with you. You will likely misplace these things at least once, so think about labeling them with your name and phone number. No need to carry your sphygmomanometer around, though! Your residents will constantly be “borrowing” pens from you, so stock up on cheap black-ink pens. It is also typically useful to have some alcohol swabs, tape, and a granola bar or two stashed away. Don’t forget your pager!

**Smartphone Applications**

Previous versions of this handbook have included sections entitled “Do I Need a PDA?” Their answer was “Yes. No. It’s up to you.” The same is still true, but given the proliferation of iPhones, Androids, and a whole host of other technological devices that fit in your variously-sized pockets, you probably already have something that functions similarly. There are a number of excellent applications available to medical students. A partial listing is included below, and there are a few further suggestions in the clerkship-specific chapters, but ask around for more suggestions.

- **TextPage**: Costs $3 for the full version, but allows you to page your residents and attending from your phone.
- **DxSaurus**: Free, super-helpful way to come with a differential diagnosis to round out your assessments.
- **MedCalc**: Pretty much every medically-related calculation you could want.
- **AHRQ ePSS**: Compiled by the USPSTF... just enter someone’s age and gender and you’ll get a list of all their recommended screening tests.
- **Micromedex**: Easy way to look up drug names and side-effects.
- **Eponyms**: Bamboozled by all the random terms your attending keeps throwing around? This app will explain different tests, conditions, and symptoms named after individuals.
- **Generics**: Derived from a Brown alum’s Community Health project, this allows you to look up which drugs are on a local pharmacy’s $4 list to help your uninsured patients. As great as it is, you should always double check with the pharmacy.
- **Epocrates Essentials**: A very comprehensive app which will allow you to look up medications and their side effects, information about different diseases and...
management algorithms. However, it is expensive, with subscription to the entire suite of resources weighing in at more than $150/year. In years past, students have been able to sign up for free each August, so keep your eyes peeled.

- **Medscape**: Another comprehensive (and free for students) app with a whole variety of different guidelines, medication information including an interaction analyzer, a calculator for pretty much anything you could want, and more.
- **DynaMed/SkyScape**: Again, a comprehensive (and free through Brown) app with multiple resources for learners. You may have to jump through some hoops with the library to get access, but it’s definitely worth it.
- **USMLEWorld QBank**: A great way to work through questions during your downtime on the floors. Obviously will only work if you have a currently active QBank subscription.
- **AFP By Topic**: Produced by the American Academy of Family Physician, this will let you search for topics from the *American Family Physician* journal by subject. While some resources are only available to AAFP members (free for medical students) it gives a great overview of a number of primary care topics, as well as links to patient resources.
- **MediBabble**: While communicating with a patient who does not speak English is ideally done through an interpreter, this free app offers a host of basic history and physical questions in a number of different languages.
- **Google Translate**: In a similar vein, this app will translate whatever you might want to ask your patient with relatively high fidelity. Not medically-specific, but harnesses the power of Google.
- **UpToDate**: Your favorite comprehensive website, available free in pocket form if you download the app using Lifespan’s institutional subscription.

Something still relevant from previous editions: with the advent of PDAs and smartphones, there is also development of an unwritten etiquette associated with them. If someone is asking you a question during rounds, it is inappropriate for you to whip out your mobile device and look up the answer—the purpose of the question is to probe your knowledge base, not how quickly you can find the answer on your little gizmo. Appropriate times to use your device include if the entire team is stumped and wants to know an answer, or if you want to supplement your own knowledge of a disease and then share this with the team in a non-ostentatious manner. Above all else, don’t text on rounds. It’s rude, just like it is at the dinner table.
FAMILY MEDICINE

What is Family Medicine?
Family medicine is the medical specialty of general primary care. As such, family physicians 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 are to: 1) teach all Alpert medical students the clinical skills and the knowledge, beliefs and attitudes they need to perform at an outstanding level in any specialty; 2) teach medical content that is evidence-based and up-to-date; and 3) give all students an understanding of the role and importance of primary care (and specifically family medicine) in providing quality health care to patients and communities. Additionally, for those who might be interested in a career in family medicine, they aim to give an accurate and positive exposure to the specialty.

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 learn to broaden their differential diagnoses to diseases of the outpatient setting.

Main Contacts and Sites
The clerkship director is Dr. David Anthony (401-729-2753, David_Anthony@brown.edu). The assistant clerkship directors are Dr. Paul George (729-2753, Paul_George@brown.edu) and Dr. Jordan White (Jordan_White@brown.edu). Dr Julie Taylor (Julie_Taylor@brown.edu) is a previous Clerkship Director and remains involved in the course. Your primary contact person is the clerkship coordinator, Jane Shaw (729-2763, Jane_Shaw@brown.edu). The clerkship administrative assistant is Lisa Blangeard (729-2753, Lisa_Blangeard@brown.edu).

The department ombudsperson for Family Medicine is Melissa Nothnagle (Melissa_Nothnagle@brown.edu, 401-729-2236).

Your home base for all lectures, discussions, and exams is the new medical school building. Each student is also assigned to a family medicine outpatient practice with somewhere from one to ten attending preceptors. These practices are scattered across various towns in Rhode Island, Southeastern Massachusetts, and nearby Connecticut. You can expect to drive farther
for this clerkship than for others, with most students travelling from 10 to 50 minutes each way.

The Family Medicine clerkship is now paperless. Check out the web site: https://sites.google.com/a/brown.edu/family-medicine-clerkship/ which has the orientation manual and didactic materials, Powerpoint presentations, Silva cases, related readings, the encounter logs, and links to the fmCASES. Note that you will need to be logged into your Brown Gmail account to access the website.

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 practice preference (private practice group or solo, federally funded community health center, academic teaching practice, etc.), learning objectives, your strengths and weaknesses, what career path you are currently interested in, 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. The clerkship team works very hard to make this match possible – a difficult task, given the various requests – and they most often succeed!

Clerkship Schedule
Family Medicine is a six-week rotation taken as one block. This involves a day of didactic and seven “half-days” at your clinical site each week. 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. There are mandatory didactics on Wednesday that preclude doing a longitudinal on Wednesdays.

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 is generally flexible with creative scheduling if you include them in your plans for say, family emergencies or interviewing crises.

Didactic sessions are all-day on Wednesday and mandatory. Thus, 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>
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<tbody>
<tr>
<td>AM: SACC</td>
<td>AM: Preceptor’s Office</td>
<td>AM: Lectures and</td>
<td>AM: Preceptor’s Office</td>
<td>AM: Preceptor’s</td>
</tr>
<tr>
<td>Proposal time</td>
<td></td>
<td>Group Discussions</td>
<td></td>
<td>Office</td>
</tr>
<tr>
<td>PM: Preceptor’s</td>
<td></td>
<td>PM: Workshops</td>
<td>PM: Preceptor’s Office</td>
<td>PM: Preceptor’s Office</td>
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<tr>
<td>Office</td>
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Other Clerkship Experiences

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 health and illness. This project is paired with a ½-day orientation session early in the rotation. During that session, students are led on a community assessment of either the town of Central Falls 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. For the project, students are asked to perform a community assessment involving investigating available state databases, interviewing (at least) 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, one student created a project around ride-sharing for geriatric and disabled patients coming from South County, RI to Providence for medical appointments.

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 seven minutes, but the evaluators are fairly strict about keeping your presentation within these time limits. It is a good lesson in condensing your presentation, as you would do at a conference presentation. There is a growing partnership between the Family Medicine Clerkship and Population Health rotation (formerly the Community Health Clerkship). Your evaluator for the oral presentation will be a faculty member from the School of Public Health, and you will have the opportunity to actually develop and implement your proposal if you take the Population Health elective.

2. Keep a log of patient encounters. Log sheets are now on the family medicine web site: you can use this or any other method you want to quickly keep track of what kinds of patients and chief complaints you see at your preceptors office. You will use this at the end of the clerkship to complete your OASIS Experience Requirement Report (for example logging you saw 5 patients with hypertension). If you update your log continuously it will help you avoid headaches with this requirement at the end of the clerkship.

Overnight Call
There is none. 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 at Memorial Hospital. If you have any interest in family medicine, obstetrics or pediatrics, it is a great experience. Some students have called it an “absolute highlight” of the clerkship. Again, this experience is strictly optional.
**Didactics**
Didactic sessions occur all day every Wednesday. The Wednesday didactic sessions are where faculty teach you various bread-and-butter topics. Half-day workshops include orthopedics, procedure workshop, chronic disease management, geriatric assessment, maternal-child health, and dermatology.

Wednesday mornings include a one-hour lecture followed by small group cased-based discussions facilitated by community faculty, similar to the problem based learning sessions you’re familiar with from pathophysiology blocks. The case-based curriculum centers around the fictional Silva family. There are on average two cases each week with learning objectives, readings and questions. Much of the medical background material for the cases is done before hand using fmCASES (an online family medicine curriculum that teaches you about common disease presentation). 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.

*Silva who?*
The Silva family is a virtual Cape Verdean 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. 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 Silvas 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 they interact 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.

**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.). You will receive your clinical placement during orientation. Wednesday afternoon sessions at the med school building are casual dress.

When you travel to your preceptor’s office, bring your white coat, pens, reflex hammer, stethoscope, smart phone, 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, as they are some of your best education allies.

**fmCASES**
Through a collaborative effort of STFM, iInTIME, and numerous FM educators around the country, there now exists a network of online virtual patient cases that cover the content laid out in STFM’s Family Medicine Curriculum. In place of assigned textbook reading, students are expected to complete the 40 cases. Many of these are integrated into preparation for the weekly Silva cases. The content of the cases is constantly updated, carefully thought-out, and incorporates interesting multimedia formats like fill-in-the-chart, videos, and short-answer questions. They are also closely annotated with references to current medical articles, and they include lots of further reading for topics you find particularly interesting. These cases will likely form the basis of your studying for the shelf exam.

**Clerkship Grading**
Honors are awarded to those students who score 88-100; and pass to 70-87. The grades will not be rounded up.

*Preceptor Evaluation* (45 points)
Evaluations are all done online through OASIS. This is obviously a heavily-weighted component of your final grade.

*Didactic Participation* (15 points)
This is assessed by your small group leader in the didactic sessions and by the core faculty. Preparing for the Silva cases and being an active participant will ensure you get a strong grade for this component.

**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 (25 points)**
This is a written 3-hour exam consisting of 100 multiple choice questions generated directly from the fmCASES. It is therefore the same basic format as the other shelf exams you will take, despite not being the NBME-sanctioned family medicine shelf exam. The exam is derived from **all 40 fmCASES cases**, so the savvy student gets started early on them and finishes all 40. (As Dr. Anthony says, there are 40 cases and 40 days, so that’s more or less one case per day!). Exam performance clearly correlates with the number of completed cases!

We advise you not to get distracted by the wealth of information in the “Expert” tab, as this will not be tested. Also, both Pretest Family Medicine and NMS Family Medicine have some good practice questions. Some will assume this test is easier than other Shelf exams, but the faculty encourage you to take it seriously as the breadth of family medicine can prove to be a challenging load of material to cover.

**Recommended Resources**
For the most part, fmCASES is all you’ll need. Pay particular attention to the summaries of the cases, which provide excellent overviews of high-yield information. Some previous students also recommend the Case Files: Family Medicine book or Blueprints Family Medicine, as well as the resources recommended for pediatrics, medicine, and OB/GYN.
I N T E R N A L  M E D I C I N E

What is Medicine?
Medicine is shorthand for “Internal Medicine.” As Dr. Harlan Rich likes to say, this is where “the bulk of the pathophysiology comes to life.” In the grander scheme of things, Internal Medicine is the basis of all medical subspecialties, similar to the way that Surgery is the basis of all surgical subspecialties. Your medicine rotation will teach you how to manage the “average” medical patient (as if there is such a thing).

Goals of the Medicine clerkship include:
• Improving your ability to obtain a history and perform a 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 sites for your Medicine rotation: Rhode Island Hospital, The Miriam Hospital, the Veterans Affairs Medical Center, and Memorial Hospital. The clerkship directors vary with each of the hospitals, and each has a separate clerkship coordinator you should contact with questions about your daily schedule, team assignment, and pretty much any other issue that may arise. They are:
• Rhode Island Hospital: Dr. Mark Fagan
  o Kerri King (KKing4@lifespan.org or 401-444-8472)
• The Miriam Hospital: Dr. Beth Gentilesco
  o Diane Boulais (dboulais@lifespan.org or 401-793-4001)
• The VA: Dr. Amos Charles (amos.charles@med.va.gov or 401-457-3603)
  o Donna Golomboski (donna.golomboski@va.gov)
• Memorial Hospital: Dr. Joseph Ratabin
  o Evelyn Valois (evelyn_valois@mhri.org or 401-729-2859)

The departmental ombudsperson for all medicine clerkship sites is Dr. Christine Duffy, who can be reached by email at christine_duffy@brown.edu or phone at 401-444-0360.

The clerkship website (with links within to pages for each of the clerkship sites) can be found at https://sites.google.com/a/brown.edu/medicine-clerkship/. As with other clerkship websites, you will need to be logged in with your Brown Google account.

Overall Clerkship Schedule
The Medicine clerkship is twelve weeks long and is divided into three four-week blocks. A total of eight weeks (two of the blocks) are spent as part of an inpatient ward team and may or may
not be consecutive blocks. Students at the Miriam have the option of spending one of their inpatient weeks in the Coronary Care Unit (CCU). The remaining 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 with a social worker, and a litany of other opportunities.

The clerkship typically begins on a Monday with orientation and ends on a Friday with the NBME exam for Medicine, also known as “the shelf” following an OSCE earlier in the week.

A sample schedule for an individual student on the Medicine clerkship is as follows:

<table>
<thead>
<tr>
<th>Block One (Weeks 1-4)</th>
<th>Block Two (Weeks 5-8)</th>
<th>Block Three (Weeks 9-12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Ward Team</td>
<td>AM: Outpatient Clinic</td>
<td>Inpatient Ward Team, with OSCE</td>
</tr>
<tr>
<td></td>
<td>PM: Lectures</td>
<td>and shelf exam in the final week</td>
</tr>
</tbody>
</table>

Weekends between blocks are off. For example, if you are transitioning from inpatient wards to an outpatient block (as is the case in the sample) and your team is on weekend call, you are not required to come in: you get an automatic “golden weekend.” Weekends during the outpatient month are also off. During your inpatient months you will be off when your team is off. In a typical month, most inpatient teams will have one weekend completely off (“golden weekend”), one entirely on (“black weekend”), and then work one day of each of the other two weekends.

Outpatient experiences vary substantially based on your site assignment. The RIH outpatient month is spent working at the clinics in the Medical Primary Care Unit or at community practices. Students at the Miriam will spend their outpatient time either at a private practitioner’s office or in the VA system. 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. Subspecialty outpatient experiences including hospice, dermatology, oncology, and several may also be available, either upon request or through routine scheduling depending on the site.

**Inpatient Schedule**
When you are on a ward service team, a typical (non-call, more on this later) day will include:

- Getting signout from the night float intern, typically at 6:30 or 7am.
- Pre-rounding on your patients and finding out about any significant events.
- Checking morning labs, images, and any other test results.
- Writing daily progress notes. Try to think up assessments and plans on your own and to not rip off your interns’—it is of course perfectly okay to talk to your team about questions you have, but you will learn much more if you make the effort to think through it on your own first! Try your hardest to have your notes finished before rounding with your team; otherwise, they become quickly outdated and you will play catch-up for the rest of the day.
• Attending morning report if applicable (this may be site-dependent).
• Rounding with your team on all of the patients. These may be either “walk rounds”/“bedside rounds” or “sit-down rounds”/“table rounds”/“card-flipping” where you discuss patients in an office. Most attendings will combine these methods, seeing the new or sick patients as a group and then card-flipping the stable patients who are already known to the service. You may have separate rounds with your senior resident and your attending. Attending rounds are a time for you and your team to review your patient load, talk about treatment strategies, and be taught—usually something related to your census. Teaching quality varies with each 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.
• Carrying out your team’s agreed upon plans for the day.
• Attending didactics with the rest of your team, as well as medical student-specific teaching sessions.
• Giving signout to the cross-cover intern, typically sometime after 4pm.

What Does “On Call” Mean?
Being on call means being the admitting team. That is, patients admitted to the hospital will be the responsibility of your team. As mentioned before the specifics (e.g., number of patients admitted, the time until which you admit, etc) may differ between sites. In general, “long call” means your team admits more patients and stays later than the other teams, as you might have surmised from the name. While long call days can be busy, they are also great learning opportunities to see patients from the beginning and work on your skills at formulating a differential and diagnostic plan.

As a medical student, you should expect to be on call when your team is on call. While the specific nature of the call schedule is site-specific (and can even vary between different services within a site, so be sure to pay attention to this during orientation!) the general system is a four day call cycle. This means you will be on call (“long call”) every four days (Q4). Students should pick up at least one new patient per call cycle. Following your call day, residents refer to the days respectively as “post-call,” “short call” (when your team picks up a specific number of patients in the morning who have already had an initial workup overnight), and “pre-call”/“good day.” Given the new ACGME work hours restrictions, all the sites use a night float system, so you will not have any overnight call.

Outpatient Schedule
As might be expected, typical days in the outpatient setting are hard to characterize. In general, you should expect to:

JMS Says: When a patient is admitted to your team, your resident may ask if you would like to follow the patient, or you may just be assigned the patient. You may be tempted to follow a patient with a really unique, interesting pathology (like Moyamoya disease). This is fine. However, remember also that you are here to learn the basics of medicine. That means you really should experience how to work up and treat a patient with CHF, COPD, chest pain, diabetes, hypertension, etc.
• Go to your outpatient site in the morning (perhaps after Grand Rounds or M&M).
• See patients with your preceptor or on your own.
• Return to your hospital for the afternoon didactic teaching sessions. If there are no afternoon lectures that day, you may continue working with your preceptor or have the afternoon off, depending on your preceptor’s policies.

Didactics
You are special in that you get your own special medical student didactic sessions. However, these hospitals are teaching hospitals, and that also applies to attendings, residents, and interns.

Didactics for Everyone
• Morning Report: Moderated by the Chief Residents, this is when residents present a recent case or article of educational value. Often attendings will be present to highlight teaching points, and the presenting resident will frequently have a short didactic PowerPoint or other talk to review a challenging aspect of the case. This typically occurs every day, although timing may be changed by Grand Rounds or M&M. Check with your team about specifics.
• Grand Rounds: Tuesday at 8am, George Auditorium at RIH. If you are not at RIH, Grand Rounds will be simulcast to your hospital, so there’s no need for you to commute! Typically an invited speaker from another institution will present on a topic of current interest. Roughly once per month, Grand Rounds will be a system-wide M&M.
• Morbidity and Mortality Conference (M&M): A resident will present a recent case resulting in a poor outcome and hopefully address systems issues that can be changed to prevent further occurrences of this issue. Times vary with each hospital site.
• Noon Conference: This is a didactic session occurring every day for residents and interns where an attending lectures on a pertinent topic. The goal is for residents to be exposed to all the topics necessary for their board exam (yes, they still exist!) by the end of their training. Definitely worth attending for the educational experience, and also because there is typically free lunch! Confusingly, this does not always occur at exactly noon, so be sure to check with your team.

Didactics Just for Medical Students
Teaching sessions – afternoon conferences, lectures, and didactic sessions – are the dedicated education 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 and EKGs, how to manage common medical problems seen in adults, and how to approach an unknown patient. To accomplish these goals, you will have the following sessions essentially each week:
• EKG Class
• Casebook Session: A bit like small group during the preclinical years, this is a problem-based learning exercise that you will work through with the other students rotating at
your site. Typically you will get only the first page of the presentation prior to the session and will have to work from there.

- **Radiology Conference:** Although there is a primary focus on reading chest radiography, you will get an introduction to all types of imaging modalities.

- **Preceptor Session:** Students are assigned to a preceptor during each inpatient month. The preceptor (not your attending) meets with students to offer independent feedback on your presentation style, write ups, and assess how you are faring on the wards. This can also be a great time to talk about a case which is puzzling your team, as another set of attending eyes on the problem frequently brings clarity (or at least an additional avenue of investigation!)

- **Ethics Session:** Usually two to three times over the course of the clerkship, with an accompanying written assignment.

Each hospital also has its own special didactics. For example, at Miriam you are lucky to have “Dr. Carpenter Rounds,” where every Friday morning 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.

In short, there is a lot of stuff on your schedule! You will learn to manage it. Over the clerkship you will acquire the skills to balance patient management with didactic sessions and other commitments, and prioritize appropriately. For example the general conferences (noon conference, Grand Rounds, etc) typically should be secondary to patient care.

**Team Structure**
The Internal Medicine residency program is entirely team-driven, which means your clerkship will be too. Each hospital has either eight (RIH) or four (everyone else) medicine teams consisting of: a senior resident (PGY-2 or PGY-3), one or two interns, possibly a sub-intern, you and potentially a classmate, and possibly another student, such as a pharmacy or PA 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.

Your resident is the ultimate arbiter, but you should expect to carry at least two to three patients at a time, depending on how complicated their management is deemed to be. In general, you should pick up at least one new patient during each call.

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**JMS Says:** Superstar medical students know as much as they can about their patients— not just the H&P. If a patient has an interesting CBC, go to the lab and look at the smear under a microscope. Ask the radiologist to review films and images with you. You need to personally experience and learn as much about the patient as possible: it will help the team and your overall learning.
For each of your patients, your responsibilities will typically be as follows: be the first person from your team to see the patient, writing your initial H&P. Write admission orders and review them with your intern and resident. Pre-round on your patients in the morning and present your patient to your team during rounds. Formulate a plan for your patient, discuss the plan with your resident, and 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 (Like every other rotation, you should bring cheap pens to “lend” to your interns and residents, who will likely forget to return them to you.)
- The list of important hospital phone numbers (radiology, chemistry and microbiology labs, admitting, etc) provided to you at your clerkship orientation
- Rulers and calipers for reading EKGs, if you have them
- Some sort of resource for medication either in print or on your smartphone
- A pocket medicine guide (see below for details)
- Notecards, notepad, clipboard, or whatever other system you have figured out for your own records keeping

**Clerkship Grading**
There are plenty of opportunities for you to be evaluated, particularly since this clerkship is twice as long as your other rotations! Evaluations account for 50% of your grade, the shelf for 25%, and the OSCE for the remaining 25%.

**Resident Evaluations**
Your residents fill out evaluations 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, accurate, and informative H&P to whether you dress and behave professionally. If you did your job as best you could, remained positive, and were a team player, you should do fine. Interns are not required to evaluate students, however, students can request these by asking their respective clerkship coordinator. Most students ask one or both interns on the team to complete evaluation forms.

**Attending Evaluations**
Whichsoever attendings oversee your team are asked (but not required) to complete evaluations of your performance. Do not worry about these evaluations, but just do your job as well as you can.
Faculty Preceptor Evaluations
Students are evaluated by the two faculty preceptors assigned for their inpatient ward months, as well as the outpatient site coordinator (whose evaluation represents a consensus of the attendings you worked with in that practice).

Feedback Sessions
Midway through the clerkship, you will have a feedback session with the clerkship director at your hospital site. This is an opportunity for you to preview any evaluations which have been completed up to that point, and to focus on areas of improvement for the rest of the clerkship. There is also usually a final feedback session (although scheduling of that can be tough once you’ve moved on to your next rotation) which will similarly review your evaluations, strengths and areas to improve, and also give you a chance for career or specialty advice from your clerkship director. These can be very enlightening sessions as you reflect on your Medicine clerkship experience, one of the formative blocks in medical school.

The Shelf Exam
Brought to you by the same people who brought you the USMLE, this multiple-choice exam is similar to other standardized tests you’re hopefully used to by now. A score of 60% or higher is required to pass the clerkship.

To study, you should read whenever you can. Find resources that suit your style, whether it be dedicated Medicine clerkship books (see below to for examples), reference books, or review questions. The casebook sessions you complete with other students will also be helpful. There are a number of different question banks specific to the rotation, which are discussed below. You should also ask your residents, interns, and sub-I to help you prepare. They want you to do well, too!

The OSCE
The Objective Standardized Clinical Exam (OSCE) is an exam that gauges your clinical skills. It is held sometime during the last two weeks of your Medicine clerkship in the Clinical Skills Suite at 222 Richmond. All students on the clerkship take the exam on the same day: there are sessions in the morning and the afternoon.

There are six stations, each lasting 30 minutes. At each 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 scenarios and other didactic sessions you’ve completed throughout your clerkship. This experience will also help you prepare for the Step 2 Clinical Skills exam.

It is, depending on who you ask, is “actually a lot of fun” or “so stressful 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, their professors, and their mothers – 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 consequently pass the OSCE.

Example OSCE stations include:

- Read a chest x-ray
- Read an EKG
- Counsel a patient with a medical problem (such as high cholesterol or diabetes) about lifestyle changes, potential medications, complications, etc
- 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 an attending
- Provide a differential diagnosis and treatment plan
- Write about an ethical issue

At each station, you will be evaluated by a standardized patient and/or you will record your findings on paper. You cannot pass the clerkship if you do not pass the OSCE. A score of 60% or below and also below two 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 Resources**

*For Reading and Reference*

- **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 place to start for all medical issues that you will encounter on your clerkship. You do not need to own it, but you may want to eventually. There is a pocket version to carry around with you (see below), or you can access the online version for free through Lifespan or Brown.
- **Cecil Essentials of Medicine**: Again, not for reading cover to cover (although previous editors have known medical students to attempt 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**: Typical for a Blueprints text, this is 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 text, but this version presents pathologies in a case presentation format. Some people find it easier and more applicable to the clerkship structure. It also has 200 practice questions.
• **Step Up to Medicine:** The quintessential text, you will probably see many of your classmates toting this highly-recommended resource through the hospital. It is presented in a similar format to its Step 1 counterpart. It provides comprehensive information, but unfortunately does not include questions.

• **First Aid for Medicine:** Also a popular text with thorough coverage of high-yield topics presented in an outline format. It has received great reviews for its format and can be good preparation for the shelf exam when supplemented with a reference text and practice questions.

• **Internal Medicine Essentials for Clerkship Students:** Produced by the American College of Physicians and the Clerkship Directors in Internal Medicine, this is a relatively short text aimed specifically at clerkship students. Since the same organizations produce MKSAP (see below) it is available as a package with the question book.

• **UpToDate:** This online reference guide is available at all Brown-affiliated hospitals. It is a popular source that provides a good starting point for all you need to know about the most common illnesses, diseases, and medications, à la Wikipedia. Note that although it is designed as a quick reference, it is also meant to be comprehensive and may include research summaries that can complicate your reading. However, if you are asked to do a presentation on a particular topic, it is generally insufficient to rely on UpToDate for your information.

**For Questions**

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

• **MKSAP for Students:** MKSAP = Medical Knowledge Self-Assessment Program. This book comes highly regarded by many students (and clerkship directors), although some feel that the questions are easier than on the shelf. It contains a series of clinical vignettes with questions and covers the standard topics. Mastery of these vignettes should ensure a good grade in a third-year rotation, but requires a fair amount of effort. Of particular note are the quality of the explanations of correct and incorrect answers.

• **PreTest Medicine:** The typical PreTest book, it contains approximately 400 shelf-type multiple choice questions (as well as matching). It is also considered to be somewhat less challenging than the shelf exam, but it easily fits into your white coat pocket and therefore is a good book for quick Q&A sessions.

• **Your favorite question bank:** You’ve survived Step 1, so you know the drill. Pick one (UWorld seems to dominate at Brown) and go from there. Just be sure to leave some questions for your Step 2 studying!

**For Reading EKGs**

• **Rapid Interpretation of EKGs:** 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
task of EKG interpretation into bite-sized, digestible bits. Very helpful for your weekly EKG class and preparation for the OSCE.

- **The Only EKG Book You’ll Ever Need:** An increasingly popular book. More thorough than the Dubin book (above). It may be a better long-term purchase that can remain useful beyond the medicine rotation.

**For Your Pocket**

- **Pocket Medicine: The Massachusetts General Hospital Handbook of Internal Medicine:** Chances are you won’t even realize that that’s what this book is called—you’ll just 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 workup and management. It changes color with each edition, so you may hear your interns describing it as “the green book” or “the red book.” The small print and heavy usage of acronyms can be challenging at first, but you’ll likely see all of your classmates toting one around as well.

- **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. It is a quick way to review the main points of a disease (differential, workup, treatment, etc) on your way to morning report or prior to rounds. Some students find it easier to read than other pocket texts.

- **The Washington Manual of Medical Therapeutics:** Another option of what you may see your intern carrying around. More information and detail than you will need to carry out your responsibilities, but an investment to consider if you are able to understand it. If you think you are going into internal medicine, it may be worthwhile to purchase this prior to your medicine sub-i.

- **Harrison’s Manual of Medicine:** The pocket version of the aforementioned *Harrison’s Principles of Internal Medicine*, this is an excellent resource for those questions which need quick, concise answers. Each chapter from the larger text is neatly summarized into a quick two or three page précis, with many helpful charts and management tips. Depth and underlying pathophysiology are not well covered, but that is what the larger book is for. Additionally available in a smartphone version, although this is not covered by Brown or Lifespan.

- **Current Clinical Strategies: Medicine:** Particularly helpful for your wards months, this 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 back to it so that you don’t end up relying on it instead of your brain. It also reviews medical therapeutics and management for most presenting complaints.

**Summary**

Have fun, and learn, learn, learn! This clerkship forms the foundation of your future career in any specialty. Dr. Mark Fagan (the clerkship director at RIH) provides this list of the top ten
things to do to succeed on the Medicine clerkship, originally 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, and obtain outside records.
5. Practice your presentations.
6. Do not read your write-up while presenting.
7. Offer a plan, even if you’re not sure. Explaining your rationale will create great teachable moments and earn the respect of your evaluators.
8. Take advantage of opportunities to be taught. Ask to go over x-rays, physical exams, gram stains, etc. Volunteer to do procedures (with supervision).
10. Have fun!
OBSTETRICS AND 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
Drs. Star Hampton (BHampton@wihri.org) and Rebecca Allen (RAllen@wihri.org) are the two clerkship directors. Both directors are very nice and very accessible by email! The clerkship coordinator (also super-kind and super-helpful) is Kristine Ricci. She can be contacted at 401-274-1122 x1805 or by e-mail at kricci@wihri.org.

The departmental ombusperson for OB/GYN is Trevor Tejada-Berges (TTejadaBerges@wihri.org; 401-453-7540 or 401-453-7320).

The OB/GYN clerkship is run out of Women and Infant’s Hospital, located next to RIH. Despite their co-location, these two hospitals are run by different hospital systems, meaning that you’ll have to get a new badge, learn a new EMR, and otherwise adapt to a different way of doing things. It can be confusing initially, but you’ll get the hang of it!

The OB/GYN clerkship website is located at https://sites.google.com/a/brown.edu/ob-gyn-clerkship/?pli=1. As you probably know from other clerkships, you will need to be logged in with your Brown Google account, not your personal account, in order to access the site.

Clerkship Schedule
OB/GYN is a six-week clerkship divided into various blocks: two weeks of Labor & Delivery (including an optional week of MFM), two weeks of Gynecologic Surgery, one week of Night Float, and one week of Outpatient Experience. Your last week will be truncated on Tuesday afternoon by the OSCE (including Breast & Pelvic exams that evening) as well as the Shelf exam on Friday.

Service Structure
Like many other clerkships, your day-to-day activities depend on which service you are currently rotating on. In general, while your times to come to the hospital vary, you leave at the same time each day – around 5pm or so, after your didactic lecture (which happens just about every day!)
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 are 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).

On L&D, you can expect to come in each morning around 5:30am or 6am, depending on how many patients are on your census. On Wednesdays and Fridays when you have CORE lectures at 6:30am, you will need to come in earlier. The Orientation Packet that Kristine will provide you with will help you figure this information out.

During the day, check “the board” on L&D (the second floor of the main building) and find patients who will be giving birth. Ideally, the patient’s name should not be listed in red (which suggests that they’re a clinic patient, meaning the OB/GYN intern will get first dibs on delivery, not you) and should have a physician’s name (not something with the word “midwives” in it) next to it. Once you’ve done that:

1. Text-page the patient’s obstetrician to let them know you’ll be following their patient. No need to provide a call-back number; a call-back pager is fine. They expect medical students to help out (or even carry out!) their patients’ deliveries, so they won’t say no.
2. Introduce yourself to the patient’s nurse – the nurse will help make sure you don’t screw anything up epically and will also provide you with the supplies you need (e.g., a cord blood tube) as the time approaches.
3. Introduce yourself to the patient and any family in the room. Ask her if you can help out with the delivery. If she says yes, you have a patient! Ask her if there’s anything you can help her with (getting ice chips, blankets, etc.)
4. During the day, periodically check on your patient to see how she’s progressing. If you feel awkward walking in with no obvious purpose but to check if the patient’s in active labor, you can always walk in and check the fetal heart tracing. All of the fetal heart tracings are available outside the room, of course, but it gives you something to do!
5. During downtime, you should actively ask to learn from the nurse midwives. They are exceptionally nice and helpful, and their main job each day is to help train you and the residents. You can ask them for help with OSCE stations (baby delivery, episiotomy repairs), presenting an OB progress note orally, interpreting fetal heart tracings, etc.
6. When your patient progresses far enough, help deliver her baby as well as the placenta. Some OBs will have you deliver the placenta after they deliver the baby; others will
allow you to deliver the baby with their hands over your hands; while some will just tell you to deliver the baby and placenta yourself while they watch!! Be prepared for any scenario and, obviously, see if you can deliver the baby yourself. Once the baby starts crying and crawling around in your arms, it’s a truly extraordinary experience!

**Maternal-Fetal Medicine (MFM)**
Specializing in the care of high-risk patients, this service is quite unique in that you get to help out in a much more hands-on way than your other week of L&D. If you choose a week of MFM, you will work on this service in lieu of your antepartum week. The patients you see will have gestational diabetes, pre-eclampsia, pre-term premature rupture of membranes, and more. The service is busier and functions more like an Internal Medicine service would, with pre-rounding with your residents and then formal rounding with the attendings. You participate in all MFM conferences, rounds, surgeries, and deliveries.

**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.

You can expect to come in around 6am or so each morning to round on your patients – the exact time will depend on your census and what your team requests. One of you (work out the schedule between you and the other medical students) will be “on call” to find out about any clinic patients who were admitted overnight. If this happens, you’ll get a phone call or cell-phone text (give the intern your cell phone number beforehand!) around 5:30am that morning asking you to come in, see the clinic patient, and present the patient to your team. During your two weeks on Gyn Surg, you can expect to be “on call” like this about 2-3 times.

After pre-rounding, you typically attend morning report in the cafeteria – here, an attending reviews topics with you and the residents while you get a chance to eat breakfast.

After morning report, you head to the OR. The PGY-4 (fourth-year resident, a.k.a. the chief) will email you the week’s OR schedule and will also assign each of you cases the Sunday before each week. Typically, you are paired with the same attending (or the same OR) all day so your cases don’t get double-booked. Try to read up on your cases beforehand so you can answer questions in the OR. In general, though, attendings on OB aren’t as mean about pimping as surgery attendings. What this means is that you should feel free to ask questions and get involved as much as you can!

JMS says: To do MFM, or not to do MFM?
**Pros:** Great way to get involved in patient care and see cases that will directly prepare you for the majority of your OB shelf questions.
**Cons:** Slightly longer hours (coming in at 5:30 AM each morning to pre-round with your team). If a sub-I is around, both of you may have difficulty getting involved as much as you would like.
Night Float
As its name suggests, this one-week block, typically Sunday night through Thursday night, has you working the entire night. You are typically paired with either the PGY-2 (who manages Triage, where patients come in with obstetric and gynecologic emergencies including their membranes rupturing) or the PGY-3 (who manages L&D as well as the gynecologic floors). If you have night float during the last week of your clerkship, refer to the Orientation Guide (that Kristine will provide you with) to find and customize your schedule.

Typically, you come in at around 6:30pm or 7pm – check the Orientation Guide or ask your resident for more information. You first round with the team in the Residents’ Lounge on the second floor of the main building, and then you head off with either your PGY-2 or your PGY-3 (you alternate each night). Make sure you bring food with you – it’s easy to get hungry at night! However, there is a 24-hour ABP in the hospital lobby. You typically are out by 4 or 5 am each morning.

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).

You typically come in each morning around 8am – the exact time will depend on your service; Kristine will provide you with more information. Your preceptors will be expecting you, so feel free to find them and help out however you can during the day. Much of your day will be like Doctoring – see a patient and present to your preceptor. On some services, though, you may end up shadowing more – either way, try to make the most of what you do!

Didactic Sessions
There are many types of conferences to attend, both for all OB/GYN services and specific to medical students:

- Grand Rounds: 7:30am on Thursdays in the South Pavilion – you can’t get in with your IDs, so just ask someone to let you in politely. Food is provided!
• CORE Lectures: 6:30am on Wednesdays and Fridays – however, there are certain CORE lectures that are geared specifically for residents so you aren’t invited. Kristine will provide you with a list of CORE lectures during orientation. These lectures are a great way to brush up on shelf exam topics (and, sometimes, the attendings even turn to the medical students to answer their questions) and your team will be there.
• Medical Student Lectures: 4pm in the conference room on the third floor of the main building (Kristine will provide you with the passcode at Orientation), just about every day. These lectures are a great way to review shelf exam topics – in addition, each of you will lead a session on one of these afternoons. There is an 85% attendance requirement for the clerkship, so be sure to sign in each day!

Preceptors
Each student is assigned to a faculty, fellow, or resident preceptor. The preceptor will help you prepare your case presentation and provide education and career guidance. You meet with them about three times. They’re one of the people who evaluate you during the clerkship. They’ve volunteered to help you with your presentation, so don’t hesitate to ask them to review your slides before you present! They’ll be there at your actual presentation as well, though, so don’t worry too much about being a world expert in the topic you’re asked to present.

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
• Pens, pens, pens (with extras in case some get “borrowed”)
• Notecards, notepad, or some notetaking system
• List of useful passcodes – you have separate passcodes for your locker room, the Residents’ Lounge, the library on the third floor (different passcodes for the elevator vs. for the stairs), triage, etc. Write them down or you’ll get totally lost!
• Pregnancy wheel loaned to you by Kristine – technically, you’ll only allowed to use Cerner’s “official” pregnancy wheel for calculations, but the pregnancy wheel comes in handy!
• Laminated cards loaned to you by Kristine – they’ll be a lifesaver when you’re asked to write a delivery or OB Progress note! They also have the OSCE grading criteria on them, so they provide a helpful way for you to review during down time.
Wait, what should I wear under my white coat?
In general, you bring whatever street clothes (scrubs, jeans, etc.) you’d like into the hospital – once in the hospital, you’ll place the clothes in your locker and change into WIH-issued green scrubs. Kristine will show you how to access the locker room and get green scrubs during Orientation. You’re not allowed to leave the hospital with your green scrubs. You’re allowed to “check out” two pairs of scrubs at a time, so most students leave a pair in their lockers so they can change quickly.

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 from clinic. 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. You are also required to complete evaluations of the faculty.

Case Presentation
You will be assigned a topic and a preceptor during Orientation. Meet with this faculty preceptor 2-3 times before your presentation and once after. For the PowerPoint itself, be sure to begin and end with a case (either a case you’ve actually seen, or a representative case that you and your preceptor have created). Avoid lecturing during your case presentation – try to engage your classmates with questions (both informal and formal, i.e. written into the PowerPoint itself).

Attendance
You are allowed up to 2 excused absences during your time on the clerkship, i.e. illnesses (with a physician's note) or conferences (where you are either presenting research or serving in a national leadership position). With regard to lectures specifically, you must attend at least 85% of your lectures/case presentations during the clerkships (be sure to sign in on the attendance sheet for each lecture!) and complete evaluation forms on each lecturer.

Objective Structured Clinical Exam
- General Women’s Health
  You will all meet in one of the W&I auditoriums. Unlike the Internal Medicine OSCE, there is no assigned order for the OB/GYN OSCE: you will go from station to station as they free up – it’s a pretty low-stress environment! The stations are:
Demonstration of emergency vaginal delivery (using pelvis model)
Demonstration of episiotomy and perineal laceration suturing skill competency
Demonstration of adequate obstetrical chart review
Demonstration of understanding at least one of: breakthrough bleeding, contraceptive counseling, annual well woman exam, vaginitis, the work up for menorrhagia

Breast and Pelvic Exam
This OSCE is administered after the other stations (typically, Tuesday evening) at the WPCC in the Medical Office Complex of RI Hospital. You will be asked to perform a breast and pelvic exam on a gynecologic teaching associate, while explaining every step and counseling her on how to perform a self-breast exam. A resident and the gynecologic teaching associate will 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 30 minutes. There is a wonderful resource for multiple-choice questions called uWise that you will have access to while on the rotation; Kristine will provide you with more information during Orientation.

Ethics Assignment
During your rotation, you will attend two lectures on ethics and be assigned a brief write-up to discuss an ethical dilemma that you may have encountered on this rotation.

Recommended Resources
Just as with any other clerkship, there are different texts with their respective pros and cons. You are also loaned a copy of Beckmann’s Obstetrics and Gynecology by the clerkship during Orientation – this is a great reference guide for looking up information, including for your presentation, as well as studying for the shelf!

Other helpful guides include:
- **UWise:** An extraordinarily helpful collection of 500-odd questions that Kristine will provide you more information with during Orientation. Additionally, each section of questions also links to an outline covering some of the relevant high points.
- **First Aid for the Obstetrics and Gynecology Clerkship**
- **BRS Obstetrics and Gynecology**
- **NMS Obstetrics and Gynecology**
- **Blueprints Obstetrics and Gynecology**
- **PreTest Obstetrics and Gynecology**
What is Pediatrics?
Well, this is a no-brainer, right? Kind of... but 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 to the field of pediatrics. You will learn the bread-and-butter issues in pediatrics, as well as determine whether pediatric (or any medical field involving the care of children) is suitable for you. You will also probably get sick.

Main Contacts and Sites
The home base for the Pediatrics Clerkship 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 times you will be outside of Hasbro are during your two weeks of outpatient pediatrics (unless you are assigned to one of the Hasbro clinics) and your week at Women & Infants and other subspecialty clinics.

Helene Felici is the clerkship administrative coordinator, and can be reached at 444-3406 or via email at hfelici@lifespan.org. Dr. Randal Rockney is the clerkship director, and is available via pager at 350-5569. Dr. Brian Alverson is his associate and is in charge of the pediatric wards sub-internship and the inpatient portion of the clerkship.

The website for the Pediatrics Clerkship is accessible at https://sites.google.com/a/brown.edu/pediatrics-clerkship/ and requires that you be logged in through your Brown account.

The departmental ombudsperson for the Pediatrics Clerkship is Pat Flanagan, who can be reached at 444-7987.

Clerkship Schedule
The Pediatrics Clerkship is six weeks long, divided into three weeks of inpatient experiences (two with a single team during the days, and one on night float), two weeks of outpatient medicine, and one “potpourri” week. Dr. Rockney, Dr. Alverson, and Helene do a great job of organizing the clerkship and soliciting feedback. This clerkship also provides its own syllabus (provided at orientation and found on the website), which explains the nitty-gritty details of the clerkship in depth. The best thing you can do in preparation for the rest of the clerkship is to read that handbook! A note about longitudinal experiences: due to the scheduling of required didactic sessions, it is recommended that you schedule your longitudinal clerkship for Monday, Wednesday, or Friday afternoons during this elective.
Inpatient Schedule (Days)
For two of your inpatient weeks, you will be on an inpatient team consisting of a hospitalist, senior resident (either PGY-2 or PGY-3), two to three interns (they could be from pediatrics, family medicine, med/peds, psych, EM, or triple-board), perhaps a sub-I, and you. There are only three primary inpatient teams at Hasbro, so most teams may have more than one third-year student at a time.

A typical daily schedule during your inpatient weeks:
- Get sign out from the night float team at 6am.
- Pre-round on your assigned patients and write your notes for the day.
- Go to Morning Report from 8-9am. Typically, a resident or intern will present an interesting case, although other topics include evidence-based medicine, quality improvement, etc.
- Radiology Rounds with your team. You’ll review the x-rays and other radiographic studies of the previous day for your patients with an attending radiologist.
- Round with your team, presenting your assigned patients and your plans for the day.
- Teaching rounds (scheduled at the discretion of your attending). Members of the team will typically present a topic for discussion, or the attending will give a short talk, etc.
- Go to Noon Conference from 12-1pm. Typically, attendings present topics for residents. You’re on your own for lunch, unless you happen to be rotating during the magical interview season, where lunch is provided several days per week.
- Do work.
- Sign out to the night float team when they arrive at 6pm.

Other learning opportunities!
- **Teaching Resident Rounds**: A senior resident (usually PGY-3) is assigned to teach medical students. This typically occurs three times per week, for an hour each time. Many teaching residents will solicit input from students on the topics they want to review, so this is a great resource for your exams!
- **Medical Student Conference series**: Typically Tuesdays 4-5pm, you and your classmates will present case-based conferences with an outpatient focus.
- **Clerkship Lecture series**: Typically Thursdays 3-5pm, these are like noon conference, but specifically designed for the medical student audience. Attendings will discuss topics such as immunization schedules, fluids and electrolytes, pediatric exam skills, ethics, and clinical dilemmas.
- **Grand Rounds**: Held Fridays from 8:30-9:30am in George Auditorium at RIH, usually only during the academic year.
- **Morbidity and Mortality**: As with their adult colleagues, once per month the pediatric providers meet to discuss poor outcomes and possible systems changes.
**Night Float Schedule**
At Hasbro, 70% of patients are admitted overnight. While you admit every day as an inpatient team during your two weeks of days, working nights is a rewarding and enriching experience! For one week of your rotation (or, specifically, five consecutive nights—typically Sunday-Thursday) you will serve on the night float team. The night float shift runs 7pm-7am, although frequently students are sent home earlier by the night float team. You are expected to stay awake for the duration of the night, admitting patients from the emergency room and the transport team.

**Outpatient Schedule**
You will spend two weeks rotating at an outpatient pediatrician’s office or one of the clinics in the basement of Hasbro. Schedules and expectations vary substantially between different offices, so it’s best to check ahead of time! During these two weeks, you continue to attend the afternoon didactic sessions at Hasbro, so be sure to leave enough time to travel.

**Newborn Medicine/Subspecialty Week Schedule**
As the name implies, this week is designed to give you a number of exposures to the breadth and depth of pediatrics. Typically you will spend two days in the Newborn Nursery at Women & Infants, two days at various specialty clinics or in the pediatric ED, and one day in the Neonatal Intensive Care Unit (pronounced “nick-u”).

While in the Newborn Nursery at W&I, you will observe and participate in the care and physical exams of newborns. The nurseries are located on the fifth and sixth floors of the main building W&I. While in the NICU, you will attend “complicated” deliveries (e.g., when meconium is present, all c-sections, etc) as well as gain familiarity of the common problems of premature or sick infants. The NICU is located on the second and third floors of the new pavilion at W&I. There are didactic sessions specific to NICU, and each Newborn Nursery and NICU have case presentation sessions you are expected to give for the attendings.

The remaining sessions of your “potpourri” week are scheduled in various subspecialty clinics and time in the Hasbro ED. If you are interested in a specific pediatric specialty, let Helene Felici know and she will do her best to accommodate your choices.

Confusing? Yes. An example schedule for this week is provided below. Your mileage may vary.
Didactics
As mentioned above, there are two dedicated sets of didactics. You will be required to present one of the Medical Student Conferences throughout the clerkship (signup occurs during orientation), and attendance is taken at all sessions. These didactics form the basis of your OSCE and are important review for the NBME shelf exam, as well.

What to Wear and Bring
Typically, you should wear your normal, professional attire. During night float week, it is appropriate to wear scrubs, which you should provide. During your newborn medicine experiences in the Nursery or the NICU, you should wear W&I-specific scrubs. Helene has a scrub card which will allow you to obtain scrubs, and can also explain how to acquire them. Otherwise, you may find it useful to bring:

- Your white coat (although this may get ditched at your outpatient site... many kids have white coat phobia, so follow the lead of your preceptor!)
- Your stethoscope, with pediatric-sized diaphragm if you have one
- Reflex hammer, penlight, tape measure for measuring head circumference
- Pens, pens, pens
- A calculator (very handy for pediatrics, since all drugs and other calculations are weight-based)
- All the cute, smiley toys you or your family or friends have found for you to use on this rotation.
- Other resource materials (see below)

Clerkship Grading

Evaluations
As with every other rotation, pretty much everyone you interact with will evaluate you. Specifically, attending, residents, interns, outpatient preceptors, and the folks from your newborn medicine week will fill out evaluations of your performance. There is also a mid-clerkship feedback form which must be returned and other specific points of evaluation. Be your usual eager, helpful little self, and you will be fine.

NBME Shelf Exam
You know the drill. Like other Shelf exams, this exam has 100 multiple-choice questions to be completed within 2 hours 30 minutes. Pediatrics has a reputation of being a very difficult Shelf exam, given all the genetic and metabolic disorders it can cover, as well as developmental milestones, and many other topics.

The OSCE
Typically held on the last Wednesday night of the clerkship, the OSCE is an oral and performance evaluation of the skills you have learned during your 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. Other potential OSCE stations include writing admission orders (including calculating fluids and medication dosages); a basic neurologic exam on a standardized patient; counseling a teenager on drugs or contraception; and a postnatal well-child visit, including advising the mother. 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 and Resources

- **Blueprints in Pediatrics**: Considered by many to be the best *Blueprints* book there is. It contains most of the information you will need for the clerkship, and is easy to read with a solid introduction to common pediatric problems. *Blueprints* also produces a pocket series of pediatric specialties, so these are worth looking into if you are doing pediatric electives.

- **Pediatrics for Medical Students**: Available on loan from the clerkship office, this textbook is written by the American Association of Pediatrics and highlights what this specialty-specific group thinks medical students should learn in their pediatric clerkship.

- **NMS Pediatrics**: It's comprehensive and has great practice questions, but is dry and reads like a phone book.

- **Pre-Test Pediatrics**: A typical *Pre-Test* tome containing plenty of practice questions.

- **Signs and Symptoms in Pediatrics**: A great book for formulating differentials. You can typically find a copy in the residents' library.

- **Nelson Textbook of Pediatrics** and **Oski's Pediatrics**: Both are excellent, comprehensive reference texts. Don’t sit down and try to read the entire thing!

- **The Harriet Lane Handbook**: Another stalwart in pediatrics, this text addresses a wide range of pediatric maladies and treatments, including a comprehensive drug formulary. You’ll find them scattered throughout Hasbro, and they’re also available electronically through the Brown Library.

- **Shots by STFM**: Produced by the Society for the Teachers of Family Medicine, this free app has links to the CDC immunization schedules for all ranges of pediatric patients.
What is Psychiatry?
Psychiatry is the medical specialty that deals with the diagnosis and treatment (including psychotherapy and pharmacology) of mental illnesses. Yes, you already knew that, and yes, you have already seen the Brain Sciences block during first year. Now it’s time to apply what you’ve learned.

Hospital Sites and Contacts
There are five main sites for the Psychiatry clerkship: Butler Hospital, RIH, the VA, The Miriam, and Bradley Hospital. Unlike in other clerkships where the directors can somewhat plausibly claim you’ll have a similar experience at each site, psychiatry will substantially vary from hospital to hospital and even service to service. Ultimately you’ll be expected to have the same knowledge base, but from a different perspective.

Dr. Robert Boland (Robert_Boland_1@brown.edu) is the Clerkship Director and will be a familiar face from your time in Brain Sciences; Dr. Tracey Guthrie (TGuthrie@butler.org) is the associate clerkship director; Dr. Jane Eisen (Jane_Eisen@brown.edu), who also functions as a CIM faculty member for the Green Academy is the Director of Medical Education in Psychiatry; and Kelly Whalen (Kelly_Whalen@brown.edu and 401-444-1901) is the Clerkship Coordinator.

Dr. Laura Levine (Laura_levine@brown.edu and 401-273-7100 x3878) is the departmental ombudsperson.

The clerkship leadership has traditionally maintained a MyCourses site, which includes a number of resources including orientation materials, lecture notes, links to good electronic psychiatry resources, and suggested readings. As with other clerkships, they are transitioning to a Google-based website with the above material, which can be found at https://sites.google.com/a/brown.edu/psychiatry-clerkship/. Note that you will need to be logged in to your Brown Gmail account to access this website.

Butler Hospital
As the state’s main psychiatric facility, Butler offers a wide range of services focused on different patient populations. The general treatment floors (D3 and D4) admit patients needing acute care (i.e., patients who need immediate medication adjustment or 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 those suffering from dementia. The partial hospital program (aka Day Hospital) sees patients who need day-long supervision and daily psychotherapy, but are safe enough to return to their homes at night. Butler Hospital is also home to the Patient Assessment Service (PAS). Although PAS is colloquially known as the Butler Emergency Room, no actual treatment occurs there. Patients are admitted if needed or referred for outpatient programs. You will most typically work on D4 and in the partial hospital.
**Bradley Hospital**
Between hospitals, the largest difference is between the Bradley experience and the others. Butler, RIH, TMH, and the VA are all inpatient adult psychiatric services (although there is a child and adolescent unit at Butler), but Bradley offers only child psychiatric services. It is the only freestanding psychiatric hospital in America devoted to children and adolescents. It’s a great learning experience in child psych and offers excellent opportunities to evaluate patients with Asperger’s, conduct disorder, disordered eating, and suicidality, as well as learning about family structure and the basics of family therapy. Bradley is also home to the Bradley School and two partial hospitalization programs (for pre-school age children and adolescents), as well as many outpatient child psychiatric resources. If you’re looking for a bread-and-butter psychiatric experience, though, you’re better off sticking with one of the adult sites.

**Rhode Island Hospital**
Much like Butler Hospital, there are several different services at RIH, although as you are aware these are interspersed with a whole host of non-psychiatric services. On your Psychiatry clerkship, you will spend time in one of two areas:

1. The inpatient psychiatric units are on Jane Brown 3, 4, and 5. The patient populations on these units cover the spectrum of psychiatric illnesses, and you will be exposed to pharmacotherapy, family meetings, and group psychotherapy. There is a dedicated geriatric unit. Students working on the inpatient floor stay mainly on the unit.

2. The consult liaison (CL) service with Drs. Harrington and Gallo treats the various medical patients throughout RIH who have psychiatric issues (e.g., delirium, psychosis, etc). Students evaluate and chart on patients individually during the morning hours and then round with the team in the afternoons.

As with at Butler, there is a psychiatric emergency services area at RIH. Known as the D-Pod, it is downstairs from the main ED. You typically will not spend much time here, but you will be assigned one shift time over the six weeks here “on call.”

**The Miriam Hospital**
The experience at Miriam Hospital is like the RIH consult service described above. Students are part of a team including psychiatrists, residents, psychologists, and psychiatric nurses consulting on patients in the hospital and in the ED. Interestingly, the psychiatric consult service at TMH also serves as the pain management service, which gives you exposure to some different patients than you might see at other hospitals.

**The VA**
The VA again runs the gamut of adult psychiatric patients. Given the demographic characteristics of typical VA patients, you may expect to see drug and alcohol issues as well as PTSD relatively more frequently here.
Clerkship Schedule

At Brown, the Psychiatry clerkship is a six-week clerkship that is subdivided into two three-week blocks of time. During one block of the time you’ll be at one of the adult inpatient units (either at Butler, RIH, or the VA). The balance of the time is spent in another setting: an inpatient child and adolescent unit, inpatient consult service, or outpatient partial hospital program. Most of these options are pre-assigned; the only choice given to students in advance is whether they want a pediatric psychiatry experience.

The rotations are relatively straightforward with ample opportunities to practice and learn a variety of pathologies. You will shuttle between sites for lectures, didactic sessions, and outpatient clinics, but will be primarily based at your main hospital site. The typical day varies substantially from hospital to hospital, but in general you will work like any other service: pre-rounding, walk rounding, and writing notes. Some attendings do all the interviewing, whereas others will let you interview patients once you gain more experience.

After rounding on patients, you and your attending will write daily progress notes and orders on all of your service’s patients. This will usually take you to the lunch hour, and what happens after that varies according to your schedule and your priorities. Afternoon activities include:

1. Lectures and didactics: One afternoon per week. See section below.
2. Outpatient site: One afternoon per week during the three-week inpatient block of your clerkship (so, three total sessions). This is intended to allow you to gain a flavor for how outpatient psychiatry works.
3. Interview practice session: An hour-long session during one afternoon per week, scheduled individually at each hospital site.

If you don’t have one of the above scheduled for your afternoon, you should spend your afternoon finishing your progress notes, discussing the plan with your attending, spending more time getting to understand your patient, or “studying” (location to be determined in conjunction with your attending). You may also need 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.

Didactic Sessions

Psychiatry conferences include...

- **Grand Rounds:** These take place from 11:00am until noon on the first Wednesday of each month in Ray Hall on the Butler campus. A nationally-recognized speaker presents his or her current research. Attendance at Grand Rounds is expected of all trainees and faculty.

- **Medical Student Lectures/Didactics:** There is a unified educational series for the psychiatry clerkship, meaning that regardless of your site, you will converge at one location (usually Butler, but once Bradley and once RIH) for each session. That way, you are getting the same lectures instead of in-house variants at your own site. Each Wednesday afternoon 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 attend: sign-in sheets are available and attendance is factored into your final grade. **Given the occurrence of the mandatory lectures, your longitudinal MAY NOT be on Wednesday afternoons.**

- **Site-Specific Conferences:** Patient presentations, case conferences, etc. The site director for each location should let you know where and when these occur.

**Other Experiences**

- **Call:** Students take call at both Butler Hospital PAS and the RIH D-Pod. The current requirement is one session at each site, and allows ample opportunity to work 1:1 with the attending and residents at each site. This is scheduled in the evenings for roughly three hours per session. You may also be expected to come in on a weekend day to round on patients; this is site-specific and varies somewhat depending on time of year.

- **ECT:** Everyone is required to observe the administration of electroconvulsive therapy (ECT) at least once during the clerkship. If you’ve seen *One Flew Over the Cuckoo’s Nest* or *A Beautiful Mind* (well, actually, the latter was insulin shock therapy—you hopefully won’t be seeing that!), 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 procedures take place in the morning at Butler where you will work with Dr. Furman, who is both an expert and a great teacher.

- **Mental Health Court:** Medical students are also required to spend a morning observing mental health court. These are trials in which a doctor might petition to keep a patient in the hospital or on outpatient treatment against that patient’s wishes. A judge will rule on whether to commit the patient. These sessions take place on Friday mornings at either Butler Hospital or Eleanor Slater Hospital’s Pastore Center. You will be assigned a date to observe during the clerkship orientation.

**Service Structure**

Your exact role will vary depending on the hospital site, but in general you will work with an attending (and sometimes a psychiatry resident or psychology intern), who will assign patients to you following their admission. Medical students are expected to carry up to five patients and follow their progress. As mentioned above, you may also be expected to perform admission physicals. At most sites, new patients to the psych unit are required to have a basic physical exam within 24 hours of admission.

**What to Bring and Wear**

The first day of the Psychiatry clerkship begins with a general orientation for everyone in the clerkship in the Residency Training Office in the Duncan Building of Butler Hospital, followed by hospital-specific orientation sessions at your respective sites. The only sites where white coats
are worn (because the attendings wear them) are at RIH and TMH. Whether you bring your coat to the other sites is a personal choice. Regardless, on the first day, you should bring:

- Pens, pens, and more pens (again, always black ink!)
- Notecards, notebook, or whatever you’ve developed as your own note-taking system
- Whatever pocket resources you’ve decided are handy, with a particular focus on psychiatric medications and their side effects.
- DSM-IV (pocket-sized or actual guide) for reference. (Stay tuned for updates as DSM-V is due out soon)
- A copy of how to do a Mini-Mental Status Exam (*Maxwell’s* lists it on one of its pages, or you may remember from Doctoring) as well as a Mental Status Exam cheat sheet (categories, descriptive terms, etc)
- The usual suspects of physical examination tools

**Clerkship Evaluation**

Your final grade is based on several factors. The clerkship leadership has developed a formula to weight all the different components of your evaluation and will provide you with a copy of and the rationale behind the different weight assignments during your orientation session.

The shelf examination for psychiatry is the same structure as every other NBME shelf: 100-question, multiple choice, 2 hours and 30 minutes. Some of the lectures and didactic sessions will help you prepare, and the practice that you get during your clerkship in working up, diagnosing, and treating patients is generally applicable to the exam. Like many other shelf exams, we also recommend doing practice questions.

Again, as usual, you will be evaluated by all individuals you work with, including your attending, any residents on your team, your outpatient preceptor, and the residents you take call with. As always, you should do fine on your evaluations if you act like yourself—be helpful, enthusiastic, and eager to learn.

Although there is no OSCE for this clerkship, the observed patient interview stands in its place. You are expected to perform a patient interview in front of your supervisor (or his or her designee) that is rated as at least “passing.” This can be repeated during the clerkship as necessary. We recommend doing at least two graded patient interviews (one per block of your clerkship).

Lecture attendance is mandatory and included in the determination of your grade, so be sure to sign in for each didactic session that you attend!

**Recommended Resources**

- **Clinical Psychiatry Essentials** (Roberts, Hoop and Heinrich): This is the officially recommended text for the clerkship.
- **BRS Psychiatry**: As of this writing, the latest version of BRS is outdated. However stay tuned to see if a new version comes out, as this was previously recommended as a manageable outline of important points in psychiatry with great question sections.
- **NMS Psychiatry**: It reads like a telephone book (albeit a small one) but it’s full of information you need to know and includes great question section.
- **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.
- **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, and should be on the lookout for the newest edition, which is due out imminently.
- **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.
SURGERY

What is Surgery?
Surgery is practically everything that is not medicine-related, with quite a bit of medicine as well. At Brown, surgery is the chance to be “hands-on” (and “hands-in,” as the case may be) with patient management. It is also the chance to experience sleep deprivation like no other rotation will provide you with—except perhaps the surgical subspecialties.

It is a tough rotation, even if you consider yourself a morning person, but it will provide you with the chance to see “living anatomy” in ways that will hopefully awe and inspire you. By the end of the rotation, you will emerge 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. Many of the administrative offices are located on the fourth floor of the Ambulatory Patient Center (APC), while the majority of patient care happens across Dudley Street in the Cooperative Care Building (pronounced “Co-op”) or in the Medical Office Complex (MOC) next door. Some of your very sick patients may be in the SICU (Surgical ICU, pronounced “sick-you”), TICU (Trauma/Transplant ICU, pronounced “tick-you”), or 5-ISC (aka Step Down)—all three of these units are on the fifth floor of the main hospital building. While on trauma call, you will likely spend a lot of time in “Trauma Alley” in the Emergency Department.

Some students will rotate at the Miriam or the VA for the general surgery component of the rotation. However, the rest of the rotation (such as didactic lectures, feedback sessions, etc) takes place at RIH.

Dr. Beth Ryder and Dr. Manuel Garcia-Toca are the co-Clerkship directors; both are super nice and are willing to answer any questions you might have—just keep in mind that they are surgeons, for whom free time doesn’t come readily! More easily accessible is Leslie Cabana, the clerkship coordinator who is in charge of managing your surgery rotation. She can be reached by phone at 401-444-0369 or by email at lcabana@lifespan.org.

The departmental ombudsperson for the surgical clerkship, Dr. Kevin Charpentier (kcharpentier@usasurg.org, or 401-444-6461).

If you are logged in to your Brown account, you can access the course website for the clerkship at https://sites.google.com/a/brown.edu/surgery-clerkship/.
Clerkship Schedule
The 2013-2014 academic year is the first year that surgery clerkship will be shortened to just six weeks of general surgery at RIH, TMH, or VAMC. Previously, students would spend four weeks on general surgery and four weeks on surgical sub-specialties. You will now do those sub-specialty weeks during your fourth year instead of during the core clerkship, for a total of twelve weeks: six in the clerkship and six as “surgery-related electives.”

In general, you will work Monday through Friday and come in on one day per weekend to round. If you need to take a certain weekend off entirely, you can talk to your team—they may have you work two days the weekend before instead. For the most part, medical students are widgets to the surgery residents, so as long as one student is there, they don’t much care who it is. You will be on trauma call 2-3 times during the rotation, which entails staying after your ordinary day through the night and rounding the next morning (so about 26-30 hours of staying awake, all told). You will also meet your preceptor once per week for an outpatient experience.

Daily Schedule
Your day-to-day schedule will vary depending on the needs of your service, but a typical day may look like this:

- 4:45am: Arrive at the hospital. For students at RIH, the surgery clerkship team strongly recommends that you park at the CORO garage and take the shuttle over. Alternatively, you can park curbside—at this ungodly hour, even the most coveted spots are likely to be open.
- 4:50am: Pre-round. What this word means will totally depend upon your residents, and it will also dictate how strictly your schedule matches this one. On some services, you will be expected to perform daily exams and write daily SOAP notes in LifeLinks on the patients you are following. On other services, you may simply be asked to record vital signs and “I’s and O’s” onto a blank copy of Signout and make copies for your team. More on all of this later.
- 5:30am: Rounds typically begin now, or at 6:00am—it depends on the team and even on the day of the week. Talk to your team the afternoon before to figure out when you’ll be rounding, and ask to be added to their text message chain if that’s how they communicate logistics.
- 6:30am: Write your SOAP notes if you haven’t already done so and help out your team with whatever odds and ends need to be attended to before conference begins.
- 7:00am: Morning conference.
- 8:00am: Surgeries typically start. Since most surgeries are planned, you can choose which cases you’ll scrub in on the night before. Often, each team keeps a list of the week’s surgeries in Signout. If there is another medical student or sub-I on your team, discuss how you want to split up the surgeries.
- Lunch between cases, if you have time. You should probably get used to carrying a granola bar or other easy snack in your white coat at all times, since OR cases can get moved at a moment’s notice.
• Afternoon: Read, study, or help your interns out with whatever tasks need to be carried out on the floor. You may also have office hours to attend with your preceptor. If there are still OR cases going on, you should attend. In general, surgeries supersede everything on this clerkship, other than your scheduled lectures.

• 4:30pm: Go to lecture at RIH, which happens pretty much every day of the clerkship. Talk to your team before leaving, either in person or by phone: find out when you are rounding the following day, if there are any cases you should be in, etc. You are not expected to come back after lecture! (Unless you are on trauma call, that is...)

What is Trauma Call? How Does It Work?
As mentioned above, you are scheduled for trauma call several times during your rotation. Trauma call entails showing up for a usual day with your own team, spending the night with the trauma pager, and going home post-call the following day after rounding. Ideally you’ll be out by 7:00am of day two, but some teams will ask you to attend morning conference or scrub into a case or two. If you are on call during a weekend, nothing changes.

If you’re doing overnight call on a weekend, pick up the trauma pager after rounding the first morning. On a weekday, you should pick up the pager after lecture (around 6:00pm or so). When you’re on trauma call, you are working with the trauma team and not your own team. The trauma student pager typically lives in the TICU (on the fifth floor of the main hospital building). Walk into the TICU, round the corner, and go to the desk where the TICU residents sit. This desk is labeled with the names of the TICU residents and will be messier than the other workstations in the unit. You should find the student pager somewhere on that desk.

After you have the trauma pager, you should page the on-call trauma resident (350-2727) and surgery consult resident (350-1018) to let them know that you are on call with them overnight. Ideally you will run into them in the TICU, but if not, you will certainly see them in the ER when you are evaluating traumas.

When a trauma page comes, you respond to it in the Critical Care wing of the ER. “AAA” on the pager means a level 1A trauma (typically super-intense, and one requiring that the trauma attending urgently see the patient); “111” is a level 1 trauma (not quite as bad as a level 1); and “222” means a level 2 trauma (again stepping down in severity). If the trauma pager reads “4-900” in addition to one of the other codes, it is a pediatric trauma. You are not required to respond to the Hasbro traumas, but it can be great exposure, particularly if you’re interested in working with kids. There will obviously be more level 2 traumas than level 1A traumas on most days, but all are good learning experiences, and you’ll likely get more hands-on experience with the lower acuity levels.

During a trauma, you can help by willing out the “Trauma H&P” which is also known as the primary and secondary write up. You can find copies of it in almost all of the Critical Care rooms; the papers tend to be arranged alphabetically. The ER or surgery resident who is
performing the primary and secondary survey will call out the information from their exam, which you should assiduously jot down on the paper. If the trauma case ends up going to the OR, you should definitely try to go along. Understandably, though, these scenarios can be quite chaotic and involve lots of people, so try your best to follow directions and be as helpful as possible, even if that means staying out of the OR.

When you’re on trauma call and not actively working on a case, you can try to help out the surgery residents or try to get some studying in. It’s a good idea to try to establish ground rules with the trauma chief early in the night so that you know what their expectations are (e.g., some will want you to respond to every trauma until midnight, but then only level 1 or 1A traumas after that). If you try to sleep, make sure you keep the trauma pager on.

Conferences and Didactics
In the Surgery clerkship, there are a number of didactic experiences you are expected to attend with your team. Be sure to check the sign-in sheets at these conferences to see if there is a sign-in sheet for medical students!

- **Trauma Conference:** Mondays at 7:00am, George Auditorium. You’ll see pimping at its worst here—luckily, only the residents are pimped, not the medical students! Nevertheless, it’s a good way to brush up on trauma algorithms, a potential topic for your oral exam as well as the shelf exam.
- **Grand Rounds:** Tuesdays at 7:00am, George Auditorium. Typically an attending from RIH or an outside institution presents on a current surgical topic. You should **not** wear scrubs to this. You will commute to this from other hospital sites.
- **Morbidity and Mortality (M&M):** Wednesdays at 7:00am, George Auditorium. Typically a poor surgical outcome is presented, analyzed, and discussed. While many of these may end up boiling down to “the patient was slightly irrational” there is the occasional chance that this conference will become heated as attendings accuse other attendings and residents of showing poor judgment.
- **M&M at Miriam:** Thursdays at 7:30am.
- **Service-Specific Conferences:** Typically on Friday mornings—all of the attending on your service meet and discuss the overall census. Some pimping of medical students can be expected here, and this is the setting in which you will be expected to do your case presentation.

Since the departmental conferences are variable and do not cover the range of topics you are expected to know for your oral exam and shelf, there are didactic sessions specially for medical students nearly every afternoon at RIH. You should read on the topic the night prior, as the
attending might pimp you and/or cover lots of material which will be lost on you unless you have a basic understanding going in. These conferences are interactive, which enables you to get the most out of the lecture series. Common topics include surgical oncology, abdominal pain, breast problems, lung cancer, jaundice, and a litany of others. In addition to lectures by faculty members, there are resident teaching conferences which include even more topics. These are led by PGY-2 and PGY-3 surgery residents, as well as a faculty proctor. They are of variable format, from lectures to case-based presentations to group discussions. All of the lectures are scheduled at the end of the day, and medical students from all sites converge in the APC 415 conference room.

You should sign out with a member of your team prior to heading to lecture, so that they know you are done for the day. Of course, some residents may ask you to return following your lecture on a given day—resist! The post-lecture time is protected time for you as students.

Since surgery is more than just sitting and shoveling knowledge into your head, skill workshops are held during the first week of the clerkship and give you hands-on experience with suturing, knot-tying, proper ways to scrub, etc. Although these skills are not directly tested during your end of clerkship exams, they are very important to succeeding as a medical student on the surgical service, so take them seriously and continue to ask for feedback from your residents and attendings throughout the clerkship.

**Service Structure:**
Your rotation is service-driven. More simply, you will spend the entirety of your six weeks on a single service working with (largely) the same residents and attending.

- **Acute Care Service (RIH):** This service is triage, or a consult service for the other general surgical services. In other words, if someone looks like they have a surgical problem in either the ED or on the floor, from an inflamed gallbladder to a cold foot, the ACS resident gets called first. It is staffed by trauma surgeons who rotate each week. One of your senior residents will also run the surgery clinic with Dr. Shahinian and you are expected to attend.

  - **Tips from prior medical students:** Always offer to write notes, particularly if you don’t have OR cases. You should save (but not finalize) the note, writing your name and “MS3” in the plan section. The resident can then appropriate your note but you will still get credit for writing the note in the eyes of the attending. Say yes when you are offered a first pass at consults. They know you have no idea how to evaluate a small bowel obstruction. You may screw it up royally, but this is how you learn. Any help you can provide in getting the H&P or clinic notes done will be greatly appreciated. Update OR cases in the notes section of signout first thing in the morning before you get vitals so that it is on everyone’s sheet. Ask your resident how to do this if you’ve never seen the OR schedule converter before. Over time you might be asked to strip JP drains, flush NG
tubes, and more. If you do these things you’ll probably get to do progressively more fun stuff. Just express initiative and interest.

- **Surgery I (RIH):** Truly “general surgery.” Does not have a specialty affiliation other than thoracic surgery. Surgeons tend to be the more senior general surgery attendings. You will see mostly thoracic cases, but also a fair number of cholecystectomies and hernia repairs. Less often you will see a colorectal case, such as a hemorrhoidectomy or hemicolecction. No endocrine or bariatric surgeries.
  
  - **Tips from prior medical students:** Collect vitals from the flow sheets in the Step Down unit. Know the topics for thoracic conference and Cioffi/Harrington conference ahead of time. If you haven’t heard anything by the Wednesday prior, ask an attending. Learn the relevant anatomy and technique of thoracotomies, cholecystectomies, and ventral hernia repairs. Ask to take personal ownership of a patient. Your residents will often suggest that you follow the patients whose surgeries you scrubbed in on.

- **Surgery II (RIH):** Everything colorectal. You’ll see a lot of hemorrhoid procedures, colectomies, etc. There are a mix of true gen-surg cases as well, like hernia repairs. Overall, though, you should expect A LOT of poop, ostomies, etc. Yes, it smells sometimes. On Thursdays and Fridays, there tend not to be many OR cases because the surgeons are performing colonoscopies. You are more than welcome to attend, but should remember to wear professional clothing instead of scrubs.
  
  - **Tips from previous medical students:** You’ll be asked to present at least once on Friday during Surg II conference. You might as well ask your resident in advance to see which week he will want you to do so. You’re allowed to choose a more general (and therefore straightforward) colorectal topic like “Surgical Indications for ______” or “Surgical Approach to ______” instead of something super-specific. Have a one-page handout ready for everyone, and make sure that it has references besides UpToDate! Make your presentations approximately 5 minutes long, and be prepared for pimping from the attending.

- **Surgery III (RIH):** Endocrine, oncologic, and hepatobiliary surgeries. This includes all surgical oncology cases (e.g., melanomas and breast cancer) as well as all thyroid cases.
  
  - **Tips from previous medical students:** Read. You’ll be pimped on anatomy, pathophysiology, diagnostic workup, management, and other stuff you could not possibly know about. But, nobody’s mean about it. Surg III conference typically include case presentations with relevant teaching points. You will have to present at least once, so be super prepared because you will get tons of questions. Even if you’re not presenting, you are not immune from pimping, so make sure you read ahead of time!

- **Miriam:** There are three teams at Miriam: Red (vascular and general), Blue (bariatric and general), and Colorectal (...duh). You will decide amongst yourself yourselves on the first day which student is on which service, and can also decide to switch teams halfway through. In general, the services at Miriam tend to operate with a lot more
porosity than at RIH, so you should have no problem seeing a very wide range of cases throughout your clerkship.

- **Tips from previous medical students:** Pre-round on your patients. Rounds move very quickly in the morning, but try to get your residents to listen to and offer feedback on your plans. There is a lot of flexibility in terms of which cases you scrub in on, so take advantage of that and see as wide a variety as possible. You can also ask the consult resident to let you hold the consult pager and have first pass at the consults, which can be a great learning experience.

- **The VA:** General surgery. Just like it sounds. Lots of vascular and GI cases in the OR, with relatively few oncology or endocrine cases. There are frequently lipoma and cyst removals in the minor procedure room that are good opportunities for you to practice your suturing. And yes, 99% of your patients will be men.

*Who’s Who on the Surgical Team*

**The Chief Resident** – The senior resident. A fourth- or fifth-year resident, depending on the service, who is responsible to the attendings for everything that happens to everyone (patients, residents, students) on the service. Also helps attendings with high-profile or difficult cases in the OR. Not every service will have a chief resident; in that case, the mid-level resident is your go-to person for all questions.

**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. She is probably your best bet 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 management of patients on the service. They are also the most overworked and most beaten down, as well as the least likely to see the inside of the OR.

**Sub-Interns** – The fourth-year medical student, who is theoretically interested in a career 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.

**The Medical Student** – You! 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 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 signout, updating it as needed, and distributing it to team members.
2. Pre-rounding and writing daily SOAP notes, as per your team’s protocol.
3. Obtaining supplies for re-dressing wounds during morning rounds, again as per your team’s protocol.
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, those lists will not have nearly the same importance as THE LIST in Surgery. Fundamentally, the list is a list of patients on your service, their age, diagnosis, surgery performed or to be performed, antibiotics they are on, etc. THE LIST is all-knowing and all-powerful. If it’s not on the list, it is not happening or it is not important—and frequently it is your job to make sure that it is accurate.

Each service team will have a copy of their list on Signout. THE LIST must be ready for morning rounds with a copy for every member of the team (so make a few extras just in case). Your interns will teach you what the most important components of updating the list are. While the ultimate responsibility for the day’s list lies with your intern, you will either be delegated some responsibility or you may help out with the work just because you are a nice medical student. Hence, you should stay on top of any 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 comparing notes with your intern.

There are two other issues related to THE LIST on Surgery: “running the list” and folding the list. The former is the equivalent of super-lightning-turbo-fast-speed sit-down medicine rounds. After your team finishes rounding and before the workday starts, your team will sit down and talk about each patient on the service, making note of what the day’s plans are. One of your interns or junior residents will go through the vitals of each patient and run through the plan. 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 know what is going on and how you may be able to be help. Secondly, pay attention to how your residents fold their lists. There are efficient and inefficient ways of folding that 8 ½” x 11” piece of paper, and they have optimized it for their purposes. You’ll see.

Life in the Operating Room (a.k.a. “The Only Time in Your Life 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, scrub out, and a whole host of other rituals important for maintaining the integrity of the operating room. Some things to remember, though...

Who’s Who on the OR Team:
- 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 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. He will probably be the most vigilant
regarding maintenance of the sterile field. Learn his name because he 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 roams the operating room, fetching equipment, moving things, keeping track of the comings and goings of the room. Learn this nurse’s name as well, because she will be a big help in getting you a step stool, answering your glove-size questions, adjusting your face mask, and making everything else run smoothly as well.

- The anesthesiologist/CRNA: This person will be in charge of the anesthesia and immediate pre-op and post-op care of the patient. When you are writing the Op Note after the surgery, the anesthetist will provide you will necessary data, such as IVF provided during the case, and the patient’s estimated blood loss.

**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 that 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.

Three simple rules regarding the sterile field:

- Anything that is blue is “sterile” and therefore should not be touched with any part of your body that is not part of your own sterile field.

- 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 else is considered unsterile.

- When you rest your hands, clasp them together over your abdomen. Do not fold your arms over each other (the position people assume when they are impatient), as this places your hands away from the sterile part of your chest. Do not stand with arms akimbo (hands on hips), as your waistline is not sterile.

Other than **NOT BREAKING THE STERILE FIELD**, the other important thing to remember about your actions in the OR is to **DO ONLY WHAT YOU ARE ASKED TO DO.** Hold retractors, cut sutures, staple wounds closed, sing (it’s true!), etc., but only as you are instructed to do so. Do not scratch or ask to go to the restroom. You may ask to do things you would like to try (like suturing or using the electrocautery knife a.k.a Bovie) but only do so after having received permission to do so. It is important to remember that surgeons and their nurses have a routine and a pattern to how the OR typically runs and you are there as a visitor. While you might think it helpful to try to take the scalpel from the scrub nurse to hand to the attending, your hands just add a layer of variation and therefore danger to all those involved.
You may get to a point during your Surgery rotation when you wonder what you are doing at an operation, particularly if you are not interested in a procedural field. You may be at your tenth laparoscopic cholecystectomy (affectionately known as a “lap chol-ee”) and suddenly think “Do they need me here?” Most of the time, the answer is “probably 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 the 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 your pocket as a surgical fashion statement. A surgical attending will chastise you for wearing a “flea collar” when you keep your stethoscope draped around your neck as Internal Medicine doctors are wont to do.
- Black ink pens (and extra cheap ones in case they are “borrowed”)
- Notecards or small notepad
- Whatever pocket texts you find to be helpful (see below)
- Trauma shears
- A granola bar or several other easily-eatable snacks in your pocket
- An assortment of supplies for dressing wounds (different types of tape, Kerlix “super sponges,” 4x4 gauze pads, etc)
- Professional clothing v. scrubs: Generally, you should follow the lead of your resident. Scrubs are the surgical uniform, worn when you are in the OR throughout the workday, to most lectures, on call, etc. Professional clothing is required for Grand Rounds (Tuesday morning) and at some of the service-specific conferences. You should also dress nicely when working with your preceptor in the outpatient setting or while observing outpatient procedures.

Clerkship Grading
There are several methods by which you are evaluated during the Surgery clerkship. Evaluations account for 50% of your grade, the oral exam 25%, the NBME shelf exam 20%, and quizzes 5%.

Team Evaluations
You know the drill. All residents on each team will complete evaluations on each student who rotates through the service. The evaluations are completed online using OASIS, as is the case with the other clerkships. Your outpatient preceptor will also automatically be asked to
evaluate you. 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 evaluations from attending with whom you participated in many OR cases. The input from additional evaluations will be added to the team evaluation and are valuable to the student file.

**NBME Shelf Exam**
There is an interesting dichotomy between what you do and learn on the Surgery clerkship and what is on the shelf exam. During your clerkship, your primary duty is to attend, observe, and help out on surgical cases in the OR. Thus, you will 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—knowledge that is not easily garnered from the day-to-day activities of the clerkship. The shelf is somewhat difficult because many people feel that, aside from didactic sessions, 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 possible and talk to other people about how they are studying. *NMS Surgery* is popular because it has chapters on each topic with associated practice questions.

**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 (approximately 10 minutes each). Essentially, this is a structured pimping session. Both questions are formulated from a list of topics provided at the beginning of the clerkship. Focus your energies on high-yield areas, such as colorectal surgery, abdominal pain, indications to go to the OR, post-operative complications, and peri-operative care. A number of study guides are passed down from class to class, so ask your classmates for outlines that have been previously assembled.

The examiners are one of the clerkship directors as well as one senior resident. Students are graded on a rubric containing sections on knowledge of the disease, diagnostic approach, management approach, as well as verbal and non-verbal communication skills. Dress well, smile, maintain eye contact, speak clearly, and maintain your confidence. A practice session may be scheduled for students to assist with preparation, and you should study with another student by running scenarios from the *Manual of Surgical Objectives* or *Surgical Attending Rounds*. The exam format is quite formal.
**Case Presentation**

Students should deliver formal case presentations at service conferences at least once over the course of the clerkship. You should get immediate feedback by the faculty and senior resident, as well as an evaluation form that counts towards your final grade. In general, you should make a handout or PowerPoint presentation, but ask the residents on your service what their expectations are. Include pertinent details from the actual patient case and (ideally) throw in a few literature references which justify your team’s management decisions. That way, you’ll not only impress your attending but have something to fall back on when you begin to get pimped.

**Quizzes**

Don’t worry about these. They are open book and you’re allowed to ask fellow students and even residents and attending for help. They are typically based off information from WISE-MD modules. They account for 5% of your course grade but have never decided, by themselves, someone’s grade.

**Recommended Resources**

- Use the textbooks available to you through the medical school library to prepare for cases and lectures. They will typically cover information about the surgical aspects of the disease (diagnosis, physical exam, etc) as well as the surgical procedures in the OR.
- For exam preparation, previous students have used *First Aid for the Surgical Clerkship*, *NMS Surgery*, *Appleton and Lange Q&A Surgery*, and *Pretest: Surgery*.
- *Surgical Recall* is used by many students. If you have it, use it and love it. It is a perfect anti-pimp book, using a handy Q&A format that allows you to brush up on potential questions that you may be asked. Two warnings though: many attendings have adapted their pimping to include questions not found in this book, and it is useless for studying for the shelf exam.
- The SAGES Surgical Education Video Library is available to you as a resource to familiarize you with the surgical procedures as they are performed in the OR.
- The WISE-MD website features web-based modules for surgical education. These modules are interesting and comprehensive, but may sometimes be overly detailed for what is expected of you as a third-year medical student.
LOOKING AHEAD TO FOURTH YEAR

Whew! We’ve covered a lot of information, and you are probably even more confused than you were before starting to read this silly document. Still, you may be wondering: what good is all of this? Didn’t those upperclassmen tell me that life would get better? The answers, respectively, is that while third year is for exploring various medical specialties, fourth year is the really fun stuff, where you get to delve into what you find most interesting, and yes, that’s typically when life gets better. Still, there are some aspects of fourth year that you should at least be aware of now, because time in medical school has a way of passing much more quickly than anticipated.

Fourth Year Electives
After third year, you are free of the grid system that confuses even those of us who are not colorblind. Fourth-year electives are typically four weeks in duration, although many of the faculty members who run them are flexible and willing to accommodate your schedule. A full listing of the electives can be found on OASIS, where you will be able to sort via specialty and a plethora of other criteria.

The Lottery
The fourth year lottery takes place in mid-March, and occurs in two portions. The first allocation of electives is for the sub-internships, and the second is for the more general electives. For each, you will enter and rank your preferences for that specific category of elective and the results will be available several days later. Each elective can be ranked multiple times on the basis of when it is offered. For example, you could rank plastic surgery in July as your first choice, and plastic surgery in August as your second choice. You will get detailed instructions from Lori Avallone, Eileen Palenchar, and others regarding the technical details of how to input your choices. One important thing to keep in mind is that these lotteries are primarily for scheduling your electives through the fall semester, and that there will be plenty of flux in terms of scheduling as your classmates realize they would rather be vacationing. There are also a host of electives (such as the international experiences) which are not eligible for selection through the lottery. You will get specific instructions on how to apply for these if you are interested.

Sub-Internships
As the name perhaps implies, this rotation is your opportunity to be more than “just the medical student,” even if all of your orders will still need to be co-signed. You are required to do at least one to fulfill your graduation requirements, and most students choose to do it in the field most related to their chosen specialty. However, this is not a requirement. If you are doing a sub-i in your chosen field, many students prefer to do this very early in the summer or
fall of fourth year, so as to allow time to ask for a letter from an attending who supervises you in this more independent position, as well as so that residency programs see the grade when assessing your application.

Making Changes to Your Elective Schedule
Basically, Lori Avallone will be your best friend, as if she’s not already. Outside of the lottery period, you are also permitted to add/drop electives through OASIS, as long as it is a certain amount of time prior to when you are scheduled to start your rotation. If an elective you’re interested in is full, be sure to get on the waitlist! You’ll then be notified automatically if a spot for that elective becomes open.

Organizing Important Information
If Dean Gruppuso has gotten to you at all, you’ve been making use of the Electronic Medical Student Record during your preclinical years. This tracking tool helps organize your experiences in a format similar to what’s asked for in ERAS, and can relieve much of the pressure of trying to remember what your eager-beaver medical student self has been up to over the past few years. If you haven’t tried it out, you can log in at https://apps.biomed.brown.edu/emsr.

Each fourth year seems to have a distinct system for organizing the huge influx of information you’ll get over the course of this year: labels in their email inbox, filing cabinets, color-coded Excel spreadsheets, etc. The most important part is to find a system that works for you and stick with it. It may also be useful to track down your USMLE and AAMC ID numbers. You’ll be using them for a host of different functions this year and it’s just more helpful to have them in a convenient location.

Step 2: Revenge of the Standardized Tests
The not-so-secret truth about exams in medicine is that they never stop. You’ve likely just gone over the Step 1 hurdle, and now there are two more standardized exams staring you in the face prior to graduation. Luckily, they are much less painful than Step 1.

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 you are expected to demonstrate knowledge similar to what you have learned in each core clerkship and previously been tested on with the shelf exams, and that the exam is computer-based. CS, as its name implies, is designed to test your clinical skills, like an OSCE on steroids.

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 the material 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.

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 firsthand 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 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 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), unless you really need a strong score to make up for a weaker Step 1 performance.

Which books are helpful for studying?
You should have some basic Step 2 CK review resources:

1. A comprehensive review book, e.g. First Aid for the USMLE Step 2 CK or Conrad Fischer’s “Master the Boards” Kaplan book.
2. However, perhaps the most useful resource in preparing for Step 2 is a question bank. You probably became intimately familiar with USMLEWorld or other of its ilk while studying for Step 1, and each of the companies also have their counterpart for the later exam. As with Step 1, Brown students seem to prefer UWorld, although this means you
may have to ration questions if you’re also using it to prep for shelf exams throughout the core clerkships.

3. 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 and love them, if they’re your thing.

4. Whatever study guides and resources you’ve used throughout the year to prep for shelf exams and other clerkship evaluations.

**What is Brown’s take on Step 2?**
You do need to sit for the exam. All students must take CK by the end of December of the fourth year in order to graduate.

**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?**
It 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 summer or early 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 do well on it is freshest in your mind in the fall.
- If you do 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.

If you take Step 2 CK late in the fall 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 highly, they do not have to worry about you passing Step 2 CK. October can be a great time to take this as it is a relatively low-stress time in the application cycle.

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 proficiency in English, and tests your ability to exhibit good interpersonal skills, and take medical histories and perform physical exams on standardized patients. 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.).

The test is composed of 12 encounters. You are given 15 minutes to perform the H&P and 10 minutes to write a patient note.

The SOAP note is simplified to four sections. The first is your HPI, ROS, and relevant PMH, Medications, Allergies, and Family and Social Histories. The second section is your focused physical exam (which may be absent if there is no patient to examine). The third section asks you for a list of up to 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 five initial work up tests you would want to order or do (may include physical exam maneuvers such as rectal or GU exams).

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

**Step 2 CS Logistics**

You will need to travel to City X on your own dime 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).

Just like Step 2 CK (and probably even moreso), you should register as early as possible for CS so that you get the most flexibility of dates and locations possible. Again, October is a great time to take the test: your applications are in, but most programs haven’t yet begun interviews.
**VSAS and Away Electives**

Like anything else in medical school, the answer to “should I do an away elective?” varies from person to person. Doing an away can be a relatively big gamble, since it is essentially a month-long interview, but it can also set you up for a much easier experience in the Match process.

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. This typically occurs if you are geographically constricted in choosing where you’re going to continue your training, or program X has the world’s foremost expert in whatever it is that interests you, or your specialty is super-competitive.
2. You want more letters 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 be functionally required (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. Most programs will participate in VSAS (the Visiting Student Application Service), which you will get access to and directions about through the Student Affairs Office. Like many other things in medical school, there is a fee for applying through VSAS: don’t say we didn’t warn you! 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. If you don’t have friends or relatives in your desired area who want to house you for the duration of your away elective, several websites (such as www.rotatingroom.com) facilitate the process of matching sublets for rotating medical students. 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. Lori Avallone will be your key contact person.

ERAS and the Match
ERAS (the Electronic Residency Application Service) is the service that you use to apply to residency programs. You will spend an interminable amount of time completing a basic application form with a poorly designed user interface, uploading your personal statement(s), and having the Medical Student Affairs Office upload your Dean’s Letter (aka MSPE/Medical Student Performance Evaluation) and letters of recommendation, transcript, photo, etc.

You will then select the specialty and programs that you want to apply to, and your materials will magically be transmitted to these programs. Thus, there is typically only one application (although you can choose which letters of recommendation or which personal statement is sent to an individual program), making your life 10,000,000 times easier than for people who applied the old-fashioned way by mailing away for each application component.

The ERAS system opens for applicants at the beginning of July. Check your email for more details, as Janice Viticone will send you your password and other information once it becomes available. ERAS applications can be submitted starting September 15, so hopefully you will know what you want to do for the rest of your life by July in order to have time to ask for letters of recommendation and work on your personal statement. There are also specialties which participate in the Early Match and have earlier deadlines.

In order to encourage wise decision-making and discourage blitzing of applications, it costs money to apply to programs using ERAS. The scale is determined on the basis of the number of programs that you apply to. For the 2013 application season the fees for programs in the same specialty were as follows:

- *Up to 10* - $92
- *Programs 11-20* - $9 each
- *Programs 21-30* - $15 each
- *Programs 31 or more* - $25 each
Example 1
30 Emergency Medicine programs \[\$92 + (\$9 \times 10) + (\$15 \times 10)\] = \$332
Example 2
20 OB/GYN programs \[\$92 + (\$9 \times 10)\] + 10 Family Medicine programs \[\$92\] = \$274

You’ll also have to pay a one-time $70 fee to have your USMLE transcript transmitted to ERAS so that it can be downloaded by individual programs. If you’re confused about how to decide which programs to apply to, the AMA maintains a database known as FREIDA Online (https://freida.ama-assn.org/Freida/eula.do) which lets you search and classify residency programs on the basis of many different characteristics and can be a good starting point for your search. If you sign up for a student account through AMA, you’re able to save your searches for the next time that you sign in. Previous editors have found this to be a big help during a stressful time and well worth the registration fee.

Not to be confused with ERAS, the NRMP (National Residency Matching Program) is the service that you will use to rank whichever residency programs you interviewed with. Additionally, the program collects specialty-specific data related to each year’s Match, which can be very helpful in assessing your overall competitiveness (http://www.nrmp.org/data/index.html). The theory behind the NRMP is part of the award for the 2012 Nobel Prize in Economics, but it’s not actually that complicated. Each applicant ranks the program she wants to be at, and the programs do the same for the applicants they interviewed. These Rank Order Lists are submitted and the algorithm crunches the numbers and spits out the optimal pairings for every medical student and residency program. On Match Day (the third Friday in March), pretty much every medical student across the nation finds out where he is going to train for the next few years at exactly the same time.

_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 aforementioned NRMP “Charting Outcomes in the Match” can also be helpful, but is obviously not definitive. The best way to get the answer to this question would be to talk to Alex Morang and your specialty 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. Make sure that your overall demeanor, letters of recommendations, and other application materials reflect this.
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 resource. 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. The Senate is also working with the Brown Medical Alumni Association to facilitate matches between students and alumni with ties to specific programs or geographic locations, and those alums can serve as an excellent resource. The form to request an alumni match can be found at: http://brown.edu/go/med_alumni_contact.

3. If you are applying into a specialty that requires a prelim, you must interview for two separate groups of programs: one for your specialty and one for your prelim.

The Dean’s Letter
Technically known as the Medical Student Performance Evaluation (MSPE), the Dean’s Letter is a narrative evaluation of your performance during your clinical rotations. The final content and edits are in the hands of your specialty advisor, although you will need to approve it. Alex Morang also reads each letter before it is submitted to residency programs, so there are several sets of eyes on it.

Depending on how creative your specialty-specific advisor is, the MSPE will typically be a compilation of the evaluations you received in each clerkship, with minor tailoring. While you may be nervous about that one bad comment from a particular clerkship, don’t fret too much: your Dean’s Letter writer should read through all of your comments and make a judgment regarding overall trend and remove any obvious outliers. In addition to clerkship evaluations, the Dean’s Letter is where residency programs get bits of information about your life prior to medical school. A template will be provided for you early in the summer, where you will fill in details about your childhood, undergraduate experiences, research projects, and the seventeen different languages you learned to speak while volunteering abroad.

It’s important to note that although your MSPE cannot be updated once it is submitted to programs, Alex Morang’s office can send updated grade cards (along with the subjective evaluations) to residency programs.

Letters of Recommendation
Hopefully you’ve impressed an attending or three along the way, because you’re going to need to ask them to write a letter for you, advocating for your position in a residency program. Most specialties require three letters, and you’re best off if at least two of
them come from practitioners in your area of interest. Others (particularly surgical specialties) will require that one of these letters be from the chair of the relevant department at Brown, so be sure to check their websites to make sure your ducks are all in a row.

It is worthwhile to have an updated CV and maybe even a draft of your personal statement at the ready when you ask attendings to write letters for you—each may have different collateral information that they find useful in crafting a recommendation which will cast you in the best light! Of course, you should be cognizant of the fact that attendings are very busy and probably have higher priorities than writing letters for you, so ask early and don’t be shy to follow up if the Office of Medical Student Affairs hasn’t received the letter.

**Interviews**

If you have leftover loan money, you might want to consider investing in the services of a travel agent. Seriously. Scheduling interviews is a total pain, but remember to be polite and courteous to everyone, and you will go far. Make sure you know how many days you are permitted to miss from any rotation you’ll be completing, or consider taking the whole month off if you are going to be interviewing over the course of many days.

As the number of applications for a limited number of interview spots continues to rise, you should aim to respond to interview offers as quickly as possible in order to secure dates that are more convenient for you. Of course, if you decide that you do not want to interview somewhere or you are not able to do so due to a conflict, you should cancel that interview as soon as possible so that the slot can go to someone else.

To help with accommodations, check out the HOST program, which will attempt to match you with a Brown alum in the city where you’re interviewing so that you don’t have to spring for the cost of a hotel room. You can find the application form here: [http://brown.edu/go/md-host](http://brown.edu/go/md-host).

On the day of the interview, common courtesy again rules the day. You will soon grow sick of the question, “So, what do you want to know about us?” but it is important to demonstrate enthusiasm for the program and particularly your potential future specialty. For many of us, this is the first time in our nascent professional careers that programs are also trying to impress us, so ask questions and enjoy! Obviously different specialties have different interview reputations, so be sure to talk to your specialty advisor or older students to get a flavor of what might be in store for you.
A FEW FINAL WORDS
This final note, written by Melisa Lai, appeared in the first edition.

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!