The Third Year Survival Guide

Students Advising Students Stritch
School of Medicine
Loyola University of Chicago
Last Update: Spring 2019
Congratulations!

You’ve finished second year, Step 1 is over, and third year is finally here! While you will still have to work hard to do well, you will finally be able to do the things you came to medical school to do in the first place – scrub for surgeries, deliver a baby, work in the hospital, and most importantly, play an integral role in patient care every day.

Third year presents a different set of challenges than you have encountered thus far in medical school. Unlike first and second year, “book smarts” and good test taking skills alone will not equal success. You’ll need to figure out the ins and outs of your role on each rotation, get along well as a team player, become increasingly more efficient, and find ways to stand out among your peers on the floors. In the pages that follow are valuable tools to help you excel through each clerkship, from sample notes to recommended study materials. While it’s a pretty comprehensive resource, if you have any other questions, feel free to contact any of our 4th year members – we’d be happy to answer them for you!

We hope you find this a helpful, high-yield resource throughout third year, and from all of us to all of you: best of luck, and enjoy the ride!

Your Students Advising Students M4 Members – 2019-2020

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SAS: Crash Course for 3rd Year
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General Advice & Information

**Cardinal Rules of 3rd Year:**
1. Know your patients better than anyone else on the team.
2. Read around your patients (i.e. some topic pertaining to your patient), & read something EVERY DAY. It doesn’t have to be an article from NEJM - something like Up to Date will suffice.
3. Ask your team what their expectations are on day 1 of each new service.
4. Ask for feedback and ways you can improve EVERY FEW DAYS. Make sure that you act on the feedback - residents and attendings notice.
5. Always have something to study with you (small books, flashcards, tablet, UWorld app, UpToDate app). Random downtime is common.
6. When you’re not sure, ask.
7. Don’t ever say you did something that you didn’t do or say you know how to do something when you don’t.
8. Nobody likes a complainer or someone who seems lazy. Work hard and be enthusiastic.
9. Wash your white coat when it gets grungy (probably weekly).
10. Find something you can enjoy about every rotation, keep a positive attitude, and learn as much as you can.

Finally, while it seems most of this goes without saying, **don’t be the jerk that throws other people under the bus!** For example...

- Only answer questions directed to you or the group. Refrain from jumping in when a peer was asked a question they did not know or need a moment to answer.
- Only pre-round on YOUR patients. (Seems ridiculous, but it does happen!)
- Don’t steal other students’ patients, admissions, or surgeries. Divide and conquer, keeping things evenly distributed among all students on the team.
- Just because you want a letter from a specific attending does not mean you should “hog” all of their time. All students on the service need evaluations so play fair. Then, be sure to rock the time you do have to impress them.
- **NEVER, under any circumstances, bad-mouth another student, resident, or attending with any members of your team. It will inevitably come back to bite you in the butt.**
- Communicate with the other students on your team to make sure you’re on the same page. **Planning to bring in an article?** Give the other students you’re working with a heads up so they can find a related article to present, too.

*Remember: Both students looking good is far better than only YOU looking good. Solid teamwork can make even the worst of clerkships enjoyable experiences and nearly all cases will result in a better evaluation for both students.*

Plus... It’s lonely at the top if you stepped on everyone else to get there.
Play nice. :]

SAS: Crash Course for 3rd Year
A Note on Choosing a Specialty:
While the ERAS (residency application) process doesn’t start until summer after 3rd year, away rotation applications and planning for 4th year starts as early as January! Realizing this, it is in your best interest to actively contemplate your future during 3rd year. Do you like the topics covered in your current rotation? Do you get along well with the residents/attendings? Can you see yourself working in that field? Do you prefer the intellectual internal medicine approach, or are you more satisfied doing procedures and working with your hands? Do you prefer outpatient or inpatient settings? Is continuity of care important to you? Reflecting on these questions to narrow down your choices to 1-3 fields by the spring semester will help you better plan when to complete your Sub-I’s, take boards, do away rotations, etc. Meet with specialty advisors (http://www.stritch.luc.edu/advisorprogram/), attendings you have worked with, and residents early in the year to help you in your discernment process.

What goes in those white coat pockets?

- ID badge & Pager
- Pens & Highlighter
- Penlight
- Stethoscope with your name on it! On many rotations you will also want your reflex hammer.
- Maxwell’s Quick Medical Reference (print or e-book version)
- Blank paper/notepad
- Note cards/scut sheets with complete info for your patients (see Appendix for sample)
- Granola bars/quick snack and money/credit card
- Articles to share with the team or read during downtime (try to always have one article in your pocket at all times)
- Yellow “student log” card to tally the types of patients you see (req’d by all clerkships)

NOTE: Long white coats are required for Surgery and OB/GYN clerkships as well as the Nursery portion of Pediatrics. Coats should extend to the knees and be large enough to accommodate all of the stuff you will need to stuff your pockets with (e.g. dressing changes for surgery). Additionally, when you are wearing scrubs in common areas of the hospital, your long white coat needs to be buttoned!
Who’s Who?

- **ATTENDING**: Short for “attending physician” - a board certified or board eligible physician who has completed their residency and serves as the leader of the team, ultimately accepting responsibility for the patients on your service.

- **FELLOW**: Having already completed their residency, fellows are receiving training in a subspecialty. For example, a Cardiology fellow has already completed their Internal Medicine residency (3 years) and is now completing an additional few years of training in Cardiology.

- **CHIEF RESIDENT**: Depending on the program, this person is either in their final year of residency or has stayed an extra year to be the chief. They are responsible for many administrative tasks, like making the residents’ schedules, planning noon lectures and conferences, and ensuring that all residents are on track to meet their training program requirements. The chief normally has attending privileges and can act as the head of a service team.

- **SENIOR RESIDENT**: Simply, the resident on the team who is furthest along in their training (i.e. a 2nd or 3rd year medicine resident or a 3rd, 4th, or 5th year surgery resident). Sometimes these residents are called “chiefs,” but don’t get them confused with the actual chief resident(s) as described above.

- **INTERN**: a first year resident

- **SUB-I**: “Sub-intern” – 3rd or 4th year student with increased responsibility (aiming to manage patients at the level of an intern)

What is rounding?

Exclusive to inpatient services, “rounding” consists of discussing the patients on your service and then seeing them together as a team. This can be done as **“walking rounds”** (going to each physical patient room, standing outside the door to discuss their case, then going in to see them together) or **“table rounds”** (sitting as a group and discussing all of the patients, then going to see them together). Generally, someone on the team (e.g. you!) “presents” the patient (shares the H&P or daily SOAP note out loud) and the treatment plan is then discussed by the team, with the attending or senior resident having the final say on what will actually happen for your patient that day.

Rounds typically involve teaching, both during your discussion as well as in the room with the patient where you may be shown specific physical exam findings or how to perform a specific exam technique. They are also one setting for the infamous “pimping” (being “put in my place”) you hear about – the attending or residents asking the students questions to test your knowledge regarding the disease process and treatment methods for your patients’ diagnoses. This is another reason it’s important to read every day and know as much as you can about each patient you’re assigned!

Writing Notes

Writing notes in the patient’s medical record is the primary way physicians communicate and are referenced by consultants and specialists long after you graduate and move on to residency. Notes should be **complete, but concise**, and contain only accurate information. You should confirm information you gather from the medical record with the patient rather than blindly copying and pasting into your note since you don’t want to perpetuate misinformation and are responsible for what you write. Your student notes will be much longer than the resident’s or attending’s since you are expected to include every pertinent detail of the history and develop an extensive, well thought out A&P. You will be evaluated on your ability to synthesize all that you have learned from the patient’s story and chart with the information you’ve learned from your studying/reading in order to develop a reasonable plan. It is worth noting that different clerkships and specific attendings will require different lengths and breadths for your H&Ps, so be sure to refer to the clerkship sections of this booklet for specific guidelines for each rotation! Furthermore, some clerkships (e.g. medicine, OB/GYN) will give you a document at orientation about how to format your notes; follow these guidelines.
Full (New Patient) H&Ps:
When you see a patient for the first time in an outpatient clinic or when you’re admitting a new patient to the hospital, a full H&P should be completed the way you were taught first and second year. This includes the chief complaint, HPI, PMH (past medical hx), PSH (past surgical hx), Current Health/Screening, Medications, Allergies, Social History (including where the pt lives and who lives with them, their occupation, sexual history, drugs, alcohol, smoking), Family History, and Review of Symptoms. For the physical exam, you should record the vitals and comment on the patient’s general appearance/state, cardiovascular system, lungs, abdomen, extremities, and whatever else is pertinent to your particular patient’s complaint and medical history. Any recent labs and imaging should also be included (new since the last outpatient visit or those done in the ER for a new hospital admission). The A&P (assessment and plan) should present your prioritized differential (at least 3 different possible diagnoses with reasons why one diagnosis is more likely than another) and address the patient’s treatment plan either by problem (e.g. CHF, HTN, asthma) or system (CV, Respiratory, Heme, Neuro). The specific requirements will vary depending on the clerkship. Systems-based problem lists are usually just used in the surgical and ICU settings.

SOAP/Daily Progress Notes:
SOAP notes are reserved for return outpatient visits or daily progress notes for inpatient settings. They contain a brief list of 24-hours events (critical events overnight, such as the patient was intubated due respiratory distress), Subjective update (essentially the HPI for that visit/day), an Objective section (for the physical exam and any lab or imaging updates), and an Assessment and Plan. These notes are briefer than full H&Ps and focus on information most pertinent to your current service/clerkship.

Admission Orders:
At Loyola, students are often not involved in writing admit orders for patients, which is unfortunate since it’s an important skill to develop for residency. You may need to write admitting orders for rotations outside of Loyola (such as West Suburban) and you will be tested on this skill during your medicine clerkship OSCE. Be proactive and ask if you can at least help or observe your resident go through this process. You can also practice writing admitting orders and ask your resident to review your work even if it doesn’t go in the patient’s medical record. All admit order topics are easily remembered using the acronym ADC VAN DISMAL as follows:
- Admit to: service, floor/unit, attending, resident (with pager #)
- Diagnosis: or chief complaint if the diagnosis is not clear yet
- Condition & Code Status: fair, stable, guarded, critical; “Full Code” or “DNR,” etc.
- Vitals: routine, Q4 hrs, Q shift, criteria for when to alert resident/attending…
- Allergies: list all and give adverse reaction if known. Otherwise, write “NKDA.”
- Nursing Orders: DVT prophylaxis (TED/SCDs), Accucheck Q6, strict I&Os…
- Diet: NPO, General, ADA (diabetic), Cardiac (low fat/Na), CLD (clear liquid)
- IV Fluids: NS, LR, ½ NS, etc… @ rate (100cc/hr)
- Special: respiratory therapy, vent settings, dressing changes…
- Meds: name, dosing; includes O2 needs, insulin regimen (ISS = insulin sliding scale)
- Activity: ad lib, bed rest, with assistance, as tolerated, OOBTC (out of bed to chair)
- Labs, Imaging, Studies: CBC daily, CT in am, CXR now, EKG stat…

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Oral Presentations

Oral presentations are your best opportunity to show your stuff to your team. In order to impress your superiors (and the people who will fill out that clerkship evaluation!), you want to ensure your presentations are succinct, accurate, and relay information in a fluid manner. Oral presentations on rounds are the team’s primary form of communication, so if your presentation is jumbled, out of order, or incomplete/inaccurate, your patient’s care may suffer… and you won’t impress anyone. Presenting is a learned skill perfected over time, so don’t fret too much if it takes you a while to get it right. Because you need to master that skill relatively quickly, though, here’s how to get it right from the get-go:

1. **Always ask a new attending how they would like you to present.** Some like very formal presentations, while others like it to be shorter or more conversational. While one may want a full physical exam report every day, some will want you to say, “on exam, no changes from yesterday.” There is no way to know which your attending prefer without asking, so ask!!! You can also ask your resident if they know your attending for feedback and suggestions.

2. **Even if you will present information without using notes, have something prepared for back-up/reference.** You can type up your note, pend it in EPIC and print it in the morning, use a scut sheet, or hand-write a free-form reference to use during your presentation.

3. **Start off with a brief sentence that reminds everyone who your patient is and why they’re here.** For example, “Mr. Jones is our 54 y/o patient with history of type 2 diabetes, hypertension, and 10 years of cocaine use admitted 4 days ago for acute renal failure.” This ensures you’re all on the same page going forward. Often on your second or third day of presenting a patient the team will not want or need you to give this one liner anymore but always err on the side of being thorough and stating it if in doubt.

4. **Summarize overnight events.** This may be as simple as, “no acute events overnight,” or may involve concerning information – “he had a run of tachycardia to the 130s between 12am and 1am.” Did they require any prn medications?

5. **Give the subjective information obtained when you pre-rounded on the patient that morning.** “This morning, he reports mild nausea with one episode of vomiting around 5am, relieved by Zofran…”

6. **Review all pertinent objective information.** This will always include vitals and your exam and may include ins & outs (e.g. urine output for the past 24 and 8 hours), changes in medications or dosing, pertinent lab values (often only abnormal values or numbers you’re following for that patient) and imaging results.

7. **For lab values, offer trending information.** “WBC count is 13.4 this morning, which is elevated but down-trending from 15 yesterday.” It’s almost always okay to say “BMP within normal limits”. Just make sure if you say it, the labs are ACTUALLY normal. ***Pay attention to the dates for the labs. Some templates auto-populate the most recent labs but those might have been done days ago***

8. **Give your assessment and plan** just the way you write it in your note, but without reading off a piece of paper! Start with that same summary sentence from the beginning of your presentation (Mr. Jones is a 54 y/o…) followed by your assessment of each problem with the appropriate next steps. “Given his improved urine output and mental status with down-trending BUN and Cr, Mr. Jones’ renal health seems to be improving. I suggest we…”

SAS: Crash Course for 3rd Year
9. **NEVER read straight off your paper.** Except for lab values, you should know your patient well enough to do your presentation with very little reference to your paper notes. This will get easier as the year goes on.

10. **Read about your patients EVERY DAY!** This will help you to answer any questions the attending or residents ask you during your presentation pertaining to your patient, a practice often referred to as “pimping” ("put in my place" – taken from the old practice of attendings asking tough questions to prove to everyone they knew best and give overconfident residents and medical students a healthy dose of humility). Furthermore, when you describe your A/P you can make statements such as, “I recommend that we order a CT scan as I read last night that CT scans are more sensitive than plain films in this situation.”

11. **Speak up, be confident, and take criticism in stride.** Accept that you will be interrupted, corrected mid-sentence, and sometimes embarrassed in front of the rest of your team. Use each criticism as a chance to improve and always strive to do better next time. You can always ask for feedback from your team as well.

12. **For a helpful article with more information on presenting, visit:** [http://meded.ucsd.edu/clinicalmed/oral.htm](http://meded.ucsd.edu/clinicalmed/oral.htm)
A Few Phone Numbers to Know

- **Operator:** 0
  - When in doubt, dial 0 and ask the operator to transfer you
  - Also call 0 to connect to a **non-local outside line**.
    - Say, “Could you please connect me to an outside line” They will say yes and then ask for the phone number.
- **Outside Lines w/(708) area code:** Dial 9, then XXX-XXXX
- **Outside Lines w/ different area code:** Dial 9, then 1-XXX-XXX-XXXX
- **Loyola Scheduling:** dial 68563
- **Security:** 9-1-1 from any Loyola phone
- **Paging:**
  - **Phone**
    - Dial 6-8777 from a campus phone or 708-216-8777 from an outside line
    - Enter the pager number you want to call, then your call back number (i.e. the numbers that the landline phone you are using is labeled with)
    - To "tag" a page with your pager number to alert the recipient that it’s you calling (residents hate blind pages), hit *, then your pager number after you enter the callback number.
      - Ex: say your pager number is 12345 and you want to be called back at 6-7890, you enter 67890*12345#, which shows up on the recipient’s pager as 67890-12345. *That way, if they can’t call you back right away, they know who to page when they’re ready in case you’re not at the phone you originally called from anymore.*
  - **Text Paging**
    - Get on to the Loyola Wired web page -> employee directory. Alternatively, on the EPIC web page (click the globe icon), there’s an employee directory search on the bottom left column.
    - Type the name of the person you need to page into the directory search
    - Click on the person’s pager number and a window will pop up
    - In the “callback number” portion type the 5-digit landline you are by. Then *, then your pager number (e.g. 67890*12345)
    - Type your message. Identify who you are at the beginning or end. Keep your message brief.
How to Call a Consult

- If you don’t know who to page → Web on Call (see pictures below)
  - you should almost always page the intern when in doubt
- If you know the last name but not the pager → Phone directory
- Page the person (see paging instructions above)
- When they call back ---- What to say:
  - Hi I’m _(Jane Doe) _calling from __(Gen Med 4)___ and we have a consult for you.
  - The MRN is ______ and the last name is ______
  - Our question is ____ (which antipsychotic would be most appropriate given the patient’s delirium and comorbidities) ______?
  - Age, gender, and Pertinent past medical history,
  - Pertinent history from course of hospital stay,
  - Possible social issues they need to be warned about
  - Where they should page back to
  - KNOW YOUR PATIENTS!! and be CONCISE

Getting the Patient’s Medical Record

- Try to call the medical records department of that hospital
  - look-up number online
    - Outside Lines w/(708) area code: Dial 9, then XXX-XXXX
    - Outside Lines w/ different area code: Dial 9, then 1-XXX-XXX-XXXX
    - When in doubt, call 0 (operator) and ask to be transferred to an outside line
- Introduce yourself as so and so on the medical team caring for ____, who has received care at their office/hospital and say that you would like to request the patient’s medical record.
- Faxing:
  - Obtain record release form from nurses station (ask someone to help you)
  - Fill out release form, get patient’s signature, ensure that patient’s DOB is on the document for identification
  - Fill out cover letter (usually at fax machine), include the return fax number
  - Same instructions as above for dialing on fax machine
  - Wait for confirmation
  - You may need to call medical records to ensure they got your fax if there is a delay in getting the records
  - Materials that get faxed back are usually put in the patient’s chart
Getting EPIC Access From Your Computer

1. You need to download to your computer a “Citrix Receiver”
   - FYI, once you have the citrix receiver downloaded you don’t have to have it running or really do anything with it. As long as it is on your computer you should be able to just go straight to step #2.

2. Go to apps.luhs.org on your internet web browser.
   - Use your regular Loyola computer login user/pass to log into this site.

3. Since you already downloaded the citrix receiver and have logged in, click the leftmost icon ‘Hyperspace’ (which is Epic)
   - Login with your epic username & password
   - Lost your password? call extension x62160 from a Loyola phone or 708-216-2160 from your cell
   - NOTE: the LUHS-intranet-portal icon (3rd from left) will connect you with Loyola Wired so you can search the directory and access people’s pager numbers and email addresses from home

4. Once, you have downloaded the citrix receiver you have to go to apps.luhs.org every time you want to get onto epic, click hyperspace, download the system all over again and login. Save that address as a bookmark.

5. If you want epic access from your ipad it's pretty much the same process. Download the "citrix receiver" app from the app store and then use your ipad to access https://apps.luhs.org
The Clerkships
Overview:
Family Medicine is a 6-week clerkship spent at the same site with a strong focus on outpatient care. Weekdays are normally 8-9hrs long, and most locations involve little to no call and little to no weekend workdays. There are many different sites available, from Loyola Maywood Family Clinic to centers on the south side of Chicago, to out in La Grange, and more. Spanish-speaking and underserved clinics are also available and students will be given an opportunity to give preference for these locations. As sites change a bit from year to year, it is best to check with friends who have recently completed the rotation or fourth years to see what they thought of their site. Different sites also have experiences unique to them such as more obstetrical patients, pediatric patients, inpatient shifts, or opportunities in Emergency Medicine.

Grading is based on a subjective evaluation completed by your primary attending, an OSCE, a departmental exam, and two fairly hefty and time-consuming projects. The Biopsychosocial project involves performing an extensive interview on a patient, writing up their history with a focus on psychosocial factors, and presenting the patient to a group of students for discussion. The Evidence Based Medicine project requires finding an article pertaining to a clinical question you have, completing an online module designed by the library, evaluating the article in depth, and analyzing its validity and applicability to your patient. Both projects are a substantial amount of work, so **DO NOT PUT THEM OFF!!!** Get them done early in the clerkship so you do not have to worry about them during test time. These projects can make the difference between a grade if you do well. The departmental exam is heavily based on information from the online fmCases on MedU. There are 40 fmCases so start working on them early as well. It is best to try and do two a day in the first few weeks of the clerkship so you have time to review at the end.

Recommended Study Materials:
- **MedU fmCases** – take the time to do 1-2 of these a night, and then reread the pdf summaries; the ONLY resource you absolutely need. Some students choose to skip through the cases online and just read the pdf summaries at the end.
- **USPSTF Screening Recommendations and CDC Vaccine Schedule** – be **VERY** familiar with these! Know your vaccine schedule and screenings like the back of your hand! You will look like a STAR student if you suggest various vaccines or screenings when you present your patient to the attending.
- **Case Files: Family Medicine** – good overview of pertinent topics (but not necessary to do well on exam)
- **Pretest** – book of review questions (again, not necessary to do well on exam)

Smartphone Apps (free unless noted)
- **Diagnosaurus DDx** - great differential diagnosis tool
- **Epocrates** – great pharm reference, has dosages written out for various indications per medication
- **Micromedex** – another great pharm reference
- **UpToDate** – good resource for daily reading around your patients
- **MedCalc** – awesome tool that helps you calculate things like ASCVD risk, CHADSVASC2 score, FeNa, pregnancy due date, and many more by just inputting the numbers
• AHRQ ePSS – great app that provides recommended screening interventions based on a patient’s age, sex, pregnancy status, social habits and sexual activity
• CDC Vaccine Schedule – pretty self explanatory

Additional items to carry in your pockets:
• Checklists for what to cover when you see a patient with depression (PHQ-9), diabetes, asthma, a well-child visit, and a prenatal/postnatal visit.

A Typical Day on Family Medicine:
• Arrive around 8:00am (depends on clerkship site)
• Review the list of patients your attending/resident will see that day and perform a brief chart review (if possible) for each. Mark any interesting patients you would like to see. Be assertive and let them know if there is a specific patient that you would like to see!
• Go over the list with your attending (if they want)
• The remainder of your day will be seen seeing patients and writing encounter notes (full H&Ps for new patients, SOAP style notes for return patients). Aim to see 3-5 patients per half day of clinic, 6-8 per full day of clinic.
• Some sites will have other requirements or opportunities for students – a few overnight calls, weekend clinic, shifts in the emergency department, some time on the labor and delivery floor, visits to elementary schools, didactic lectures, etc. These specific requirements will be reviewed with you as they pertain to your specific site.

Tips for Success:
• Be as efficient as possible with your time. There is no question that will be the rate-limiting step in your patient’s care that day, so ask your resident/attending beforehand how long they would like you to take with the patient and which issues they would like you to be sure to cover. Often, there is no time for you to discuss all of your patient’s medical issues in one 15 minute appointment. Patients with long problem lists will see their PCPs more frequently and thus the attending/resident will probably want to focus on one or two items at a time and address other problems at a later visit.
• Be comfortable with your musculoskeletal exam and back exam from PCM! A common complaint is back pain or knee pain and a requirement for the course is to have a supervised back exam.
• Although you may shadow some of the time, be sure to speak up if you are not getting enough hands-on practice or time to interview patients! Much of Family Medicine is about you being proactive and asking to do or see more.
  ---Take advantage of the opportunity to be hands on by doing diabetic foot exams, administer injections, perform urine dipsticks, wart removal, pap smears, etc.
• Always include Routine Health Maintenance as an item in your A&P and problem list! Mention vaccinations, cancer screening, diet/exercise counseling, contraception, and anything else that pertains to the patient’s routine/preventative care.
• Family doctors like to try to solve problems before referring them off to specialists. When you present, try to come up with lab tests/exams/scans you can do or order before suggesting a referral.
Overview:
Internal Medicine is an 8-week clerkship divided into two 4-week blocks. One of the blocks must be inpatient general medicine at Hines, Loyola, or West Suburban Hospital (Oak Park), complete with daily didactic teaching sessions and patients with more complicated disease processes. For the other 4 weeks, students may do an additional inpatient general medicine month (at a different site), inpatient specialty (cardiology, hematology, hematology-oncology) at Hines or Loyola, or outpatient/ambulatory internal medicine at various sites (will rotate through several specialties as well as general internal medicine).

Grading is based on evaluations completed by your residents/attendings (one for each rotation site), an OSCE with a free-text exam portion, and an in house final exam.

Additional items to carry in your pockets:
- **Pocket Medicine** by Marc S. Sebatine ($$$ but worth every penny. Especially helpful for preparing A&Ps. Buy online or in the hospital gift shop)
- “How to read an EKG” handout from PCM2 (available in SAS Google drive or LUMEN)

Smartphone Apps (free unless noted)
- **Epocrates** – great pharm reference, has dosages written out for various indications per medication
- **Micromedex** – another great pharm reference
- **UpToDate** – good resource for daily reading around your patients
- **MedCalc** – awesome tool that helps you calculate things like ASCVD risk, CHADSVASC2 score, FeNa, pregnancy due date, and many more by just inputting the numbers
- **AHRQ ePSS** – great app that provides recommended screening interventions based on a patient’s age, sex, pregnancy status, social habits and sexual activity. Will be useful for outpatient medicine.
- **CDC Vaccine Schedule** – pretty self explanatory, will be useful for outpatient medicine.
- **Journal Club** - this costs $5 (alternatively you can access the mobile website for free). Reviews top articles in internal medicine and puts landmark trials at your fingertips. Casually whip this out and present an article to an attending during rounds, and you’ll look like a rockstar.

Recommended Study Materials:
- For the final exam:
  - Everything is based off the objectives. If something isn’t in the objectives, chances are, it won’t be on the test. Use the objectives to guide your studying - don’t be extra!
  - **StepUp to Medicine** - a comprehensive textbook on all internal medicine topics. Loyola library has the PDF version for download, hard copy costs around $50.
- **Online MedEd** - online lecture series that’s the internal medicine version of Pathoma. Highly recommend this, and it’s free!
- **Q bank medicine questions such as UWorld or MKSAP Question book.**

  - For the OSCE
    - Study the Wednesday lectures, small group handouts, and objectives correlating to topics covered up until point of OSCE.

**A Typical Day on Medicine:**

- **Arrive around 6:00am**
- **Find out how your patients did overnight (“pre-round, chart review”)**
  - Collect all objective data from EPIC – vitals, ins/outs, lab values (BMP, CBC usually), ins/outs, follow up on cultures and/or images, check the med history (how many pain pills did they take, did they refuse their bowel regimen?), check the order history to see what your intern might have added while you were gone
  - Review new notes from any consult teams, social work, etc.
  - Check in with tele (3rd floor Loyola, 8th floor Hines) if your patient is on telemetry monitoring
  - Talk to the patient to collect daily subjective data and complete a physical exam
  - Talk to the patient’s nurse to ensure you’re aware of anything that hasn’t been charted yet!
  - Talk to your intern who is also following your patient to go over the assessment and plan and practice your presentation
- **Divide up any new patients with other students on your team. Review their admit H&P as well as all overnight events.**
- **Begin and pend SOAP notes on all of your patients before rounds so that you can update and submit them after rounds.**
- **After pre-rounding, meet with your team to formally round on all of the patients on your service with your attending (“rounds”)**
  - You will give an oral presentation on each of your patient’s, complete with an assessment and plan.
  - Try to touch base with your resident(s) if there is time in the morning to run your A/P with them. This gives them an opportunity to see that you are reading and thinking through your plan but also gives them the chance to teach you and help you to look as good as possible on rounds.
- **After rounds, complete your SOAP notes ASAP. Other teams and even your residents may want to read your note before they submit theirs.**
- **The remainder of the day is spent calling consults, following up on any new labs or imaging, and adjusting the patients’ plans as appropriate.** Be sure to ask your resident if there are any ways you can help, and don’t hesitate to check in with your patients throughout the day to monitor their progress! Take the time to read around your patients in the afternoon as well.
- **You will often have lectures, small groups, grand rounds, or educational conferences that supersede floor duties at various times during the day. You should receive a schedule of these sessions at the beginning of the clerkship. Keep on top of these.**
- **When the ED calls with a new admission, you will complete the initial H&P and present the patient to your resident. Again, be prepared to include a well-developed A&P with a multiple item differential! The Pocket Medicine binder or Up to Date is incredibly useful for this.”
Tips for Success:

- Keep a note-card or scut sheet (see Appendix) for each of your patients, noting changes in their status/medications each day. This is particularly helpful for when your attending asks you a question like, “What’s his baseline creatinine?” or “What was her WBC count on admission?” Alternatively, you can print out your pended SOAP note each AM and keep a stack of them in your pocket to reference for each patient.

- In medicine, a thorough and complete assessment and plan is best. In contrast to surgical specialties, the residents and attendings want you to write out your thoughts, explaining why the patient’s current diagnosis is the most likely diagnosis and why others on your differential are less likely. Have at least 3 differential for each acute condition.

- To develop your A/Ps, open the Pocket Medicine book to the section corresponding to your patient’s chief complaint (e.g. chest pain, shortness or breath, syncope) or go to Up to Date and go over the differential, work-up, and plan to ensure you aren’t missing anything important.

- Make sure to go home and read around your patients including work-up for a specific symptom or mechanisms/diagnosis/treatment of a disease. This can be an article or the section from Step Up or Online MedEd. It helps to always have some notes written on a topic with you because your attending might out of the blue ask you what you have been reading about or if you have any topics to present. These are most often informal few minute presentations on a topic related to your patient.
INTERNAL MEDICINE H&P TEMPLATE

CC:

HPI:

PMHx:

PSHx:

Medications:

Allergies:

Social: Living situation, occupation tobacco use, ETOH, illicit drugs, sexual history

Family Hx:

ROS:

Physical Exam:

- Vitals
- General appearance
- HEENT
- Cardiovascular
- Pulmonary
- Abdomen
- Extremities

Labs: Include recent or baseline labs (i.e. normal Hgb, baseline Cr) and anything done in the ER

Cultures: Since this admission, including ones that are pending

Imaging: Include new or recent such as that performed in the ER

Assessment & Plan:

In medicine, all A/P should start the same way (with the assessment):

“[Patient Name] is a *** y/o M/F with PMH *** (list any pertinent past medical hx) who presents to the ER (or from clinic or transfer or wherever they’re being admitted from) with *** (chief complaint and any super pertinent findings related to CC ex: “SOB, hypotension”) suspected to/found to have ***X vs. Y vs. Z (From here, discuss your differential and anything that has already been ruled out with testing or on exam. Be sure to prioritize it with the most likely diagnosis first! Then proceed with the plan by PROBLEM in order from most to least important/acute. Be sure to include 1) anything needed to stabilize the patient (hydration, oxygenation, bleeding, etc.), 2) ALL medications, 3) further evaluation needed (labs, imaging, tests), 4) any other treatment needed (procedures/surgeries, follow-up, lifestyle changes)).

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For the plan, order the problems from most acute (what they came in for) to least acute/the chronic medical conditions.

For example:

Assessment
Jennifer Doe is a 58y/o F with PMHx significant for hypertension, prior MI (s/p stent 2008), HFrEF, and DVT who presents to the ER with 4 hours of shortness of breath suspected to have pulmonary embolism v pulmonary hypertension v CHF exacerbation.

Plan
1. Shortness of Breath:
   - Ddx: Pulmonary embolism v pulmonary HTN v CHF exacerbation
   - Most likely pulmonary embolism given hx of DVT and sudden onset of SOB. Less likely CHF exacerbation given BNP

   - wnl and no signs of effusion on cxr, etc etc.
   - CT now to assess for pulmonary embolism
   - Oxygenation improved with 3L O2 via nasal cannula. Continue PRN. (etc.)

2. HTN
   - H/o well-controlled HTN, baseline BPs 130s/80s. Elevated now to 140/92.
   - Continue home HTN meds.
   - Monitor BP

3. Hyperlipidemia
   - Total cholesterol 1 month ago 120
   - Continue home Simvastatin

After you’ve addressed each problem, always include Fluids, Electrolytes, and Nutrition (“FEN”) as well as any prophylactic treatments (DVT and stomach ulcers usually), the patient’s disposition (“DISPO” – patient’s current status and location in the hospital), and the patient’s code status.

FEN:
- Fluids: Continue IV fluids @ 100cc/hour
- Electrolytes: Check and replace lytes PRN (as needed)
- Diet: General diet (alternatives: cardiac, diabetic, NPO, clear liquid, etc.)

PROPH
- DVT: Heparin 5000 units subQ
- Ulcers: PPI

DISPO:
Stable on 7th floor. Likely d/c this afternoon.

FULL CODE or DNR/DNI
Pt seen and discussed with Dr. ***
YOUR NAME, MS3
Pager 1234

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INTERNAL MEDICINE DAILY PROGRESS NOTE TEMPLATE (SOAP note)

24-hour events: Document pertinent events that happened since you last rounded/overnight (if anything). Examples are, responses from consults, pertinent imaging or culture results, a procedure that was done. Some attendings will only want big deal events (e.g. Did the patient code? Was the patient intubated?)

Subjective: How the patient feels. This should be the patient’s perspective. Things to ask are how they did/slept overnight, mood, pain, chest pain, shortness of breath, fevers/chills, if they ate anything, nausea/vomiting, bowel movement, urination, etc

Objective:
I&O: (Patient “ins & outs”— fluids, urine, stool, emesis, NG tube, drains)

Physical Exam: (At minimum do heart, lung, abdomen exam + anything else pertinent to your specific patient)
- Vitals: (Include T-max from last 24 hrs and current Temp, BP, RR, O2 sat)
- Gen: A&Ox3, NAD (alert/oriented to person, place, time - no apparent distress)
- CV: RRR, nl S1, S2, no m/g/r appreciated (rate and rhythm regular, normal S1/S2, no murmurs/gallops/rubs)
- Pulm: CTAB (clear to auscultation bilaterally), no crackles or wheezes, no increased WOB (work of breathing)
- Abd: Soft, NTND (non tender, non distended), +BS (bowel sounds), no HSM (hepatosplenomegaly)
- Extremities: No edema, distal pulses intact in all 4 extremities

Medications: Note changes in meds or dosing, especially fluids and pain regimen!

Labs: Have results from the past 3 days. It’s all about the trends - are values uptrending, downtrending, stable?

Cultures: List any new cultures (blood, urine, stool, etc) that came back from the day prior

Images: New radiology reports. Just having the impression portion of the radiology result will suffice

A/P: [Name] is a *** y/o M/F with PMHx significant for *** who was admitted on *** (date) for *** (chief complaint) founds to have *** (diagnosis). Now sum up any changes/improvements seen so far this admission. Then proceed with the plan by PROBLEM as you would in a complete H&P (see above). Include any acute problems as well as any changes to medications, etc.

FEN
PROPH
DISPO
FULL CODE or DNR/DNI

Patient was seen and discussed with Dr. ***
[YOUR NAME], MS3, Pager 12345

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Overview:
Neurology is a 4-week clerkship at either Loyola or Hines VA.

At Loyola the clerkship is broken into four 1 week rotations including the Neuro ICU or night call (4pm-10pm shift), Vascular Neurology (stroke service), General Neurology (neither strokes, nor ICU patients), and an outpatient week in either pediatric or adult neurology. (Note: if you are interested in pediatric neurology and will not be able to take the four-week elective this year, this will be your only opportunity to get exposure to the field before fourth year. Hines does not have this option.)

At Hines VA, the clerkship is broken into 2 weeks of inpatient consults and 2 weeks of neurology clinic with half days of EMG/Autonomics labs.

Your grade will be based on subjective evaluations from each of the rotations, as well as a video exam (answer questions about the patients shown in brief video clips), and a 100-question departmental exam. There is no OSCE on this clerkship.

Additional items to carry in your pockets:
- Reflex hammer
- Tuning fork
- Penlight
- Safety Pins (found in outpatient clinic) - for testing pinprick sensation
- Long cotton swabs (found in outpatient clinic) – for testing soft/sharp sensation

Smartphone Apps (free unless noted):
- Epocrates: great pharm reference, has dosages written out for various indications per medication
- Micromedex: another great pharm reference
- UpToDate: good resource for daily reading around your patients
- Hospitalist Handbook: good reference for inpatient management protocols
- Stroke Scale: something good to flip through on your downtime to get a better understanding of the stroke-focused physical exam

Recommended Study Materials:
- The majority of written exam questions come from the material covered in the handouts available on the website (Lumen → Neurology → Curriculum: Clinical Neurology Topics) and the learning objectives for the clerkship.
- The videos for the video exam are all available to view and study from the link on the clerkship site (Lumen → Neurology → CAI Modules: Practical Neurological DVD Review – enter user: stritch, password: student →

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Medical Cases, then select the video you’d like to watch). At the end of each video is a paragraph or two about the video; questions on the exam are typically from these paragraphs and tend to focus on pathology/etiology, diagnosis, and treatment.

- Lecture & online Neuroradiology curriculum (Lumen → Radiology (under vertical curriculum) → Educational Resources → Neuro)

A Typical Day on Neurology:

- Your schedule will vary day-to-day depending on your rotation, specific attending/residents and how many patients are on your service at any given time. Some attendings like to round in the morning, others in the afternoon. You will just need to ask on day one to get a sense for what your schedule will be like for each block. Here is a general overview of each rotation:
  - **The Wards services** (namely, your inpatient weeks at Hines or your General Neurology and Vascular Neurology weeks at Loyola) are very similar to Internal Medicine services. You may or may not have your own patients to see, and residents will vary in whether or not they’ll require you to write notes. *If they do*, the rotation will be a lot like medicine – pre-round on your own patients, present them on rounds, write notes as described in the Internal Medicine section of this book (only specific to Neurology and with a Neuro exam included), then help out the team with calling consults, contacting outside hospitals for records, etc.. Your hours will be similar to those on Medicine as well. The General service will have primary patients and consult patients (Internal Medicine, Surgery or OB/GYN patients with a specific neurological problem the team is following). You will not be responsible for the consult patients, but the team will round on them. You will work one weekend day (usually a half-day).
  - **Neuro ICU** - The ICU will be similar to your Wards weeks with the exception that the patients are more critical and expectations tend to be a bit higher. For this reason, we would recommend that you go into this week with a general understanding of end-of-life care, code status, ventilator settings and maintenance fluids. Continue to know as much as you can about your patients, but try to go the extra mile by understanding their family situations, social barriers and POA contact information. This week, your plans should be systems-based (Neuro:..., Cardio:...., Resp:...) rather than problem-based (Hypertension:..., Diabetes:...) in your presentations and notes. Since it's an ICU, many patients have been transferred from outside hospitals, and since they have serious neurologic conditions, they are often poor historians. For these reasons, information can be unorganized, so be ready to help with calling consults, calling outside hospitals to track down records and communicating with your patients’ families. You may also be expected to give a 5-10 minute topic presentations at the end of the day, sometimes with only a few hours notice, so have solid resources in mind (PubMed Clinical Queries, Clinical Key, etc.). Hours vary, and you will work one weekend day. Again, these patients are often very ill, so do the best you can to emotionally prepare yourself for stories of trauma, limited recovery, difficult social situations, and tough family meetings.
  - **Night Call** - The Night Call resident is responsible for any new consults in the ED or on the floor as well as managing any acute problems with patients currently on any neurology service. Your shift will start at 4pm where you can read about the patients and try to help out the Neuro ICU teams, but this is often downtime. Regardless, be in the Neuro ICU for 5pm signout, where the ICU, general and vascular teams will present to you and the night resident. From there, you can see any current patients with new problems or simply wait until your resident is paged for a new consult. This is a great opportunity to practice taking a history, performing a neurology exam and presenting a patient without having the pressure of an attending. You may wear either professional clothes or non-surgical scrubs, depending on your preference. Hours are from 4 -10pm, M-F.
  - **Outpatient weeks** at Hines or adult outpatient week at Loyola - These are like any other clinic week, with the exception that you are focusing on the patient’s neurologic problem. See the Family Medicine section for a typical day in clinic if you have not yet experienced this. You will likely conduct an H&P
either alone or with a resident in the room, present the patient to your attending, then see the patient
with the resident and attending. You may have shadow for a couple of visits if clinic is too busy. Ask
your attending (who will vary by the day) if they want you to write notes. Standard outpatient hours
(around 8-4), M-F.

- **Child neurology** - Your day will start with rounds around 7am in the peds resident workroom for any
pediatrics patients the team is following. You likely will not have to present anyone unless you took
their H&P earlier in the week. If there are no inpatients, your day will start when clinic starts, usually
around 8:30 am (confirm on Epic the night before). Clinic is in the LOC Mon-Wed and on Friday. On
Thursday, you will go to Dr. Schnitzler’s clinic in Burr Ridge. See the section above and the Family
Medicine section for a typical day in clinic, and see the Pediatrics section for advice specific to working
with kids. During the day, your resident may get paged to see a new patient in the ED or on the floors,
and you may be sent to see them either before or with said resident. You may also round in the
afternoon if clinic is early. Try to be flexible, and be sure to communicate with the team!

- You may or may not need to round on all of your patients every day. It’s possible that some days you may
only need to perform a chart review and then see your patient as needed or every few days. If that is the
expectation, it still would be acceptable for the sake of learning to ask your team if it would be ok for you to
see your patients every day.

- If you write a note for a consult patient, your assessment and plan will focus on the problem you have been
consulted to address and not the management of their diabetes, CHF, etc.

- About twice a week, you will have mid-day lectures at Stritch or in the Maguire Center. Remember to go to
them!

**Tips for Success:**

- **Watch the online neurology videos. Especially** the ones on the SAS drive

- Review the basics for reading head CTs and MRIs. Almost every patient you see will have them, and it is not
uncommon for the attending or resident to ask you to read the actual image during rounds!

- Review how to do a complete Neuro exam **before** starting the rotation so that you are ready to go with your first
patient on day one! Also, the Mini Mental Status Exam is a good tool to have memorized!

- As the schedule is pretty unpredictable and slow days are common, **always** have something to study with you
to make the best use of your downtime, and communicate well with your team.
NEUROLOGY PHYSICAL EXAM TEMPLATE

General Physical Examination:
- Gen: Alert and oriented x3, NAD ***
- HEENT: PERRLA, mucous membranes intact. ***
- Neck: No JVD or bruits appreciated. No palpable lymphadenopathy ***
- CV: RRR, nl S1 S2, no extra heart sounds, murmurs, rubs, or gallops ***
- Pulm: Clear to auscultation bilaterally. No crackles or wheezes ***
- Abdomen: Soft, NT/ND, normal active bowel sounds, no hepatosplenomegaly noted ***
- Peripheral vascular: +2 b/l radial, DP and PT pulses ***
- Extremities: No cyanosis, clubbing, or edema. Warm, well perfused. No calf tenderness***
- Skin: Normal skin color, texture, and turgor. No rashes or lesions ***

Neuro Examination:
- Mental Status: Mental status is intact to conversation and history taking. There is normal facial expression and affect. Speech is fluent. Verbal expression and comprehension intact.***
- Cranial Nerves: Pupils are equal, round and reactive to light. Visual fields are full to confrontation. Optic disks appear sharp and flat. Extraocular movements are intact with normal smooth pursuit, vertical and horizontal saccades. Facial sensation is intact to light touch. There is no facial asymmetry, and facial strength is intact. Palate elevates symmetrically. Sternocleidomastoid and trapezius strength are intact. Tongue is midline with no atrophy or fasciculations. ***
- Motor: Neck is supple to passive manipulation with no rigidity. There is normal muscle bulk and tone in the extremities. There is no pronator drift or satellitising. Strength is 5/5 in all extremities, proximally and distally. ***
- Reflexes: Reflexes are 2+ symmetric biceps, brachioradialis, triceps, patellae, ankles. Plantar responses are flexor. ***
- Sensory: Sensation is intact to light touch, temperature, vibration and proprioception. ***
- Coordination: Finger-nose-finger and heel-knee-shin examination are intact. ***
- Gait and Stance: There is a narrow-based gait with normal stride length, heel-toe step and arm swing. Tandem intact. Romberg negative. ***
Overview:
OB/GYN is a 6-week clerkship with two sites to choose from – Loyola or Mercy (only one student is selected per rotation for this site). The breakdown of the clerkship varies depending on your site.

At Loyola, the clerkship is divided into three 2-week blocks: L&D (labor and delivery), and two electives assigned to you via lottery. Benign gynecology is “bread and butter” gyne (fibroids, abnormal uterine/vaginal bleeding, ectopic pregnancies, pelvic pain, STDs/STIs etc.) with many outpatient surgical cases (D&C, hysteroscopy, endometrial ablation, endometrial biopsy) and occasional major surgeries in the main OR (hysterectomy, salpingectomy-oophorectomy, myomectomy). Gynecology-oncology is the most surgery heavy and operates much like general surgery services. Urogynecology (i.e. female pelvic medicine and reconstructive surgery or FPMRS) is more outpatient heavy with 1-3 surgeries in the main OR per week. Maternal-Fetal Medicine (MFM) is an outpatient rotation focused on pre-natal care of complicated and/or high-risk pregnancies, with an occasional complicated surgery - it is “internal medicine for OB.” Ambulatory is also an outpatient rotation. Students at Loyola work with many OB/GYN residents and attendings, which is helpful for those interested in pursuing a career in OB/GYN who may need a letter of recommendation in the future.

At Mercy (downtown), you will spend one week at a time rotating through different clinics or services. You will work with Mercy’s OB/GYN residents, with the opportunity to get a lot of hands-on experience. Outside of Northwestern, Mercy’s L&D service is reportedly the second-busiest in Chicago – there will certainly be no lack of volume for you to gain experience! Your wild card may not be used for this site.

Grading is based on subjective evaluations completed by your resident or attending (it is up to whom to request to fill out your evaluation), an OSCE, and the OB/GYN NBME standardized exam. It is known for being a rigorous exam, so studying throughout the clerkship is key. Many students use the OB/GYN questions on U-WISE or UWORLD for their studying since they tend to more accurately approximate NBME-style questions.

Items to carry in your pockets:
- **OB/GYN Clerkship Guide** given to you by the department on the first day of the clerkship. It contains sample notes, a schedule of what to cover at each prenatal visit, and many other useful tools that are invaluable during this clerkship.
- **Case Files** or another review book. Particularly on L&D, there may be a lot of down time as the amount and timing of deliveries tends to vary greatly – make sure you have something to read during that time!

Smartphone Apps (free unless noted)
- **Epocrates** – great pharm reference, has dosages written out for various indications per medication
- **UpToDate** – good resource for daily reading around your patients
- **MedCalc** – helps you calculate pregnancy due date

SAS: Crash Course for 3rd Year
Recommended Study Materials:

- **Beckman’s OB/GYN Textbook** – The NBME exam is written from the information and learning objectives in this text. Although it may seem dense at times, it is one of the better resources available for exam prep. There is an e-book version available through the library. We would recommend using this only for reviewing topics for a more comprehensive understanding and/or if you’re particularly interested in OB/GYN as a career.

- Many students have had good success with the **OB/GYN Case Files book**, particularly if you’re the kind of person who gets bogged down by denser texts. If you’re more of a visual/audio learner, **Online MedEd** has sections for OB/GYN that is worth looking over.

- Clerkship “PBLs” (problem based learning) – students on the OB/GYN rotation come together weekly to review cases together. These cases cover some of the more important topics on OB/GYN and can be a good review of that material.

- **U-Wise Questions** – provided by the clerkship, this Q-bank provides over 500 questions sorted by topic designed to mimic the shelf exam for practice. Students have reported that many questions in this Q-bank are easier than those on the actual shelf exam whereas others are more difficult.

- **USMLE World Q-bank** – some students prefer to prep for the shelf exam by reviewing the U-World questions pertaining to OB/GYN since the exams are similar in format and difficulty level.

A Typical Day on OB/GYN:

For this rotation, your daily schedule will vary greatly based on which part of the clerkship you’re on and to which site you are assigned. For instance, outpatient days at Loyola (on any service) tend to start around 8am and sometimes go for half a day only (great study time!), whereas L&D days are 8h shifts. Surgical services run much like the surgery clerkship, starting between 5-7am, and ending roughly 8-12 hours later, depending on the service. Some teams will round together, others won’t. Some will require you to write notes, others won’t. Realizing this, it’s important to touch base with your residents/attending at the beginning of each part of the clerkship so you know what is expected of you and can plan to be there on time, etc.

A Few Extra Notes about OB/GYN:

What’s up with weekend call?

While the specifics of call are different at each site, all students will be required to take weekend L&D call at some point during the clerkship (unless you are assigned to L&D nights, then you are exempt). You will report to the L&D room at 8am and stay until 8pm. During call, you may involve delivering babies, heading to the OR to remove an ectopic pregnancy, or going to the ED to evaluate a woman with severe abdominal pain.

About rounding/pre-rounding:

- The expectations of you will differ with each service you’re on, so it is, as always, important to ask about them on your first day.

- Normally, you’ll arrive early enough to pre-round on your patients (chart review, speak with their nurse, daily SOAP encounter) and submit your notes before team rounds. Use the packet given to you by the clerkship to know what questions to ask your patients!

- Even if you aren’t expected to pre-round, or have been specifically told not to, be sure you have reviewed the chart and talked to the nurse so you know about any acute events or issues from overnight.

Writing Notes:

- We’re not kidding when we tell you to look at the packet they give you at clerkship orientation. It contains an outline of every note you will need to write on OB/GYN, so reference it before seeing all of your patients!

- Other helpful dot phrases you may want to include in your templates are:
  
  - Estimated gestational age: @EGA@
Estimated date of delivery: @EDD@
Gestational age: @GA@
Last menstrual periods: @LMP@
OB history: @OBHIST@

G#P#: How many gestations (pregnancies) and parturitions (deliveries) the patient has had. The “P” section is listed as 4#, remembered using the acronym T-PAL:
- T = # of term deliveries
- P = # of preterm deliveries
- A = # of spontaneous (miscarriage) or elective abortions
- L = # of living children
- ex: G3P2012 is a woman who has been pregnant 3x, with two delivered at term, none preterm, one miscarriage or elective abortion, and 2 children living.

If you’re male… Don’t be surprised if some women ask for you to leave the room during their pelvic exam or delivery. Many attendings are good at explaining you are there to learn and insisting you stay, but there are others who will not argue with the patient and expect you to leave when asked. Excuse yourself politely and move on.

Tips for Success:
- Keep an open mind. Many students go in dreading this rotation and are surprised how much they actually enjoy it! Remember - attitude is everything. Your team will like working with you much more if you can be enthusiastic about your experience and aren’t that student that obviously does not want to be there.
- Be respectful. You will be dealing with very personal issues and performing sensitive exams almost daily on this rotation. Remember that the patient is always more uncomfortable than you are, and while you may be experiencing new sights or smells, your patient is feeling particularly vulnerable in these situations and needs you to act with the utmost respect and professionalism.
- Introduce yourself to laboring patients BEFORE they deliver. Wouldn’t you want to know who all the people in the room are if you were delivering a baby?
- Turn in a wide variety of evaluations. In OB/GYN, it is up to you to ask residents and attendings to fill out evaluations for you, and you are not limited in the number you can submit. To avoid having a weak eval that pulls your clinical grade down, hand a form to everyone you work with whom you feel can speak to your performance, even if it was only for one day.
- STUDY EVERY DAY. While this seems to be true for every rotation, the NBME shelf exam is tough! To get through the entire textbook and all learning objectives at least once (which you should!) truly requires daily review. Make particular use of lighter days, such as ambulatory weeks at Loyola.
- SHARE. Most medical students have the dream of “catching a baby” before they graduate, so take turns picking up patients in active labor to give everyone a chance to experience that coveted delivery.
- For the OSCE, a large part of your grade is based on good communication with your SP. While performing a pelvic exam and pap smear on a plastic model in the middle of the encounter may feel awkward, do your best to treat the model exactly as you would a real patient and explain every, single step you perform. Same goes for the breast exam, which is on the actual SP.
- Finally, refer often to the packet given to you at the clerkship orientation.
Overview:
Pediatrics is a 6-week clerkship divided into a 2-week outpatient block, a 2-week inpatient block, a 1-week elective (additional outpatient week, Loyola pediatric ER, inpatient night shift at Loyola, or Almost Home Kids) and 1-week in the newborn nursery. Inpatient weeks are completed at Loyola, St. Alexius Hospital, St. Joseph’s Hospital, or La Rabida Children’s Hospital while students are assigned to a wide variety of Loyola affiliated or community clinics for outpatient weeks.

Grading is based on subjective evaluations (one for each service – inpatient, outpatient, nursery, and elective, weighted appropriately based on the number of weeks spent in each block), and OSCE, 3 quizzes, and a MedU standardized exam. There are several mandatory assignments as well that contribute minimally to your grade but will require some time and energy.

Additional items to carry in your pockets:
- Copy of the current CDC Child & Adolescent Immunization Schedule
- Otoscope Insufflator Bulb – provided by the clerkship
- Bright Futures pocket guide for use during well-child visits – provided by the clerkship

Smartphone Apps (free unless noted)
- Epocrates – great pharm reference, has dosages written out for various indications per medication
- UpToDate – good resource for daily reading around your patients

Recommended Study Materials:
- CLIPP Cases – online cases through the Aquifer website. You will be required to do a set of cases for the rotation but it is HIGHLY recommended that you do all of the cases and the questions at the end of each case as the MedU exam comes directly from the cases only. Some people like to go through the entire case while others just read the summary at the end. You aren’t “missing out” on important detail if you just read the case summaries. SAS also has summary guide on the Google drive.
- Online MedEd - good resource for inpatient. Doesn’t cover everything for the test and also covers topics that will not be on the test
- Peds in Review – fantastic resource for reading around your patients (like UpToDate for kids). Access through the library website
- Some students like the Pre-Test Pediatrics book for practice questions, or Case Files for Pediatrics or Blueprints Peds for topic review
A Typical Day on Pediatrics (Specific to Loyola site):

**Inpatient (similar to Internal Medicine)**

- **Arrive around 6:00am**
- **Pre-round on your patients to see how they did overnight**
  - Collect all objective data from EPIC – vitals, lab values (usually daily labs aren’t done for pediatrics), ins/outs (both 24h as well as cc/kg/hr for kids), follow up on cultures and/or images, med history, order history to see what your intern might have added while you were gone
  - Review new notes from any consult teams, social work, etc.
  - Talk to the patient or parent to collect subjective data and complete a physical exam
  - Talk to the patient’s nurse to ensure you’re aware of anything that hasn’t been charted yet!
  - Talk to your intern who is also following your patient to go over the assessment and plan and practice your presentation
- **Check with your resident to see if there are any new patients admitted overnight for you to see**
- **Start and pend your daily SOAP/progress notes for all of your patients**
- **Sometime between 8:00 and 9:00am, you will round formally with your team**
  - Be sure to consider any social factors that may influence your patient’s care. While this is true for all patients, it’s particularly important in pediatrics! *Always talk about discharge planning and what still needs to be done for the patient to leave*
  - For infants and toddlers, a birth history should be included as part of their PMH (ex: “She was born at term, normal vaginal delivery, APGARS 9 and 10. She spent one day under the bili lights for jaundice, but had no other complications and went home on day of life #3.”)
- **After rounds, finalize your SOAP notes**
- **The remainder of the day is spent calling consults, following up on any new labs or imaging, and adjusting the patient’s plan as appropriate.**
- **Be sure to ask your resident if there are ways you can help, and don’t hesitate to check in with your patients throughout the day to monitor their progress!**
- **Like Internal Medicine, you may receive new patient admissions throughout the day in which case you will either go to the ED to see the patient or see them once they get to the Peds floor.**
- **Morning reports, noon conferences, grand rounds, and miscellaneous lectures will interrupt your day, so be sure to keep a copy of the schedule in your pocket as the topics are generally high yield.**
- **Since the inpatient service waxes and wanes with periods of chaos and calm, always have something to study with you. And at Loyola, feel free to stop by the Child Life playroom and see if any of your patients are there playing or making crafts. They normally love the company! But only go in without your coat – the playroom is a white coat free zone.**

**Outpatient (similar to Family Medicine)**

- **Check with your resident/attending regarding start time. Some will have you arrive around 8:00am, while others prefer you to attend Loyola’s 8:00am morning report and come to clinic afterward.**
- **While the manner in which you choose/are assigned patients will differ at each site, you will spend the remainder of the day seeing patients for well child check-ups, acute complaints, or post-hospital follow-ups. Some sites will have you write notes while others do not, but all will have you present the patient to the attending/resident as you would in Family Medicine before going to see the patient together.**
- **ALWAYS review the patient’s growth chart and vaccine schedule**
- **The A&P will ALWAYS include anticipatory guidance – car seat recommendations, toilet training tips, what to expect developmentally with your child, sleep schedule, tummy time, “back to sleep,” etc**
- **Some questions to remember for…**
  - INFANTS: Feeding (breast? bottle? solids? how much? how often?), elimination (how many wet
diapers? BMs?), sleep (how many naps? how long?)

- TODDLERS/PRESCHOOL: Developmental milestones, feeding, sleep, elimination, toilet training
- ELEMENTARY: School, learning deficits/disabilities, attention trouble, friends, activities, screen time, eating habits, safety issues
- TEENS (seen alone for at least part of the visit): School/grades, friends, substance use/abuse in patient and/or friends, sexual activity, home/parents, healthy lifestyle, safety (helmets!), any questions/concerns.

Review and remember to use the HEADSS mnemonic.

Nursery

- Arrive around 6:00am to the nursery, change into scrubs and a LONG white coat
- Check with your resident to see if there are any new babies born overnight that need to be seen
- Chart review on EPIC
  - Each newborn will have a sheet with his/her vitals, lab values, things that still need to be done. On it, you will be expected to record your patient’s daily weight, in’s and out’s (feeding, stool, urine), bilirubin (to check for hyperbilirubinemia), etc
  - Follow up on any imaging and labs
- Pre-round (usually done with the resident)
  - The babies will most often be in the room with their mom. The nursery is mainly the resident workroom and circumcision room
  - Do a newborn physical exam. It can be intimidating at first holding such a tiny human - ASK your resident to come with you and observe the first few times if you feel uncomfortable with handling a newborn alone!
- Team rounds begin anytime between 7AM to 9AM depending on the attending
- The remainder of the day is spent waiting for more babies to be delivered, making outpatient appointments for patients (only those who will follow up within the Loyola system), or offering anticipatory guidance to moms ready to be discharged with their new babies. Bring something to read/study as down time is COMMON!
- Be proactive - if your patient is about to be discharged, make the follow up appointment before your residents ask. Nursery is one of the few places where medical students can be immensely helpful to the residents, and they will appreciate it if you make their lives easier.

Tips for Success:

- Even though the parents are normally present for patient encounters, spend at least some of the visit talking directly to your patient. While preschoolers may not have much to say, they will be able to tell you what is bothering them and building rapport is essential to a trouble-free, successful exam.
- Take care of yourself. You can wash your hands, take bleach baths, autoclave your stethoscope, and burn your clothes, but kids have a magical ability to still pass their germs on to you. It is incredibly common for students to get sick on the Peds rotation, so prevent illness by getting enough sleep, eating well, and staying hydrated throughout the rotation.
- Ignore the temptation to slack off. Peds attendings and residents tend to be incredibly friendly and relaxed, but that is not an excuse for you to not work hard! If you want a stellar evaluation, you will still have to earn it in Peds just like every other rotation.
- Do ALL of the CLIPP cases and the questions. Only a small number of them will be "recommended"/required, but the exam questions cover topics from all of the cases. It is absolutely worth your time to go through them all, so start early and be diligent in getting through them.
Overview:
Psychiatry is a 6-week rotation at one of the various sites at Loyola or Hines. Site options include inpatient units (Hines “2 South”, Madden Mental Health), consult services (Hines, Loyola), an intake team (Hines), a geriatrics service (Hines) and a substance abuse/methadone clinic (Hines “2 North”). The inpatient setting gives you the opportunity to see patients whose psychiatric issues are fully realized/acute – schizophrenia, bipolar disorder, substance overdose or withdrawal, etc. Consult services tend to see more altered mental status/delirium and acute suicidal ideation. You will also have 2 half-days of outpatient psych clinic where you will shadow an attending physician to gain exposure to that aspect of the specialty.

Grading is based on a subjective evaluation from your one main attending physician, a video OSCE, a departmental exam (written and video portion), and your SPPAM presentation (students presenting psychiatric aspects of medicine) – a grand-rounds style 20 minute powerpoint presentation on a psychiatric topic of your choosing, presented to half of the students currently on the psych clerkship, and graded by 2 psychiatry attendings.

Additional items to carry in your pockets:
- Mental Status Exam steps – you will be given a cheat sheet during psych orientation
- Folstein Mini-Mental Status Exam – you will be given a laminated notecard of this during psych orientation
- DSM-5 pocket edition – Amy Andel (the course organizer) will send an email a few weeks before the start of your rotation with sign up to check out one of these copies from her. There’s limited copies, so make sure to sign up early
- Generally, you will not need to carry a stethoscope during your psych rotation. Most psych attendings do not do a physical exam on the patient as the mental status exam is the “psych version of a physical”

Smartphone Apps (free unless noted):
- Epocrates – great pharm reference, has dosages written out for various indications per medication
- Micromedex – another great pharm reference
- UpToDate – good resource for daily reading around your patients

Recommended Study Materials:
- Clerkship lectures are an imperative source of study material for the Psychiatry clerkship. Be sure to study both the lectures delivered to the class as well as those posted online to Lumen. Dr. Schilling writes the exam, so be sure to focus on the lectures and be prepared for an exam similar to the one during M2 year.
- First Aid for the Psych Clerkship. A student favorite, and often their sole source for studying. It covers all important topics in an outline format, highlighting the most important facts for each section. Includes DSM criteria for diagnosis.
- By whatever means you prefer (lecture notes, flash cards, etc.), learn the psych pharmacology for the exam!
Mechanism of action, side effects, indication, all of the things you would have studied for an exam second year are fair game and will be tested! Look over the jeopardy cases and make sure you know them.

A Typical Day on Psychiatry:

- Because the different services are very different, there is really no “typical” day on Psychiatry. Most students start around 7 or 8:00am and are done for the day between 12 to 5:00pm.
- All students will be assigned to take “call” 2 times – once on a weeknight from 4:30pm to 8:30pm, and once on the weekend from 8am to 8pm. Students on Loyola consult will not be required to take weekend call as their hours are longer.
- Most services have you chart review and “pre-round” on your patients, though some attendings will prefer you wait to see your patients with the whole team. As with some other clerkships, some services require students to write notes while others do not. On certain services your note may be the only one from the team for that day (co signed by the attending), so do not take your responsibility lightly.

Tips for Success:

- Traditionally, most medical students do not plan to pursue psych as a career, and many students are not very interested in this clerkship at all. DON'T BE THAT STUDENT. Be open to this clerkship experience as the interviewing skills you will learn on psychiatry are invaluable, and no matter what specialty you pursue, you will have patients that suffer from psychiatric illnesses so should be familiar with their diagnosis and treatment. This is the best opportunity for you to practice and learn how to interview and work with “difficult” patients.
- Study as you go, particularly the psychopharmacology. There are a lot of drugs to learn with random side effects, etc. and waiting until the last minute will only cause you stress and make it more difficult to do well on the exam.
- For your SPPAM presentation:
  - Include an outline of your presentation on the slide immediately following the title slide. Be sure to use headings on the remainder of your slides that indicate where you are in the outline, or reshown the outline slide before each section to show where you are in the presentation. Graders for SPPAM love this kind of organization, and it can keep you from losing easy points.
  - Do something interactive with the audience. It could be a quiz game, a case study, a pre and post-test – whatever it is, get the audience involved. This keeps people engaged and gets you a better score. On the other hand, don’t overemphasize creativity and interaction at the expense of quality.
  - Do it early! There is a lot of material to study for the exam, so it helps to get the presentation out of the way in the first weeks of the clerkship. If you do end up going last, don’t wait until the last minute to start. Get it done early, then review your slides the night before your actual presentation instead of completing the whole thing the weekend leading into exam week.
  - Practice your presentation and time yourself! Points are deducted for being under 18 or over 22 minutes!
PSYCHIATRY H&P TEMPLATE

CC: Written in quotes in the words of the patient, even if it’s not the main/actual problem. For example, “I feel really sad and don’t know what to do”

HPI: Unlike other specialties, psych HPI are longer and read like a short story. It is a detailed account of how the patient got here, their past history/events, the psychosocial aspects pertinent to their CC, and their perspective on the illness. It should paint a detailed picture of who the patient is as a person. Quotes are also commonly used in the HPI.

PSYCH REVIEW OF SYSTEMS:
1. Depression: Remember SIG E CAPS (sleep changes, lack of interest/anhedonia, guilt/hopelessness, decreased energy, difficulty concentrating, changes in appetite, psychomotor agitation, suicidal ideation)
2. Mania: Remember DIG FAST (distractibility, increased energy/indiscretion, grandiosity, flight of ideas, increased goal-oriented activity, decreased need for sleep, talkative/pressured speech) as well as reckless behavior.
3. Anxiety: PTSD, GAD, specific phobias, panic attack or disorder
4. Psychosis: Audio/visual hallucinations (AVHs), paranoia, delusions
5. SI (suicidal ideation), HI (homicidal), or VI (violent): Passive or active? Past attempts? History of violence? Protective vs. risk factors?

PAST PSYCH Hx: Prior dx, inpatient treatments, outpatient treatments, medications (compliance, response, duration, side effects)

SUBSTANCE ABUSE: EtOH (When was the last drink? How much? How often? Withdrawal sxs?), illicits (ask about how do they take it (snort vs. smoke vs. IV etc, how long, how often.), OTCs, prescription drugs.

PMHx: Specifically include head trauma, seizures, stroke, DM, HTN, HL, surgeries, and PCP

FAMILY Hx: Psych hx, hospitalizations for psych issue, suicide attempts, substance abuse

MEDS:

ALLERGIES:

SOCIAL Hx: Living situation (at home, with friend, homeless, shelter, etc), marital status, education, job or disability, issues with law/debt (how are they paying for their substance addiction, could be using inpatient hospitalization to hide from the law)

PHYSICAL EXAM: In psych, the Mental Status Exam is used in lieu of an actual physical

A/P: Ask your attending how they like this written, each attending is different

SAS: Crash Course for 3rd Year
Overview:
Surgery is a fast-paced, 8-week clerkship. The 8 weeks of surgery are divided into two 4-week blocks. Each student will have one 4-week block of a general surgery or an equivalent rotation. The general surgery rotation sites include: Hines General Surgery, Resurrection general surgery, Gottleib general surgery, Acute Care Surgery (Trauma), Colorectal surgery, and Transplant Surgery. The second 4 week block each student will be placed on a sub-specialty surgical service, with options including burns, vascular, endocrine, plastics, thoracic, and pediatric surgery. The service you are assigned to for each block is based on a lottery process. You will be asked to rank the services 1-7 in each block.

Prior to your first day of surgery, you will have an orientation that will cover scrub technique, suturing, and basic do’s and don’ts of the OR so you won’t feel too lost.

Grading in surgery is based off 2 subjective evaluations completed by an attending (one for each month), an OSCE, a mini presentation on a surgical topic of your choice to one of your teams, and the surgery NBME exam.

You will need a long white coat to wear during your surgery clerkship. White coats must be worn over scrubs AT ALL TIMES when you are not inside the OR, pre- op, or post-op area. Also note that scrubs are not allowed at all inside the gym, even to the café area to grab coffee.

Additional items to carry in your pockets:
- **Note:** Many teams expect the medical student to carry supplies for wound/surgical site dressing changes. It will be your responsibility to have them handy at all times and start getting the supplies out while the resident is talking to the patient during rounds. Make sure to ask your team what supplies they need on hand at the beginning of the rotation. (You will definitely build up strong shoulder muscles from carrying all the supplies). Some services (like vascular) already have a designated supply bag that they just have you carry during rounds, but make sure it is stocked with everything you need, like:
  - Suture scissors
  - Suture removal kit
  - Steristrips
  - 4x4’s (gauze squares – you can these in the supply room or from the nurse)
  - Abdominal pads
  - Tape (silk and paper)
  - Tegaderm
  - Alcohol swabs
  - Granola bars/snacks and some money/credit card – on surgery services more than any other, you never know when your next opportunity to eat will be, so have supplies on hand and be ready at any time to grab food
Recommended Study Materials:

**NBME SHELF STUDY RESOURCES:**

- **Dr. Pestana’s Surgery Notes:** One of the most used resources for surgery shelf studying. Gives good overviews of the topics most commonly encountered during your rotation and on the NBME. It is small enough to fit in your white coat pocket and scrub back pocket so you can pull it out when you’re waiting for the patient in pre op for 2h with nothing to do. Offers questions in the back, too.
- **Online MedEd** - study all of surgery + GI medicine
- **Uworld** - most students do all of the surgery questions as well as the GI section of medicine and find this very helpful to prep for the surgery shelf. Know trauma/shock/GI medicine concepts very well and this is majority of shelf.
- **note:** While it is a surgical rotation, the majority of she surgery shelf tests MEDICINE aspects surrounding surgical patients. You will not be tested on procedural details etc, but rather the disease processes that require surgical management.
- **Emma Holliday high yield surgery shelf review powerpoint** - made by another medical student at different school for majority of 3rd year shelves & used by many across nation. Great for quick, high yield review the week or so before exam.

**WARDS RESOURCES (to read for rounds/in prep for your OR cases i.e. for pimp questions)**

- **Surgical Recall:** Best for preparing for next day’s cases. Most of the pimp questions will be in this book. Loyola library has PDF version for download; otherwise hard copy costs $60.
- For relevent procedural anatomy- can bust out your old netter or rohen anatomy atlas. Know main bloody and nerve supplies.
- **ORLIVE.com** or **MedlinePlus** surgical videos are also helpful for case prep. Loyola Library website has multiple other free surgery e-text books for reference
- **Dr. Kabaker has a link on the surgery website for WiseMD modules** that can be helpful, brief overview for many common procedures (cholecystectomy, appenedectomy, etc)

**OTHER MISCELLANEOUS RESOURCES (less common, but some people found helpful)**

- **Pre-Test Surgery:** Good for practice questions – large volume, similar in difficulty to UWORLD
- **Lawrence’s Essentials of General Surgery:** Course textbook. The questions at the end of the 4th edition chapters have been known to pop up on the exam from time to time.
- **Surgery: A Case Based Clinical Review** by Christian de Virgilio- large textbook which some people found helpful. Some people just utilize the questions in the back to supplement their main resources.
- **NMS Surgery and/or NMS Surgery Case Files**

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**A Typical Day on Surgery**

- Most of your days will begin at 5am. Technically, you are not supposed to arrive earlier than 5am, but some services will require earlier mornings on certain days.
- Pre-round on your patients – this includes chart reviewing for overnight events, talking with nursing staff, talking to and examining your patient.
  - As a general rule, you will follow patients you were in the OR for
  - Refer to surgery SOAP note below for what questions and data you should gather for
surgical patients - it’s slightly different from the other specialties
  ○ Be sure to document vitals, ins & outs, significant labs, and results from imaging and procedures done overnight.

● In most cases, you will then round with and present to your residents around 6am. Attendings usually don’t come for rounds - it’s run by the senior resident, who later calls the attending over the phone. You may do teaching rounds later in the day or on a designated day each week with your attending, but this is extremely team-dependent.

● When rounds are over, you’ll head to the OR (around 7am) for the day’s cases or to outpatient clinic depending on your team’s schedule for the remainder of the day. (See details below on OR protocol).
  ○ Make sure to divide the OR cases amongst the med students on the team ahead of time - it’s not a good look to be seen figuring out who’s going where an hour before the procedure.
  ○ If you’re on a service where the case schedule for week stays pretty stable (Hines general surgery for example), it is good practice to divide the cases between students the Friday prior.
  ○ If you’re on a service where case schedules change basically by the minute (vascular surgery, ACS) at the minimum have the cases divided night prior. That morning, recheck the cases for the day and reassign as needed. Ultimately, if an emergent case comes in just be flexible and try to split it up as fairly as possible or based on student interest.

● Lectures during surgery occur at 3 or 4pm. You may step out of OR cases or leave clinic to go to lecture, and while some teams will require you to come back to the OR or clinic after lecture is finished, the majority will allow you to go home from there. Just make sure your residents know you have lecture at the beginning of the day. It will feel strange the first time you scrub out of a case to go to lecture but your residents know you have lecture, so ~15 ish minutes before lecture if things are stable just say “I have lecture at 3pm so do you mind if I scrub out.”

● Once you are excused for the day, be sure to spend some time reading about your cases for the following day or about the cases and procedures you participated in that day. If you were “pimped” on a particular topic in the OR during a case, read up about it that night as it is likely you will be asked about it by your attending again in the future.

Heading to the OR - Student Responsibilities

● Coordinate with other med students on the team at the beginning of each week to divide up OR cases and clinic duties so that everything is covered fairly and adequately. Recheck the OR schedule daily to ensure there were no changes made to that day or the next day’s cases.

● Before leaving the OR locker room, make sure to have scrubs and a hat on. Clip your pager to your scrubs and always have your Loyola ID on you (or you won’t be able to get back into the locker room later!). You should also carry a scrap sheet of paper and a pen in your scrubs. You can also keep Pestanas handy in your back scrub pocket.

● Meet your patient in the pre-op area. This is extremely important and one of your main roles on the team - to wait for the patient to go back to the OR. You may hear people refer to this as “bird-dogging.” Introduce yourself and tell the patient you are a medical student who will be observing the procedure for the day. Remain nearby the patient’s room until they are ready to “roll back” to the OR. This is great down time that you can use to either read about the procedure or read pestanas, just keep an eye out for when your patient rolls back. Assist anesthesia in rolling the patient the patient back by pushing the bed, opening the doors, etc.

● When rolling back, page/text your residents immediately to let them know patient is rolling back.

● Put a mask on before you enter the OR with the patient. As long as the patient is in the OR, you should have a mask on.

● In the OR, introduce yourself to the scrub and circulating nurses, help transfer the patient off the bed, pull the bed out into the hallway. Try to be as friendly as possible as they can make or break your OR experience. It’s
also polite to ask if they’d like you to “pull your gown/gloves” (get your own sterile gloves from the cabinet).

- After grabbing your glove size from the cabinet, to put it on the sterile field without contaminating pull down the sides of the packaging without touching the gloves on inside with your unsterile hands, then flip or shake the gloves out onto the sterile table. If you have any questions about this process, just ask the scrub nurse i.e. “is it okay if i put my gloves here” and they’ll ensure you do it right without contaminating everything. Better to ask them for help than risk contaminating the entire field.

- Information to write on the white board in every OR:
  - Patient name and MRN
  - Name of procedure
  - Attending, Resident, and Medical Student names - make sure to write your name as the nurses need it for documentation

- Offer to insert the Foley catheter; if you haven’t done this before and are asked to do so, ask for help. You are not expected to know it all on the first day.

- Be careful not to touch anything that is sterile (blue) unless you are scrubbed. You will wait to scrub in until your attending and resident are ready to do so.

- During the procedure, be next to your resident unless told to go otherwise. Most attendings/residents are great about telling you the best place for you to stand. Then, either keep your hands directly on the patient (this signifies you’re willing and ready to help whenever needed) or if there’s a big team you can rest your hands on your chest to remain sterile. Take direction from your resident or attending to help with whatever the need.

- When the case is finished, stay with the patient. Help the OR staff clean the patient and transfer them to a rolling bed. Help move them to post-op and write the Operative Brief Note as soon as possible (see below - some teams don’t require you to do this). Being an active participant in this post-op process is not only expected, but will reflect well on you and your colleagues and will often endear you to the OR staff.

- If you are feeling dizzy or sick in the OR at any time, be sure to tell someone. Do NOT be ashamed if you feel the need to step out. Operations can sometimes last 8+ hours and it is impossible to avoid some of your body’s natural reactions. Better to excuse yourself than to risk compromising the sterile field by falling onto the patient in the middle of surgery.

**Surgery Clinic**

There will be clinic at least once a week for most of the surgical services. Some services can get crazy busy and see up to 60 patients a day. This is one of the few times where your work will genuinely be helpful to the team, as the attending usually uses your notes. Clinic times and how they’re run vary depending on the service. Some attendings want you to see the patients and others just want you to shadow. Some will have templates for taking histories, some will log you into their EPIC account to type notes directly from there, and some don’t want you to write notes at all. Some will allow you to present and some want a succinct one-liner about what is happening with the patient. Ask your residents about the flow of clinic and try to be adaptable. Also, come in clinic clothes and not scrubs for clinic days; you will still wear your long white coat.

**In General**

Surgeons are to the point. This becomes relevant during rounds when your attending cuts you off during your presentation or when your resident interrupts your brilliant, long- thought-out A/P and walks into the patient’s room without so much as a “nice job.” You will have to develop a thicker skin, as not every attending or resident will be cordial. But not every attending and resident will be a jerk either, despite plenty of rumors to the contrary. Surgery is filled with conscientious, hard-working people who have a lot to accomplish in a short period of time. Surgeries start at 7am, and you need to cruise through rounds to get to the OR ASAP. Remember that perceived rudeness is rarely personal; everyone is just trying to get work done as efficiently as possible. You will quickly learn who
you can ask questions of, who you can turn to for help (hint: interns are a great start!), who has a sense of humor, and vice versa.

Personal note— I was dreading my surgery clerkship. I figured I’d just get through it but at the end of doing 2 of the more grueling services, I can honestly say it was one of my favorite, if not my favorite, rotations of third year and the residents I had on surgery were by far some of the best teachers to date. (Still not pursuing surgery because I love EM more but just shows that it does not have to be a miserable experience).

What’s the deal with call?

- Throughout the course of the 8 weeks, you will be required to take trauma call 2 times, either 12-hour daytime or overnight
- Weekday call (M-F) begins at 6pm and ends at 6am the following day. You will then round with your normal team that morning and then have the rest of the day off (post call). If your team forgets that you had call overnight (ie. After morning rounds, they don’t dismiss you), don’t hesitate to bring it up/remind them as it’s a rule that you must have post call.
- Weekend call (Saturday and Sunday) is either 6am to 6pm the same day or 6pm to 6am the following day (there will be one student on the day shift and one overnight). If you work Sunday overnight, you have Monday post call.
- You will arrange to get the trauma pager from the student that was on call just before you (text them to meet you or have them leave it somewhere i.e. the call room, your community mailbox). Whenever there’s an incoming trauma, everyone on the team (including you) will receive the same page - report to trauma bay in the ER ASAP. You will get more information about this during your orientation.
- In most cases, your experience on call will depend entirely on your own initiative. If no traumas occur during that shift and your service isn’t especially active overnight (Plastics, Pediatrics, Endocrine, etc.), it will be up to you to seek out learning experiences. If there’s a cool surgery going on at night (ie. transplant), feel free to pop in and ask if you can observe. There will be no one looking over your shoulder to see if you are seeking out ways to be involved.

Tips for Success:

- **For the OR, know your patients.** Know their full history and physical, how they presented to clinic initially, the basics of the procedure for the day, and how you will manage them afterwards. Prepare for the case the night before by reviewing anatomy and going through the relevant portions in *Surgical Recall* - blood supply, innervation, and basic anatomy are high-yield questions in the OR.
- **Always make an educated guess.** Even if you do prepare, you will often be asked questions you don’t know the answer to. Try to avoid saying “I don’t know” as much as possible. Again, *Surgical Recall* is a fantastic resource for the most common “pimping questions” you will encounter on this rotation.
- **Eat a good breakfast** before going to the OR. Lunch is often much later than you want it to be, or sometimes forgotten all-together, so you want to make sure you have enough to sustain you throughout the entire morning.
- **Learn how and when to cut sutures during an operation.** Every resident and attending will tell you a different technique, so don’t take it personally when you cut “incorrectly.” You will get used to their different preferences in time.
- **Learn how to suture and be ready to do so when asked.** You never know when you will get the chance to help close after an operation, and it looks incredibly impressive if you know how to suture and tie on your first try.
- **Be confident.** Because of their line of work, surgeons exude confidence - if you don’t do the same, you run the risk of getting overlooked by your team. That doesn’t mean you have to interrupt or be a jerk! Try and avoid the habit of answering questions directed at you with a question mark. **Even if you aren’t sure of the answer, be**
gloriously, confidently wrong. During presentations, speak up, be succinct, and command the room with your presence. Trust your physical exam findings, and when asked about management, say how you would want to manage the patient, not what you think the team wants to hear.

- **Work hard and anticipate the needs of your team.** Surgeons are efficient and to the point. They appreciate medical students who are the same. If you try and make the lives of your residents easier, they will be more likely to want to teach you and let you do more things in the OR. Try and stay out of their way/minimize questions when they’re busy, and always be observant of what your team may need - and provide it to them before they even ask for it for example
  
  - When your team is rounding on a patient who needs a dressing change, have gloves for your team ready while they’re still talking to them, and have the gauze and tape and other supplies all ready to go
  - Offer to call consults/follow up on labs etc for your patients after rounds
  - If your team mentions that they need to hunt down a supply/item for a patient during rounds, offer to do that task right after rounds
  - When your team tells you how to do something, remember it so they don’t repeat it a second time later (especially in the OR, you can be helpful getting the patient ready)
  - Be mindful that while you’re trying to show your team that you’re an eager medical student, there are other students on the team too. **DO NOT steal a task that is meant for another student, especially if it pertains to a patient the are following!** his actually makes you look worse in front of your residents. Nobody likes a gunner. Be a team player and make sure that all the students take turns getting dressing changes ready during rounds.
SURGERY PROGRESS/SOAP NOTE TEMPLATE

24-hour events: Document pertinent events that happened since you last rounded/overnight (if anything). Examples include removal of drains/chest tubes/foleys, pt becoming hemodynamically unstable, pt coding or becoming intubated, etc.

Subjective: Document the patient’s perspective/how they felt overnight. Be sure to include/ask about pain (and look up how much pain meds they took the past 24h), shortness of breath, chest pain, nausea/vomiting, bowel movement, flatus, fever/chills, urination (burning? foley?), and ambulation for all post op patients

Objective
Vitals: Current temp/Tmax from last 24h/BP/RR/HR/O2 Sat

I/O (24h): Patient “ins & outs”— fluids, urine, stool, emesis, NG tube, chest tube (important for thoracic), drains (surgeons are obsessed with drain output. Make sure to report the output and what the liquid looks like - bloody, bilious, serosanguinous, etc)

Physical Exam: (At minimum do heart, lung, abdomen exam + anything else pertinent to your specific patient)
  • Gen: A&Ox3, NAD (alert/oriented to person, place, time - no apparent distress)
  • CV: RRR, nl S1, S2, no m/g/r appreciated (rate and rhythm regular, normal S1/S2, no murmurs/gallops/rubs)
  • Pulm: CTAB (clear to auscultation bilaterally), no crackles or wheezes, no increased WOB (work of breathing)
  • Abd: Soft, NTND (non tender, non distended), +BS (bowel sounds), no HSM (hepatosplenomegaly)
  • Incision: Clean, dry, intact. Serosanguinous drain output, no leakage. Non erythematous
  • Extremities: No edema, distal pulses intact in all 4 extremities

Medications: Note changes in meds or dosing, especially fluids and pain regimen

Labs: Have results from the past 3 days. It’s all about the trends - are values uptrending, downtrending, stable?

Cultures: List any new cultures (blood, urine, stool, etc) that came back from the day prior

Images: New radiology reports. Just having the impression portion of the radiology result will suffice

Assessment: *** is a ***y/o ***female/male with PMHx significant for ***xyz post-op day #*** from a ***surgery for *** pathology. (exactly how the resident has it on the post op note). Then briefly describe post op hospital course, complications if any, how they’re doing (is the pain well controlled?).

Plan: Surgery goes by body system rather than by problem
  • Neurologic: Awake and alert
  • Pain Control: ***
  • Pulmonary: Non labored breathing. Encourage OOB (out of bed)/spirometry***
  • Cardiovascular: HDS***
  • Hematology: Hb stable***
  • Gastrointestinal: ***
  • GI prophylaxis: ***

SAS: Crash Course for 3rd Year
FEN: Fluids @ ***. Replete lytes prn. NPO/CLD/general diet***
GU: Adequate urine output***
Infect Disease: WBC stable***
Endocrine: ***
Wound care: ***
Consults: ***
Dispo: Stable on***

Patient was seen and discussed with Dr. ***
[Your Name] MS3, pager#
Choosing your Elective

As of the 2011-12 academic year, a 4-week elective was added to the third year calendar to give students an opportunity to explore a specialty they may be interested in as a career but otherwise would not be exposed to before the fourth year.

If you are completing the Honors in Research program, you will be required to use this month for research.

Otherwise, it is in your best interest to read about different, non-core clerkship medical specialties to see if there are any you would like to try before making your decision of which specialty to apply to for residency. Besides Family, Internal Medicine, Neurology, OB/GYN, Pediatrics, Psychiatry, and General Surgery, other residencies you can apply to (not including combo programs like Med/Peds) include:

- Anesthesiology
- Child Neurology
- Dermatology
- Emergency Medicine
- Neurological Surgery
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology (ENT)
- Pathology
- Physical Medicine & Rehabilitation (PM&R)
- Plastic Surgery
- Radiation Oncology
- Radiology – Diagnostic
- Thoracic Surgery
- Urology

Gaining exposure to one of these fields during your 4-week third year elective will help you make that decision and is the best use of your elective time. You will have plenty of elective time fourth year for taking courses you believe will strengthen your skills as a doctor, so it is best instead to use the third year time to investigate a career possibility.

To find out what other students thought about an elective you are interested in, check out the elective review page on myLumen (myLumen → elective registration → internal elective evaluations)

Register for your elective on myLumen (myLumen → elective registration → register for elective courses). Note that some electives have prerequisites or require a letter of intent to be submitted.
And finally…

You’re a third year.
APPENDIX: Scut Sheets

For a sample complete H&P and SOAP note, see the Internal Medicine section, then adapt the note as needed for your specific clerkship.

For scut sheets for other rotations or for different formats use the website:

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SAS: Crash Course for 3rd Year