

**Doctors
Manitoba**

mm\$A | Manitoba Medical
Students' Association

Clerkship Guide

Class of 2025

Congratulations Class of 2025!

You have made it through Years 1 and 2 – you have studied extraordinarily hard, learned a mountain of material, and are now ready to begin the next chapter of your adventure in medicine. This year, you will have a chance to put all that you have learned over the past two years into practice in real-world patient settings, and to learn some of the practical aspects of health care delivery. You will meet real patients and participate in their care. The learning will be some of the best you will have, and with that will come added responsibility.

The purpose of this Guide is to walk you through the year, one step at a time – first explaining the basics of the Clerkship program and of the health-care team, and then breaking down each core clinical rotation to help demystify the process. Whatever questions you have, whether it is how to dress, how call works on a specific rotation, or even what a confusing abbreviation means, we hope that this guide will be able to answer most of them for you. Rotating through new specialties each six weeks can feel overwhelming, and our goal with this Guide is to make the process feel as seamless as possible.

If you have a question whose answer did not make it into this guide, feel free to contact any of our Class Council, who would be more than happy to assist you.

Wishing you the best of luck!

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Section 1: Overview of Clerkship

Clerkship is your one-year introduction to clinical practice. It puts you in the driver's seat and allows you to have meaningful patient interactions, practice your physical exam and history taking skills, learn the mechanics of the hospitals, and start making real decisions surrounding patient care.

There are **two main goals** of Clerkship:

- 01 Learning. You will learn A LOT during your clerkship, both on and off the ward. Make sure to take full advantage!
- 02 Being a Part of the Team. As a Clerk, you are a valuable, and in some cases indispensable, member of the healthcare team. As such, you will be expected to fulfill your responsibilities (these will be laid out later on in this Guidebook), and to dedicate time and energy into patient care.

Clerkship is divided into eight core rotations, each lasting six weeks. Some rotations are further subdivided into inpatient and outpatient portions, or into different subspecialties (discussed further below). Over the course of the year, you will have two weeks off over the winter holidays and two weeks off in August for summer break.

Assessment: Periodically throughout Clerkship, you will write six **NBMEs – National Board of Medical Examiners** examinations, occurring at the end of most core rotations (except Emergency Medicine which does not have an NBME). These are specialty-specific American exams that test your knowledge of the given specialty. The exams you will write are: Pediatrics, Obstetrics/Gynecology, Internal Medicine, Family Medicine, Psychiatry, and Surgery. You will also have an end-of-year **CCE**, which is an OSCE-style examination.

Section II: Overview of the Hospitals and On-Site Services

The Hospitals

Of the hospitals in Winnipeg, you will spend most of your time at the two tertiary care centres: Health Sciences Centre and St. Boniface General Hospital. Other rotations, clinical exposures, or learning experiences may take you to Grace General Hospital, Concordia Health Centre, Victoria Health Centre, Seven Oaks Health Centre, and/or Misericordia Health Centre, as well as various clinics, rehabilitation centres, and long-term care centres in the city.

Health Sciences Centre (HSC) is the largest hospital in Manitoba and serves residents of Manitoba, Saskatchewan, northwest Ontario, and Nunavut. HSC is the main trauma centre for the province, and as such, all trauma emergencies are triaged to HSC. It is also home to the Children's Hospital, Manitoba CancerCare, and Women's Hospital, among many other services. All charting at HSC is done with paper charts, except for the emergency rooms, Women's Hospital, and several outpatient clinics. Clerkship students may be at HSC for Surgery, Surgical Subspecialties, Perioperative Medicine, Orthopedics, Pediatrics (all students), Obstetrics/ Gynecology, Internal Medicine, Emergency Medicine, and Psychiatry rotations.

St. Boniface General Hospital (SBGH) is the other main tertiary care centre in Manitoba. St. Boniface is the main cardiac centre in the province, and as such, most cardiac cases are triaged to St. Boniface if possible, for access to cardiac catheterization services. It is the other main obstetrics site in the province, along with the Women's Hospital at HSC. Clerkship students may be at SBGH for Surgery, Surgical Subspecialties, Perioperative Medicine, Obstetrics/Gynecology, Internal Medicine, Emergency Medicine, and Psychiatry rotations.

Grace General Hospital (GGH) is a community hospital in the west end of Winnipeg. Along with HSC and SBGH, it houses the other main emergency department in the city, and houses inpatient beds, surgical specialties, an intensive care unit, and an urgent care centre.

Clerkship students may be at GGH for Surgery, Anesthesia, Gynecology, Orthopedics, and Emergency Medicine rotations or experiences.

Concordia Health Centre is a community hospital in the northeast end of Winnipeg. It is the main site for hip and knee orthopedics; this is the main exposure students will have to this hospital. The Concordia Hospital Emergency Room transitioned to an Urgent Care Centre in June 2019. Clerkship students may be at Concordia for Anesthesia and Orthopedics rotations or experiences.

Victoria Health Centre is a community hospital in the south end of Winnipeg. It has recently transitioned to a new psychiatry centre in Winnipeg, but also houses inpatient beds, surgical specialties, and an urgent care centre.

Clerkship students may be at GGH for Surgery, Anesthesia, Gynecology, and Orthopedics rotations or experiences.

Seven Oaks Health Centre is a community hospital located in the north-east end of Winnipeg. It houses inpatient beds, surgical specialties, and an urgent care centre. Students do not have regular rotations at this site but may attend clinics or other learning experiences out of this facility.

Misericordia Health Centre is a community hospital and care centre in West Broadway and is the main ophthalmology centre in the city.

Students will attend ophthalmology clinics and/ or ORs out of this site.

Workplace Health and Safety

If you sustain an injury at work (including a needle stick injury, scratch, or other possible contact with patient bodily fluids):

01 Obtain immediate first aid as required for injury.

- Puncture injuries and lacerations (including needle sticks): Wash thoroughly with soap and water; cover area with sterile dressing if necessary.
- Eye/ mucosa splash or exposure to non-intact, abraded or chapped skin: Flush with water for 15 minutes
- Chemical exposure: Refer to Workplace Hazardous Materials Information System (WHMIS) materials; contact clinical supervisor to access.

02 Report incident to parties listed below; participate in post exposure protocols as required.

Clinical supervisor: all blood/ bodily fluid exposures, exposures to infectious diseases, chemical exposures, severe injuries

Occupational Health: for medical assessment and incident investigation:

- **Bannatyne Campus or HSC / Children's / Psych Health:**
 - Occupational and Environmental Safety & Health (OESH), 204-787-3312
- **St. Boniface Hospital:** 204-237-2439
- **After hours:** Phone the above and leave name, phone number, and description of exposure. Attend local emergency department for post- exposure prophylaxis if necessary.
- **Outside of Winnipeg:** Discuss with clinical supervisor where to obtain assessment.

03 UM Environmental Health and Safety Office

Report all injuries requiring medical assessment regardless of nature of exposure or setting: **204-474-6633** or **EHSO@umanitoba.ca**

If immunization status record is needed, contact Immunization Program Office: 204-480-1305 or **immune@umanitoba.ca**

Safe Walk/ Safe Ride

When working after hours, Security Services offers the Safe Ride and Safe Walk program to drive or escort you to your vehicle.

Safe Ride is offered Monday to Friday until 12:00am. Outside of these hours, the Safe Walk Program can still escort you to your vehicle within Bannatyne Campus boundaries.



Safe Ride Service Boundaries:

- North to Logan Ave South to Sargent Ave
- West to McPhillips Street and Banning Street East to Isabel Avenue

To request a Safe Ride or Safe Walk, call 204-474-9312.

In addition to these services, there is a free safety app designed by the University of Manitoba that you can download onto your phone: UM Safe. This app has been designed to serve as an additional safety mechanism for when students are working alone or are walking/from their vehicles at night. In addition, you can also use the app to request a Safe Walk or Safe Ride.

After Hours Food Options

HSC

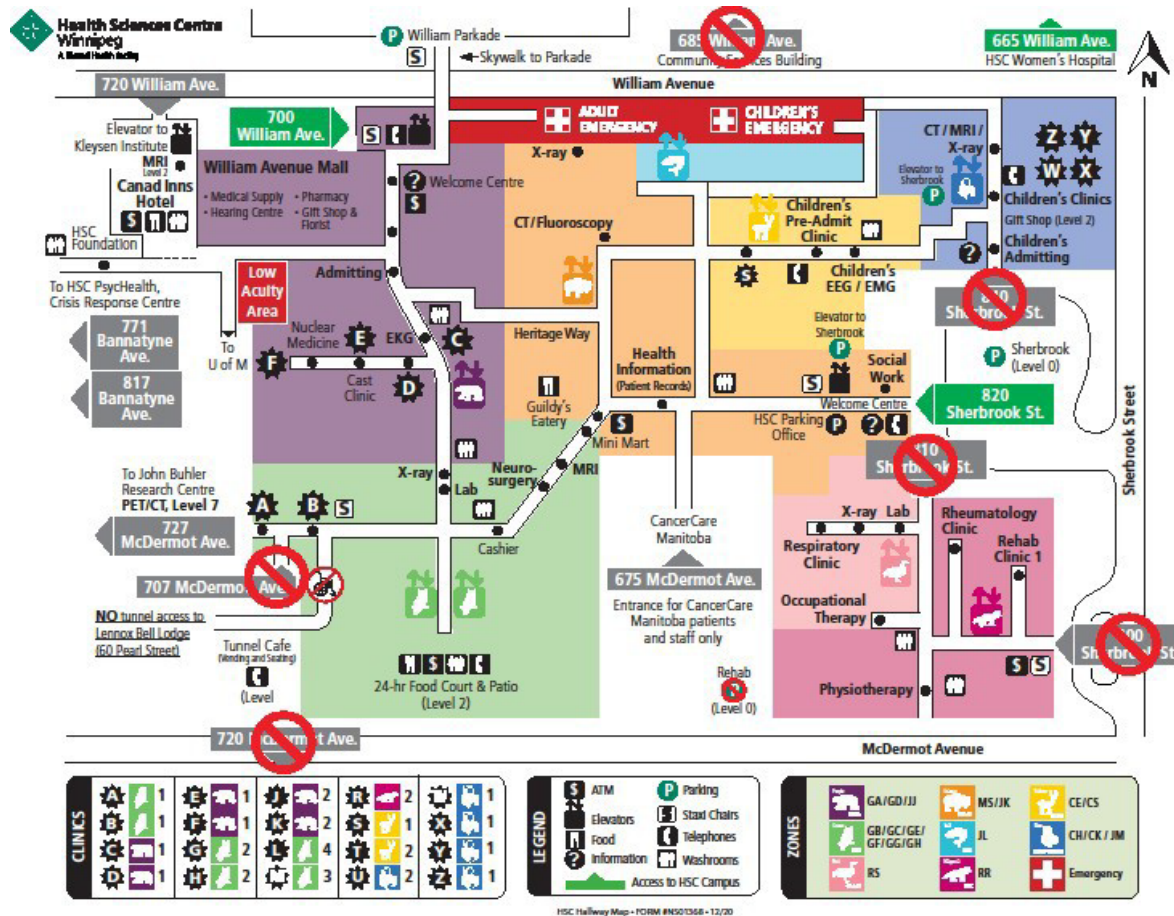
- 24-Hour Food Court (Green Owl Zone, Level 2)
- Includes Chef's Centre (open until 7:00pm), Salisbury House (open until 8:00pm), and Tim Horton's (open 24 hours)
- Tip: if you are working overnight, you can request "night menu" options from Tim Horton's which will include anything that is stored in the fridges overnight and some select hot meals (ex: Chicken Quesadilla, grilled cheese).
- Starbucks (Canad Inns)
- Open 24 hours
- Garbonzo's Sports Pub (Canad Inns)
- Open until 2:00am
- Aaltos Garden Cafe (Canad Inns)
- Open until 9:00pm

St Boniface

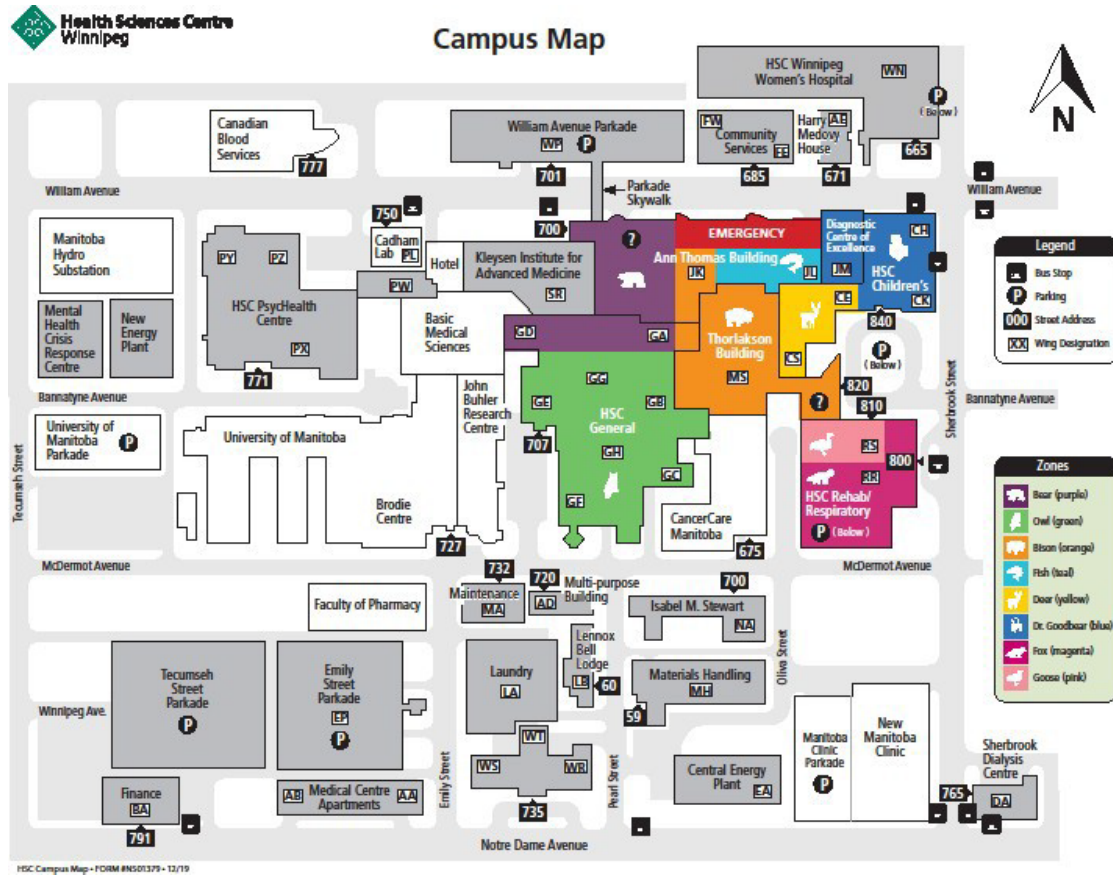
- Robin's (South Entrance) - Open 24 hours

Maps

HSC Hallway Map



HSC Campus Map



St Boniface



Hôpital St-Boniface Hospital

Welcome to St. Boniface Hospital

Several buildings are part of the hospital, including

Education Building (N)
McEwen Building (M)

Albrechtsen Research Centre (R)
Asper Institute (CR)

Access the main hospital through one of two public entrances:

Main Entrance

South Entrance



St Boniface

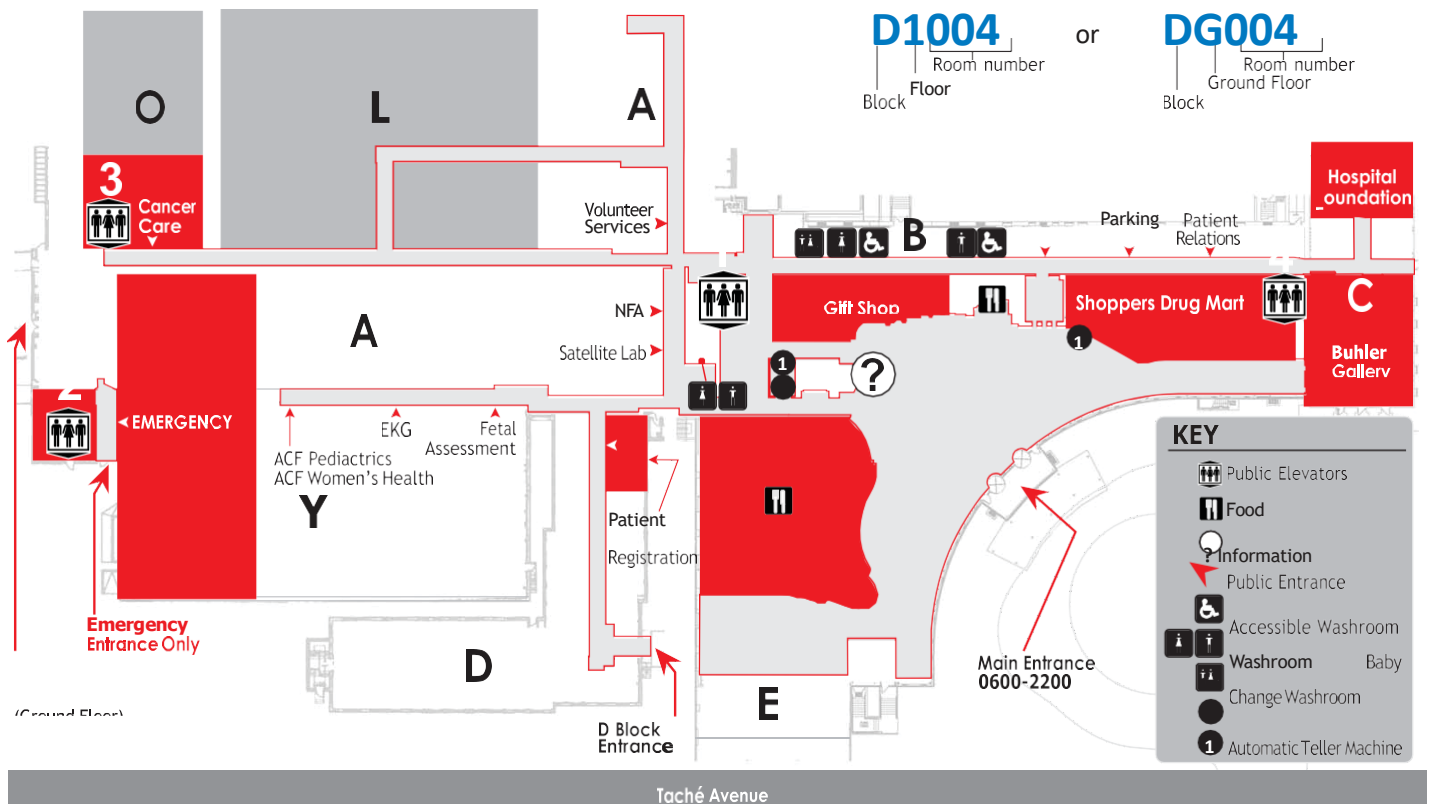
Elevators	
W	1 A, B, D, E blocks
S	2 Y Block
E	3 O Block



Hôpital St-Boniface Hospital

Main Floor and Elevators

To locate where you need to go, please note the following:

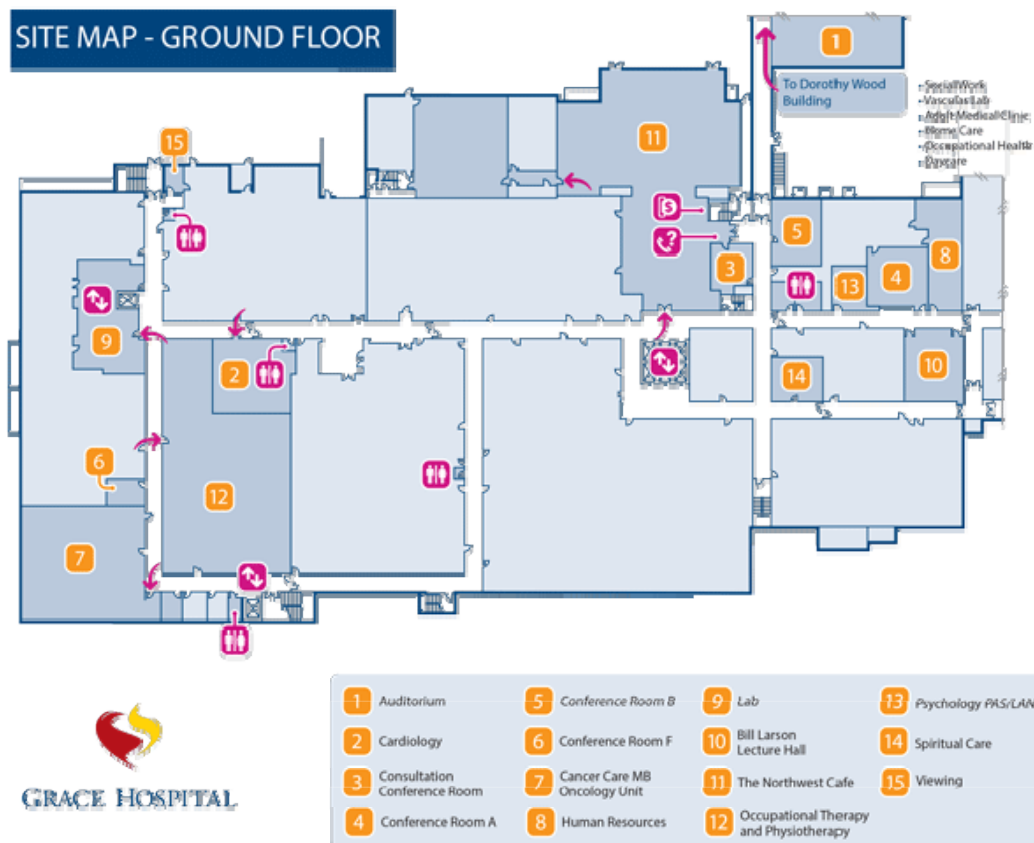


St. Boniface

Service/Department	Location	Entrance	Elevator
ACF Medicine	E 4	Main	1
ACF Pediatrics	Y 1203	D	
ACF Surgery	E 4	Main	1
ACF Women's Health	Y 1203	D	
Albrechtsen Research Centre	R	351 Taché	
Andrei Sakharov MRI Centre	MRI	355 Taché	
Asper Institute	CR	369 Taché	
Bergen Cardiac Care Centre	Y 2	South	2
Buhler Gallery	C 1	Main	
Café Marché (Retail Food Services)	Everett Atrium	Main	
CancerCare Manitoba	O 1005	South	
Cardiac Clinics	Y 2	South	2
Cardiac Surgery Clinics	CR 1015	369 Taché	
Cashier/Patient Accounts	A 1108	Main	
Chapel	C 2	Main	4
Clinical Neurophysiology	L 1010	Main	
CT Scan	O 2081	South	3
Echo Clinic	Y 2	South	2
Education Building	N	Main	
Emergency	Y 1	Emergency	
Emergency - Mid to Low Acuity (MLA)	Y 1	Emergency	
Everett Atrium		Main	
Fetal Assessment	Y 1501	Main	
Food Services, Retail	Everett Atrium	Main	
Foundation, St. Boniface Hospital	C 1026	Main	
Gift Shop	Everett Atrium	Main	
Health Care Ethics Service	A 1125	Main	
Inquiry Desk	Everett Atrium	Main	
Library, Patient/Staff	D 1034	D	
Lost and Found	B 1027A	Main	
Magnetic Resonance Imaging (MRI)	MRI	355 Taché	
McEwen Building	M	363 Taché	

Mental Health	M	363 Taché	
Obstetrical Triage	E 3004	Main	1
Pacemaker/Defibrillator Clinic	Y 2045	South	2
Parking Office	B 1039	Main	
Patient Registration/Admission	D 1004	D	
Patient Relations	B 1047	Main	
Psychiatry	M	363 Taché	
Research Centre, Albrechtsen	R	351 Taché	
Restaurants	Everett Atrium	Main	
Robins (coffee and food)		South	
Robins (coffee and food)		Main	
Sam Cohen Auditorium	R	351 Taché	
Security	B 1027A	Main	
Shoppers Drug Mart	Everett Atrium	Main	
Ultrasound	O 2047	South	3
Volunteer Services	A 1113	Main	

Grace Hospital



Paid Parking Options

HSC

The parking office at HSC is located near the 820 Sherbrook St entrance and is open Monday-Friday 8:00am-4:00pm. There are six parkades associated with HSC. Although the wait list for your preferred parkade was historically anywhere from months to over a year, this wait time has improved in the recent year. We recommend you get yourself on a list as soon as possible if wanting a spot by either going to the parking office or contacting them at hscparking@hsc.mb.ca or 204- 787-2715. A monthly pass is \$110 or \$160 depending on the parkade.

Please note that if you would like discounted parking but do not require a monthly parking pass, weekly passes (for a uniform \$50/week, up to 4 weeks maximum) and parking cards (\$10/day in 10- or 20-day increments) are available as well.

St Boniface

The parking office at St. Boniface is in room B1039, 409 Tache Avenue. They are open 8am-9pm daily. You can call them at 204-237- 2319 or at parking@sbgh.mb.ca if interested in a parking spot in a St. Boniface Hospital parkade. Monthly and weekly rates are \$157.50 and \$52.50 respectively.

If you are interested in having a combined pass that works at both HSC and St. Boniface, call the parking office to set this up. For example, if you already have an HSC monthly parking pass, for an additional \$26.25 you will be granted parking access at St. Boniface as well. Please note that the minimum time commitment for St. Boniface Hospital parking passes is 3 months, regardless of whether the St. Boniface hospital parking pass is purchased alone or as an add-on to an HSC monthly parking pass.

Victoria General Hospital

Free parking is usually made available to students via the program office for the duration of your rotation. To request free parking, you will need to contact the program office in advance of your days on site and provide your vehicle information. Alternatively, you can purchase a weekly (\$40/week) or monthly (\$90/month) pass from the Hospital Foundation, located inside the front entrance Monday-Friday 8:30am-4:30pm).

Seven Oaks General Hospital

Daily visitor parking is \$2.50/hour or \$8/day. Payment for monthly parking can be made at the parking machines in the front entrance to the hospital.

Grace General Hospital

The parking office is in the front entrance and is open 8am-3pm Monday-Friday. You can also call them at 204-827-0721. There are reduced prices for monthly and weekly passes that can be purchased in the front office. Daily 24hr max is \$9, \$2.50/hour. Street parking is available for free if you are willing to walk 2-3 blocks.

Section III: Members of the Team

The attending is the physician in charge of a given service. They are ultimately legally responsible for all patients on their service, and typically deal with high-level issues such as speaking with other attendings involved in the patient's care or attending family conferences. Some attendings choose to run clinics during the days and may, therefore, be unable to round with the team each morning. Attendings typically rotate on a weekly or biweekly basis, so you will have a new one every 1-2 weeks. For each core rotation, you will be assigned a Service Attending and this is the person you will meet with for your MITER/FITER review.

The senior resident, typically an R2 or above, is the resident leading the team. This resident typically leads rounds, is on the floor dealing with day-to-day tasks on the ward and is your point-person as a Clerk. They are the ones to go to for signing orders, or if you have any questions during the rotation.

The junior resident, usually an R1 or off-service resident, is one of the team members responsible for seeing patients, writing orders, and making treatment decisions in conjunction with the rest of the team. They were recently med students, so they are great people to ask questions of and to show you how things work.

Nurses will be found on every ward (often wearing scrubs) and are very important members of the treatment team. Their job is to administer medications, ensure patients are comfortable, insert IVs, feed patients, change dressings – basically all the practical things that need to be done to ensure patients do well in hospital. They also keep records of everything they do, so they are excellent people to ask about patient comfort, the medications a patient is getting, or any concerns that may not be charted.

The charge nurse is the lead nurse on the ward. They know what's going on with every patient and are in charge of coordinating things from the nursing point of view. They also know where everything is on the ward, know when patients come and go, and are great resources as well.

The ward clerk is in charge of processing patient intake and discharge forms, organizing

and updating medical records, answering phone calls and organizing patient assignments and paperwork for doctors and nurses. They, along with the charge nurse, know the most about patient- flow (e.g. where patients are when), and are good people to ask about what paperwork is necessary for a given process.

Many teams will have a **physician's assistant**. PAs go through 2 years of intensive medical training, and typically serve a similar function on the team as a junior resident does – seeing patients, ordering labs and medications, etc.

Some teams will also have a **pharmacist** working in close association with them. The pharmacist keeps track of patients' medications, and will make valuable suggestions about medication choices, contraindications, and labs. They are great people to ask any medication-related questions if you are ever unsure about appropriate dosing or alternatives in patients with contraindications for common medications!

Section IV: Documentation

Admission Orders

Note: when writing orders in a paper chart, the left column is for medications and fluids, and the right is for all else.

A: Admit to _____ (service)
under _____ (attending physician)

D: Diagnosis: _____ (known or suspected diagnosis; if unclear, include most likely or rule-out diagnosis)

- A: ACP Status:
- ACP-C: Comfort
- ACP-M: Medical
- ACP-R: Resuscitation D: Diet:
- DAT (full diet as tolerated)
- NPO (nil per os; nothing by mouth)
- Sips (sips of fluid as tolerated)
- Clear fluids (includes water, juice, broth)
- Full fluids (includes jello, pudding, etc.)
- Advancing diet (NPO, sips, clear fluids, full fluids, DAT)
- PSD (Pediatric Standard Diet – age-appropriate foods for pediatric patients)
- Other: eg. Diabetic diet, Renal diet, Cardiac Diet, soft foods
- Include any dietary restrictions (eg. lactose-free) or religious observations (eg. no pork)

A: Activity:

- AAT (activity as tolerated)
- Walk with assistance.
- Bed rest (include if patient may have bathroom privileges)
- Non-weight bearing (NWB) or full-weight bearing (FWB) (specify limb)
- Other: C-spine precautions, physiotherapy, etc. Specify clearly if patients to be ambulating/ sitting a certain number of times per day.

V: Vital signs (includes heart rate, respiratory rate, blood pressure, oxygen saturation, temperature)

- VSR: Vital signs routine (q8-12 hours or per nursing shift)
- q_h (eg. q1h, q4h)
- Other: include if neuro vitals, postural vitals, etc.)

I: Investigations:

This can include many investigations. Common categories include (but aren't limited to):

- Hematology: (eg. CBC +/- differential, PT/INR)
- Biochemistry (eg. Electrolytes CHEM7 (Na+, K+, Cl-, HCO3-, urea, creatinine, glucose), extended electrolytes CHEM10 (electrolytes + Ca2+, Mg2+, PO4-), etc.
- Microbiology (eg. blood cultures x 2, CSF culture, etc.)
- Imaging (eg. XR, CT, MRI, EKG, PFT, Spirometry, etc.)
- Consultations (eg. Social Work, Cardiology, Physiotherapy)

I: IV fluids (type, rate (cc/hr), duration, and additives (if applicable))

I: Ins and outs (if applicable)

- +/- daily weights if needed
- Accurate urine output

D: Drugs: (medication name, route, dose*, frequency)

- Previous:
 - If at HSC, will be filled out on a Medication Requisition – see “DPIN/ Medication Requisition below”
 - If at St. Boniface, enter past medications with other medications
- Present: Any medications new upon admission
- Future: Consider the “P’s” for possible future needs:
 - Pain (analgesics)
 - Puke (anti-emetic)
 - Prophylaxis (anti-coagulants)
 - Pus (antibiotics)
 - Poop (laxatives)
 - Pillow (sedation)

For Pediatric patients:

- Include the patient's weight on every order sheet
- Medications, IV fluids, etc. are dosed based on weight; thus, each medication order should be written **per kg** (eg. Tylenol PO 10-15mg/kg/dose q4-6h PRN)

Note:

- All orders (including medication requisitions) **must** be signed by a resident, PA, or attending physician prior to being processed.
- Include any patient allergies on every order sheet (including reaction if known)
- Lead don't follow: Use leading zeroes (eg. '0.1 mg' = good) but not trailing zeroes (eg. '10.0 mg' = bad)
- Avoid confusing abbreviations: eg. write 'daily' instead of OD, as OD also means 'right eye'; write 'sub cut' as opposed to 'SC'. Common acronyms that are to be avoided can be found on the back of order sheets, it is worth reading through this once or twice.
- Be sure to carefully consider each order's utility and purpose – eg. frequency of vital signs, frequency of bloodwork, etc. This is important to reduce the number of unnecessary tests and blood draws, improve efficiency of staffing (eg. nursing, phlebotomy), and most importantly, reduce the number of invasive tests and/ or discomfort to your patient (as per Choosing Wisely Canada guidelines.)

Notes

Note: these templates are intended to provide a resource to refer to when creating your own notes. Each physician has their own preferences and may prefer them to be arranged differently than as presented below. The following is intended to be used as a guide, not a rule.

Admission H&P

Patient ID: name, age, sex, brief relevant PMHx (if applicable) and presenting complaint/ chief complaint

- Include home community if not Winnipeg (eg. Thompson, MB)
- Include preferred pronouns and preferred name if applicable.

History

History of Presenting Illness (HPI):

- A brief overview of presenting complaint, from baseline to presentation. Should include enough relevant information to form a differential diagnosis and rule in/ rule out any concerning causes
- May supplement with OLD CARTS (Onset, Location, Duration, Character, Aggravating/Alleviating, Radiation, Timing, Severity) or other qualifiers if relevant

Past Medical History (PMHx):

- Try to list in order of relevance, including date of onset

Past Surgical History (PSxHx):

- Include date of procedure if known
- May go above PMHx for surgical notes, or combined with PMHx if preferred

Medications:

- Include name, route, dosage, and frequency
- Be sure to ask about past and present medications (as seen on DPIN), as well as compliance (if the patient is taking all, some, or none of the medications as prescribed)
- Include over the counter (OTC) medications with frequency of use, vitamins, and supplements

Allergies:

- Include reaction if known

- If no allergies, write NKDA (no known drug allergies)

Social History:

- Include occupation/ income source (employment, welfare, etc.), relationship status, living situation, IADLs/ ADLs
- Include pastimes or hobbies if relevant to presenting complaint.
- Include smoking history, alcohol use, marijuana use, and illicit drug use.

Family History:

- May include depiction of family tree if relevant.

Physical Examination

- Vital Signs: HR, RR, BP, Temperature, O2 Sats
- Avoid 'AVSS' (afebrile, vital signs stable) if possible – may not provide an accurate depiction of patient
- General appearance: well appearing, unwell, acute distress, etc.
- Pertinent positive/ negative exam findings
- May organize by system (eg. CV, Resp, Neuro, etc.)

Investigations

- Labs
- Imaging
- Other (eg. EKG)

Assessment and Plan

- May separate these sections or include together. Often written as a numerical problem list, with each point including its own differential diagnosis and plan

Addendums to Admission Notes Obstetrics/ Gynecology

- ID: include Rh status and GBS status, if known
- Obstetrical History:
- Gs and Ps: G (gravida - # of times pregnant), P (parity - # of deliveries < 20 weeks)
- Provide detail regarding each delivery, including GA at delivery, birth weight, method of delivery (vaginal/ C- section), assists, complications etc.

- Provide relevant details of pregnancy, including method of conception (if IVF, etc.) complications, etc.
- Dating of pregnancy: state EDC (estimated date of confinement, or due date), method used (last menstrual period or ultrasound dating)
- State if patient has had an ultrasound in this pregnancy.

Gynecologic History

Age of menarche

- Date of last normal menstrual period (LNMP)
- Frequency, duration, heaviness, etc.
- Method of contraception if patient is sexually active.
- History of sexually transmitted diseases (STIs) and treatments

Pediatrics

HPI:

- Include hydration status (eg. change in # wet diapers, BMs, fluid intake)

Birth History:

- Include description of pregnancy, delivery, post-partum period
- Include birth weight and APGAR scores if known.

Immunization Status:

- Include status of siblings/ contacts if unimmunized

Developmental History:

- Include milestones achieved, performance in school, etc.

Family History

- Include consanguinity/ family tree, history of childhood deaths, etc.

Adolescent History:

- HEADDSS: (home, education/ employment, activities, drugs/ alcohol, diet/ dieting, sexuality, suicide/ safety)

Physical Exam:

- Anthropometrics: Weight, height, head circumference, and growth curve
- Specific for age: reflexes (if present), fontanelles, hips, Tanner stage, etc.

Psychiatry

HPI:

- Screen for depression, mania, anxiety, psychosis, substance use, suicidal/ homicidal intent

Past Psychiatric History:

- Include diagnoses, treatment (including past and/ or ineffective treatments), hospitalizations, etc.

Forensic History

- Include past incarceration/ criminal activity

Mental Status Exam:

- ASEPTIC: Appearance/ behavior, Speech, Emotion (Mood/ Affect), Perception, Thought Content/ Process, Insight/ Judgement, Cognition

Progress Note

ID: One-sentence summary of patient, including age and diagnosis

S (subjective): How the patient feels; may be written in their own words

O (objective): Objective findings of patient, including physical exam, vital signs, ins/outs, investigations, etc.

A (assessment): Interpretation of the subjective and objective findings, including how they compare to previous

P (plan): Management plan, including new investigations or orders to be initiated

Operative Note

Pre-op Diagnosis: diagnosis at time of surgery

Post-op Diagnosis: diagnosis post- surgery (sometimes it's the same as pre-op diagnosis)

Procedure: name of procedure

Surgeon / Assistants: all surgeons, residents and medical students

Anesthesia / Anesthetist: general, epidural, spinal, local, etc. Attending, resident and/ or student anesthetists

Findings: eg. abscess, tumour (size, location, mets), etc.

Ins / Outs / Fluids: blood products, etc. – from anesthetic record

Estimated blood loss (EBL): blood loss during surgery – ask anesthesia or check record

Drains: site and type, if applicable

Specimens: type of specimen and where sent, if applicable

Complications: listed if applicable

Disposition: eg. stable to PACU, to ICU, etc.

Procedure Note

Procedure: name of procedure

Consent: benefits, risks, alternatives described to patient and appropriate consent given

Performed by: name of student, resident, or staff performing and assisting with procedure

Sterile technique used and described: type of cleaning solution, draping, etc.

Anesthetic used: eg. local or topical anesthetic, volume used

Complications: listed if applicable

Estimated blood loss (EBL): blood loss during procedure

Disposition: eg. stable on ward

Discharge Summary

A discharge summary should provide an overview of all relevant information so that any other physician who reads the document has an understanding of the patient's course in hospital, any outstanding issues, and further directions to ensure a smooth transition of care.

Patient Identification: patient name, date of birth, medical record number

Admission Date: date of admission, under which service

Discharge Date: date of discharge, total duration of stay

Admission Diagnoses: diagnosis on admission

Discharge Diagnoses: diagnosis/ diagnoses on discharge

HPI: course prior to hospitalization

Problem List: listed numerically

Course in Hospital: course after admission to hospital. May be described chronologically or arranged by problem list. Include consults and procedures if any.

Investigations: list only the most relevant findings

Disposition: eg. to own home, PCH, other hospital, etc.

Discharge Medications:

- Including dose, frequency, length of therapy
- Include modifications to medications, new medications, and discontinued medications

Discharge Instructions: (may be arranged numerically)

- Include diet, activity level, wound care, etc.
- Include signs and symptoms that should prompt patient to return to care

Follow-up:

- List appointments with dates, times, services, and physician (if known). Make it clear if patient is to initiate appointment or if it has been arranged

CC: Include primary care provider and follow-up services, if relevant

Medication Requisitions (Med Reqs)

When seeing patients in emergency, or admitting them to the ward, you may encounter a DPIN (Drug Program Information Network) sheet. This will show all medications prescribed through a community pharmacy (though not those medications from in hospital or nursing stations). Interpreting these is very important to understand the medications a patient has been or is currently taking. Furthermore, it is important to understand how to translate the DPIN into a medication order, written with medication dosages and timing. A sample DPIN is shown below:

Generic Name	Date dispensed	Brand Name	Strength	Quantity	Days	Prescriber	Pharmacy
a) Labetalol	Sept 21, 2018	Trandate	100mg	60.0	30	Dr. J DOE	ABC Pharmacy
b) Azithromycin	Sept 28, 2018	Sandoz Azithromycin	40mg/mL	16.0	4	Dr. J DOE	ABC Pharmacy
		Teva-					
c) Salbutamol	Sept 28, 2018	Salbutamol HFA	100mcg	200.0	30	Dr. J DOE	ABC Pharmacy

There are a few ways to figure out how much medication a patient takes daily, and how often:

- 01 Ask the patient:** This is sometimes the easiest way, though not all patients will know the 'correct' way or times to take their medications.
- 02 Ask pharmacy:** This is an important, and sometimes underutilized resource. Difficult medication questions can be asked to pharmacy by simply paging them.

03 Simple math! To understand the above, look at the Quantity of medication and Days prescribed. The Quantity will be divisible by the Days to tell you how much the patient takes per day. For example:

A Labetalol: 60 tablets for 30 days = 2 tablets/ day ($60/30=2$).

This means the patient is taking 200mg/day. Labetalol is dosed in divided doses BID (as per UpToDate or other medication resources you may use), so this would be ordered as 100mg PO BID

B Azithromycin: This formulation is in a liquid (mg/mL) for pediatric patients. Because these medications are based on weight, math may not always work out to a perfectly even number – it's better to ask the patient or confirm with pharmacy what the dose should be.

C Salbutamol: For any PRN medication (like salbutamol), it's important to ask the patient how often they are taking it to understand how much they are using. When writing the order, use your clinical decision making to know if more than just a PRN is needed.

Section V: How Tos

Read a Chart

The chart is where all information about a given patient is stored. They are either found on EPR, or as a hard copy in flexible blue binders on the ward, organized by room number.

Paper Charts

Paper charts are comprised of several sections:

Advanced Care Plan/Health Care Directive (pink) = contains the patient's health care directive/ACP status paperwork

Admission/Legal Forms (blue) = contains the patient's admission paperwork

Orders (white) = contains all patient orders

Consults (grey) = contains all consult requests (and responses) from various services

Database (green) = contains the admission history and physical, as well as any relevant background information on the patient

IPN/Care Maps (purple) = contains all progress notes

Flow Sheets (yellow) = contains tracking of ins and outs, +/- vital signs

Medication Administration (blue) = contains MARs

Blood and Blood Products (red) = contains consent for any blood products, as well as cross/match results

Laboratory (beige) = contains any hard-copy labs done on the patient

Diagnostics (orange) = contains any imaging/ECG/culture results

Operative Records (light blue) = contains any operative records

There are many ways to read a chart, but if you are unfamiliar with the patient, here is one recommended strategy:

01 Start with the Database. Find the admission history & physical and read it. This will give you a good overview of the patient, including their past medical history, allergies, and the reason they came into hospital.

02 MAR/Orders. These two sections will tell you what medications the patient is currently taking in hospital, how much pain medication they are taking, and any tubes/catheters/lines that are in place. The current MAR will be in a separate binder, usually placed in the nurses area.

03 Consults. Glance over the services that have been consulted for this patient. This will give you helpful information about their course in hospital, as well as whether or not they are on dialysis, on TPN, have been seen by surgery/ID/OT/PT, etc.

04 IPN. Read the last few days of progress notes, to get a sense of what's been going on with the patient lately.

05 Vital Signs. These will give you a sense of how the patient has been doing, vitally, and how they are doing today.

06 Labs/Results. Make sure to look at the trend over the past week or two, not just the labs from today! This will help you identify any outstanding issues (e.g. anemia, electrolyte imbalances, kidney failure, pleural effusions) that may need to be dealt with.

EPR

With EPR, the same information is available to you, but all in one place. You can use a similar approach as noted above, although you may want to start at the very beginning by looking at their Emergency Room note to see what their presenting complaint was and how it was managed in the ED.

Consult a Service

Commonly, a service will consult another service when they have a specific question requiring an expert opinion. Consultations should be done to answer a specific question after the appropriate history, exam, and investigations are done. There are two steps to a consultation:

- 1) filling out a consultation request form, and 2) contacting (phoning) the service

01 *Filling out a consultation request form:*

These may be done on paper (eg. at HSC) or electronically (eg. using EPR at St. Boniface). On the form, provide a brief summary of the patient and question being asked, to assist the consulting service. Please include:

- A patient identifiers (eg. 56-year old male...)
- B relevant past medical/surgical/social history (eg. ...with history of COPD and 20-pack year smoking history...)
- C current issue (eg. ...admitted with SOB and recurrent pleural effusion)
- D relevant investigations if performed (eg. pleural fluid analysis shows malignant cells and CXR shows LUL lesion)
- E Question for consulting service (eg. Please assess for further investigation of possible lung cancer)

Sign with your name (eg. Jane Doe, M3) on behalf of the patient's attending physician (on behalf of Dr. J. Smith). If using a paper chart, write an order for the consultation to be faxed to the consult service, place in the front of the chart, and flag the chart or hand it to the ward clerk.

02 *Contacting the service*

It is courteous to phone the consulting service to inform them of their consult, in addition to the paperwork behind it. Page the service early in the day if possible (before noon)—no one likes getting a consultation when they are ready to leave for the day!

- A Introduce yourself and on whose behalf you are calling
- B Provide a brief (eg. one- to two-line) history of the patient in question.
- C State the urgency of the consultation if necessary
- D Provide the service with a clear question/ reason for their consult
- E Ask if any additional investigations or treatments should be pursued prior to consultant seeing patient
- F Answer follow-up questions they may have, close the loop, and thank consultant

Answer a Page

HSC Paging: dial 72071 (787-2071 from non-hospital phone)

St. Boniface Paging: dial 72053 (237-2053 from non-hospital phone)

To page: dial Paging, state your name and service, and ask to have _____ service page you “to this phone”. The requested service will receive your page and answer it as soon as they can.

To return a page: either a complete telephone number or a five-digit will appear on your pager.

- If complete telephone number: dial the number as shown from any phone
- If five-digit number:
 - From hospital landline: dial the five-digit number shown
 - From personal phone: dial 78-followed by the number in question (78-#####)

To dial out from any hospital phone, press 9 followed by the phone number in question.

Dictate a Note

Dictations are done through the Provincial Dictation and Transcription System (PDAT). All students who are dictating must have a WRHA dictation number. To receive your dictation number, please call 787-1230. You may also have to provide or use your attending’s dictation number.

- 01** Dial 1-844-926-3600
- 02** Enter your user ID, followed by #
- 03** Enter your site ID number, followed by # (as directed by prompts)
- 04** Enter your work type number, followed by # (as directed by prompts)
- 05** Enter the patient MRN, followed by #
- 06** When finished dictating, disconnect and record Work ID number and write on chart

Telephone Keypad Functions

- 1 Play/ Pause
- 2 Rewind/ Play
- 3 Fast forward
- 4 Disconnect
- 5 Priority
- 6 Rewind
- 7 Next Report
- 8 Disconnect

Common work sites

- 1 HSC
- 2 CancerCare McCharles
- 3 CancerCare St. Boniface
- 4 SOGH
- 5 Concordia
- 11 Victoria
- 12 Grace
- 13 HSC Department of Medicine
- 21 St. Boniface Department of Medicine
- 23 St. Boniface

Common work types

- 85 Progress Note
- 81 History
- 76 Discharge Summary
- 78 Consult/ Referral
- 83 Patient Care Letter
- 84 OR Not

Note:

- Punctuation must be verbally dictated.
- When in doubt, spell it out – including names and any medical terminology.
- Any copies of the dictated note or letter should be verbally stated at the beginning or end of the dictation.

For example, a dictated letter from a consultant to a family physician may begin as follows:

“This is a dictated visit letter for patient John Brown (J-O-H-N B-R-O-W-N), HSC MRN #XXXXXXX, dictated by Jane Doe (D-O-E), on behalf of Dr. J Smith (S-M-I-T-H), general surgeon. Please cc Dr. J Smith of HSC General Surgery and Dr. Juan Green (J-U-A-N G- R- E-E-N) of Kildonan Medical Centre.

“Dear Dr. Green (comma) (new paragraph)

I had the pleasure of seeing your patient (comma) Mr. John Brown (comma) in Dr. Smith’s general surgery clinic today (period) As you know (comma) he is a pleasant 55-year old male who we have followed post-Whipple’s (W-H-I-P-P-L-E-apostrophe-S) procedure for pancreatic cancer in 2017 (period) (new paragraph) ...”

Dictate a Note Fill Out a Lab/Imaging Request

When ordering imaging, be specific! Specify the exact imaging you need, how many views you need, and pertinent clinical history to help radiology assess and interpret an image. If the patient is on any contact precautions, include this information as well. Any imaging requisition requires an order, and vice versa.

Present a Patient

Each team and attending has a different preference when it comes to presenting patients. Situation and context is important - this will differ between inpatients, outpatient clinics, and the emergency room. When in doubt, clarify expectations and observe residents and staff to develop your own style. A general format most people follow is similar to a SOAP format, with an identifying statement, overnight issues (if relevant) and patients' symptoms, vital signs (normal and abnormal) and inputs/outputs (if relevant), pertinent positives and negatives on exam, updates regarding investigations, and an issues-based problem list and plan.

Section VI: Rotations

Pediatrics

Overview (structure of rotation, sites, services, etc)

The pediatrics rotation has very recently changed and will now include 2 weeks of inpatient day work, 1 week of inpatient night float, 2 weeks of general outpatient clinics and pediatric emergency, and 1 week of subspecialty clinic.

Inpatient Pediatrics (3 weeks): This part of the rotation will take place at Children's Hospital in the Health Sciences Centre. Children's Hospital has 5 floors. The 1st floor contains clinics X – Z, which function as outpatient clinics. The 2nd floor is where you'll find teaching rooms, call rooms, as well as the Child Life playroom, and 2 more clinics. Floors 3 – 5 are inpatient wards. Each floor is divided into two wards: "CK" and "CH" (eg. "CK4" = the CK ward on the 4th floor).

On rotation, you will be assigned to one of three "services": Pine, Oak, and Elm. Prior to the COVID-19 pandemic, each service took care of slightly different patient populations: Pine Service serving primarily northern populations, Elm Service serving patients who live in Winnipeg and have a community pediatrician, and Oak Service serving patients without a pediatrician who live in the city. Previously, the patients on each service were distributed randomly throughout the various inpatient wards – in other words, not all Oak patients were found in the same place. Currently to decrease the number of people walking through each ward the services are split by location with Oak service working on CK3/CK5, Pine on CH4, and Elm on CH5.

Outpatient Pediatrics (3 weeks): For this part of the rotation, you will be placed with an attending pediatrician in one of a variety of outpatient pediatric clinics throughout the city (eg. St. Boniface AFC Clinic, HSC Clinics X-Z etc). You will be scheduled (generally) for half-days with your attending, during which time you will see pediatric outpatients for well-child visits as well as non-urgent complaints. You will also be scheduled for several shifts in the Pediatric Emergency Department.

Expectations of Clerks

Dress Code

Dress business-casual for your pediatrics rotation (ie. no jeans!). Typically, pediatricians do not wear white coats on the ward or clinic. At the time of writing, some junior residents and medical students were wearing scrubs on the wards as well.

A Typical Day: In-patient

You will meet your team in your respective “team room” for patient handover at around 0700h. Patient handover is done in IPASS format. You will then have 30- 60 minutes to pre-round on the patients you are assigned (usually 3-5 patients). Make sure to mark down vitals and fluid balance overnight, as well as today’s weight (if available).

You will then meet the team for rounds on one of the wards or in your team room. On pediatrics, rounds are done as patient-centred walking rounds. When presenting a patient, start with an ID statement, followed by any issues that occurred overnight, and end with a problem/issue-based plan. **Nutrition/ Hydration** and **Discharge** should **ALWAYS** be on your problem list. When you are not presenting, it can be helpful to bring the MAR (Medication Administration Record), vitals record, or chart for the team to look at available at the bedside or with the nursing staff. While rounding, it is helpful to have the chart open while other team members are presenting their patients, to quickly glance at notes or consults, and to write orders that are decided upon while rounding.

There is both formal and informal teaching on pediatrics. Your senior resident will often assign one team member (including yourself) to present on a relevant topic each day – this presentation occurs sometime during the workday, is informal, and usually should last about 15 minutes. Formal teaching occurs at lunch-hour on Tuesdays, during half-day on Thursdays, and at Grand Rounds on Wednesday mornings at 0800h.

After rounds +/- teaching, you will have the afternoon to get your tasks for the day done (e.g calling services, writing order, etc), as well as examining and writing a SOAP note on each of your patients. The team will meet at ~1630h for handover to the evening team.

Night Float

Night float shifts will start in the late afternoon/early evening. You will be on overnight with a junior resident and a “screening” resident. Night Float as Peds consists of two weekday shifts and one weekend shift. You always get a full post-night float shift day. For example, your night float schedule may look like shifts Sunday, Tuesday and Friday. Shifts start at 4pm (more details below) and end at 7am where you handover to the day team in your specific services workroom (details of where these are will be given during orientation).

Call rooms are on the 2nd floor right across the hall from the room where noontime teaching is done. **REMEMBER TO GET YOUR CALL ROOM KEY FROM THE PEDS OFFICE PRIOR TO THE START OF YOUR CALL SHIFT.** It is not pleasant having to crash in a hallway.

Usually, you will not start your rotation on night float. During the days of peds CTU, you will see a schedule for handover to the right. Each day a different ward will handover 1st (4pm), 2nd (4:30pm) and 3rd (5pm). For example, if you are on pine service, your schedule for handover may be M 4:20PM, T 5pm, W 4pm, R 4:30pm, F 5pm. Pine service may have a different handover schedule than this, this is just an example. This

means your night float shift starts at different times depending on your ward service and the day. If you are unsure, show up at 4pm.

At handover your day team will tell you whether a patient on the ward is stable or unstable and the specific things to check on for specific patients overnight. At around 2300h, you and your resident will meet up and split the tasks assigned by the day team. Between these times, you will be doing consults and admissions if they come up.

Specifics of the Rotation/Helpful Hints

Helpful Study Material

UWorld – 600 practice questions with detailed explanations

First Aid Pediatrics – Contains good illness scripts and helpful ward hints on high-yield pediatric topics

BRS Pediatrics – A good short review of pediatrics. This textbook was last published in 2011, so beware of old information!

Nelson's Essentials of Pediatrics – Good for more in-depth explanations of some topics, but you do NOT need to read this entire textbook.

Internal Medicine

Overview (structure of rotation, sites, services etc)

Your internal medicine clerkship rotation is 6 weeks long and you will be on the same ward for those entire 6 weeks. You will either be placed at St. Boniface (A or B service) or HSC (A, D, or H service). Your team will consist of 2-3 medical students, possibly a PA student, 3 junior residents (may be from internal medicine, “off service” from any other program, or IMGs), and 1 or 2 senior residents (internal medicine residents). Each service has its own ward, however you may also have patients located on other wards (eg. the high observation unit or the telemetry unit). You should typically be assigned ~4 patients each day, however with services often going over census, you may be asked to take extra patients (if you feel uncomfortable/overwhelmed with the amount of work, ask someone else on your team to help out!).

Expectations of Clerks

Dress Code

Business casual. Scrubs are typically acceptable. Ask your attending/senior resident on your first day if a white coat is a requirement, it is often not.

A Typical Day: Weekday

You are expected to arrive early enough in the morning to see/assess all of the patients that are assigned to you (ie. pre-round) - most students arrive between 0630 and 0700 but it is really up to you! Most wards will not have a formal handover/meeting time in the morning, but it is helpful to touch base with the overnight team before they leave about any overnight issues. Your “pre-rounding” should consist of reading the admission H+P from any patients admitted overnight that have been assigned to you, reviewing any progress notes in the chart written by the night float team/consultants/nursing, and checking important labs/ imaging tests. You also should take time to see each patient assigned to you, get any relevant history, and examine them. It is not acceptable to not see your patients prior to rounds. If a patient is sleeping - wake them up (except in certain exceptional circumstances, like a palliative care patient).

Rounding time and style differs depending on the ward. You will get an email before your IM rotation telling you what ward you are on and what time rounds are for you. We recommend getting to the ward 2 hours before your round to pre-round on your patients. Most teams will meet on the ward somewhere to start rounds. It is helpful to grab the cart with charts, and the portable laptop/stand before rounds begin. Historically, rounds have been bedside/walk rounds, where the team will go into each patient’s room to assess them and discuss the plan for the day. Although more recently, due to COVID precautions, medicine rounds are often being held as “table rounds”, where you go over the patients in a work room. During rounds, you will be expected to present your patients to the team. Presenting on rounds includes an ID statement (name, age, relevant PMHx, entrance complaint, and current Dx) and then a numbered problem list including all current issues, your impression/ assessment, and your plan to address them. Depending on the attending/senior resident, there also may be some bedside teaching during rounds.

If the patient being seen is not yours, you are expected to have the chart ready to write orders, have the bedside clipboard ready (this includes vital signs, urine output etc.), help fill out imaging requisitions, call consultants etc. Stay engaged and do whatever you can to help out. Rounds usually finish between 1100 and 1200.

There are often formal teaching sessions at noon (you will get a schedule at orientation). This is a good time to eat lunch! Afternoons consist of following up with your patients’ issues - checking on blood work/imaging, calling consultants, re-assessing acute issues and writing SOAP notes. Hand over will occur sometime between 1500 and 1700 (usually at the discretion of the attending). This is when the team will “run the list” and you will have the opportunity to update your team on any new issues. Once handover is done, and your work/notes are done you are free to go. A typical day on CTU finished around 1700-1800, but there are occasionally earlier/later days.

Typical Day: Weekend

During your 6 week rotation, you will usually be assigned to work two to three weekends (usually both Saturday and Sunday, but that is occasionally not the case). On weekends you are not expected to pre-round. Show up to your ward at 0900, get handover from the night float team, then divide patients/tasks for the day. On weekends you may be assigned 10-15 patients. This can be intimidating but it is usually acceptable for weekend notes to be shorter than during the week.

There will typically be a senior resident, and two juniors (ie. Yourself and either a junior resident or another med student). There are no formal walk rounds on weekends but you are still expected to see all the patients assigned to you, write notes/orders, and call consults etc. Often the senior resident will spend most of the day in ER dealing with consults/new admissions, so you will usually be responsible for dealing with all ward issues. Weekend shifts typically go from 0900hr to 2100hr. You may be asked to see a consult in the ER if you are finished all of your ward responsibilities earlier in the day.

Typical Day: Night Float

You will be scheduled for 6 consecutive nights during your rotation. These should always start on a Thursday night (you will be off during the day, but still expected to attend academic half day) and end on a Tuesday night. You may be the only person from your service on at night, or you may have a junior resident with you. Shifts will start at 2100h with handover in one of the team rooms. You will get handover from your ward senior about any new admissions/current ward issues. The SMR (a senior internal medicine resident who is there all night to screen consults and help with acute issues on all medicine wards) will let you know about any consults pending in the ER. Med students/junior residents from all wards will help out with ER consults. You will also carry the service phone overnight.

Most nights will involve seeing consults in the ER (where you will complete full H&Ps on patients that may need to be admitted to medicine) and addressing the acute ward issues you are called about. You are also expected to go to all of the Medical 25's and Code Blues that are on the medical wards. Occasionally there is some down time on night float and recently (July 2020) some call rooms have been assigned for the juniors (course admin will provide more info). Most students find that night float is the most enjoyable part of the rotation! Consults are the best way to learn, and you get a chance to independently assess acute patients.

Specifics of the Rotation/Helpful Hints

- UWorld is a great resource for the Medicine NBME! There are about 1500 questions so start early if you plan to make it through all of them. Although most people won't get through all of these questions, so don't fret!
- Step Up to Medicine is a textbook with a good overview of most topics you will see on the exam. There are some aspects where it may lack some level of detail but overall a good resource.
- Online MedEd - great if you like learning from videos!
- Emma Holliday - great for review and common MCQ associations, definitely not comprehensive.
- UptoDate is a good resource for reading around your patients but not as a primary resource for the exam.
- Use your time on EM to study for the Medicine NBME! There is time to study while on IM but the days tend to be longer and usually quite busy!

Obstetrics/Gynecology

Overview (structure of rotation, sites, services, etc)

Your Obstetrics (OB) and Gynecology (GYN) rotation will be made up of 3 2-week blocks of Obstetrics, Inpatient Gynecology and Outpatient Clinics.

Expectations of Clerks

Dress Code

Wear scrubs for both Obstetrics and inpatient Gynecology. You will be contacted for your HSC ID card information by their program coordinators and they will setup scrub access for when you are at HSC. They have their own scrub machine so you do not use your scrubs from Surgery for this rotation! Scrubs can be accessed at St. Boniface in the change rooms; no ID card is required.

Dress business-casual for your outpatient clinics.

Typical Day: In-Patient

Obstetrics (2 weeks):

You may do your OB rotation at either HSC or SBGH. Days start at 0730 with meeting the team and signing over patients from the night. You will be assigned to work at one of the wards: Antepartum and Gyne (you care for a small GYN inpatient ward at SBGH when on OB), Postpartum, Labor and Delivery or Triage. You are usually able to finish your duties around lunch at the latest and can help with Triage or Labor and Delivery. This is when you will get your 12 deliveries (at least 3 C-sections). Make sure you are proactive about getting your mandatory 12 deliveries in. Look at the C-section schedule in advance, and take initiative asking the patient their permission to watch, and touch base with the attending doing the section to let them know you would like to join. Most people are quite readily able to get their 12 deliveries done, but they will make you come back after the rotation ends if you are not able to for whatever reason. At noon rounds, you will meet with your team to discuss plans for patients that need care and, if time permits, do some teaching at noon. At the beginning of the rotation, you will be assigned a date and topic to teach during noon rounds. It is very informal. You meet with the team once again between 1600 and 1700 to sign over patients to the evening on-call team.

Inpatient Gynecology (2 weeks):

This part of the rotation will take place at HSC. You will meet with your team to sign over

patients from overnight at 0700. You will be assigned patients for you to see and write notes for in the morning. After finishing seeing all your patients you should join an OR for the rest of the day. One person will carry the service phone through which you will get called for consults from ER. You will meet again at lunch to go over plans for patients and reconvene at 1600 to signover patients to the on-call team. You also have one day of day surgery OR at a peripheral hospital.

Outpatient Clinics (2 weeks):

For this part of the rotation, you will be spending half days at various attendings' clinics. You may do clinics in Prenatal, Gynecology, Gynecologic Oncology, Adolescent Gynecology. Prenatal clinics are pretty straightforward (see tips below) and you may do either follow up or new consults at Gynecology **Clinic**.

You may also have the option of doing this block in Thompson depending on travel restrictions.

Call

On average, you get three call shifts each on OB and GYN rotations at both HSC and SBGH. There is no call when you are on outpatient clinic. When you are on GYNE call at HSC, you will care for ward patients as well as new consults at ER. You do consults only on GYNE call when you are at SBGH. You will at least be paired with a resident on call. When at St. B for call it is important to page the attending physician on call to let them know that you are there to do consults. OB call shifts are the best time to get your deliveries. When on call for OBS, try to meet with your delivery patients and introduce yourself, asking for their permission for you to be involved in the delivery. Make sure to check on them frequently, especially if they are almost in the second stage of labor. When you are on call over the weekend, you will also need to round on your patients each day in addition to being present for deliveries. When on call for GYN at HSC, you care for patients on the GYN and GYNE ONC ward (5th floor) and take consults from the ER. When on call for GYN over the weekend, you will also round on GYN patients as well as GYNE ONC patients when the attending is around later in the morning.

When on call at SBGH, you will only be responsible for consults from the ER. SBGH call rooms are next to the OR. You can get your key from security.

HSC call rooms are located on the 3rd and 4th floor of the Women's Hospital.

Specifics of the Rotation/Helpful Hints

This rotation can be confusing for students as at HSC there are 3 groups of physicians that work together taking care of each others patients, and there are 2 groups at St. B.

Make sure you know who is on call for the different groups so that you know which attending to call for a given patient. Patients are admitted under their OBGYN, regardless of whether that doctor is working on the wards at the time. A lot of the attendings do want updates on their patients, even if they are not going to be in the hospital at the time of delivery or during a patients' stay. If in Women's triage you should call the on-call physician to review new cases with.

GYN:

- OR starts at 730 and major surgeries are usually earlier in the day; therefore make sure to check the slate first thing in the morning so you have time to introduce yourself to first patient if you are interested in the first case in the morning.
- Gyne call is a good time to ask your resident to observe your HxPx when you are doing a consult.

OB:

- Try to introduce yourself to patients in labor and delivery as early as possible
- Some residents want you to meet with patients before they are in active labour
- Check on your patients more frequently as they are progressing through labour.
- Don't count on being called right before delivery – you may miss it! From personal
- Experience you are NEVER called for deliveries despite putting your name, phone number, pager on the board. It is on you to check on the patients frequently so that you do not miss births.

Clinic:

When seeing a prenatal patient, make sure to ask the following:

- 01 New symptoms, and any changes
- 02 ABCD
 - A Fetal Activity
 - B Bleeding
 - C Contractions
 - D Discharge (Rupture of Membrane and etc.)
- 03 Measure blood pressure
- 04 Measure Fundal Height
- 05 Feel fetal heart with doppler
- 06 Know what tests to order at each visit

Helpful Study Material

Toronto Notes - a short read recommended by OBGYN residents to get you ready for wards on first day

UWorld – always helpful questions with detailed explanations

UWise – more questions to work through for NBME exam. These questions are based on Canadian guidelines.

Hacker & Moore's Essentials of Obstetrics and Gynecology – good for more in-depth explanations of some topics, read at your own discretion.

Make sure to study during your clinic rotation, don't leave it to the last minute, especially if you end on obstetrics!

Emergency Medicine

Overview (structure of rotation, sites, services etc)

This rotation is a 4 weeklong and consists of approximately 14-16 shifts (including one EMS ride along which has not been taking place since returning after COVID). The first day of the rotation will be a simulation day in the CLSF where you will go over common scenarios in the ED and give leading simulation a try. Traditionally the last day of the rotation has been a presentation day where you are required to present an interesting case from your time on the rotation, however since returning to clerkship after COVID the powerpoint was simply submitted online.

Expectations of Clerks

Dress Code

There is no specific dress code for the emergency department. Business casual or scrubs are both acceptable options – jeans or casual clothing is not. If wearing your white coat appeals to you, then go for it but, there is no expectation to and most attendings/residents don't wear one.

A Typical Day

When on your emergency medicine rotation you can expect to have shifts starting at any hour - morning, noon and night. Usually clerks have one “graveyard” shift where you will work either until the wee hours of the morning or completely overnight and leave around 6-7.

The shifts are usually 8 hours long and you are paired up with an attending +/- a resident for the entire shift. It is a good idea to have a learning topic or objectives in mind at the beginning of each shift so that staff can find you cases that fit. You can also pick your EPA as the “topic of the day” to focus on. At the beginning of the shift the ERP you are working with will take handover. You will listen in and try to take notes, but usually they take care of the reassessments of those patients while you go and see new patients. Throughout the shift you will see patients on your own, come up with your plan and then review with the attending.

An hour before your shift is done it is recommended to not take on any new patients so that there are fewer outstanding issues for the next ERP coming on.

Emergency doctors are great teachers and mostly just want you to be keen. One of the skills that you will hopefully develop when you are on your emergency medicine rotation is how to do thorough, but concise histories, physical exams and case presentations. At the beginning of the rotation you will receive instructions on how to

best format your oral presentations and it is great to practice these throughout your rotation. Apart from having good case presentation skills, another good skill to have is being able to generate a good differential diagnosis. A good differential should include 3-5 items that encompass the most likely diagnosis as well as the diagnoses that you just can't miss. Your plan should be based on your DDx list. The emergency department can be a good opportunity to try out some procedural skills. There are often wound repair, conscious sedations, fracture reductions, intubations, thoracenteses, paracenteses and much more going on in the ED. As some of the procedures are considered Aerosol Generating Medical Procedures, students might not be allowed to attend but the COVID- related rules are dynamic and constantly changing. If you are interested in doing any of these, then speak up and ask! This will show that you are keen and you are way more likely to get hands-on experience this way.

Presentation Style Options

OCP Template (provided to class of 2021)

- ID: including demographic information, relevant past medical history, chief complaint and whether they appear well or sick
- HPI: what brought them in, OLD CARTS and +/- ROS around ddx
- PMHx/PSH
- Medications
- Allergies
- Social Hx
- Physical Exam: always start with how they look (i.e. sick/ not sick) and vitals – emerg docs love them! Then summarize the pertinent positives and negatives of your focused exam.
- Labs & Investigations: Summarize pertinent positives and negatives and attempt to provide your impression of what those investigations may mean
- Assessment and Plan: this section should include a DDx, plan for managing symptoms, what further work-up you want, and disposition planning.

SBAR (for handover):

- Situation
- Background information
- Assessment
- Recommendations

Evaluation

Each day at the end of your shift, you will be evaluated by your preceptor or resident. You will be provided with a booklet, **so don't forget to bring this with you every day.** At the end of the rotation, this booklet will be evaluated by the clerkship director for emergency medicine and your FITER will be completed by them.

At the end of the rotation, you have an oral case presentation (a PowerPoint) where you present an interesting case you saw during your rotation. This may or may not actually take place as an oral presentation – but either way, you will have to submit a powerpoint presentation. It is a good idea to keep your eyes out for these cases throughout your rotation and keep the name and MRN so you can find out the details (e.g. blood work, imaging etc.) of those patients closer to the end of the rotation when you are making your PowerPoint.

Specifics of the Rotation/Helpful Hints

If you are interested in a career in emergency medicine - tell your preceptor!
Get involved as much as possible and always say yes (if you are comfortable) to whatever you are offered to do.
If you are hoping to get a letter from your core emergency rotation it can be difficult.

It may be difficult to have the same doctor for multiple shifts, but because they spend the whole 8 hours with you, you can likely ask for a letter after 2-3 shifts if you feel like there is a good connection. You can also ask other preceptors to provide feedback about you to the person who has agreed to write you a letter.

Try to meet the residents. It is a great crew of residents and they are super open to offering advice and helping out. Don't be shy to introduce yourself and talk to them about your mutual love of emergency medicine.

Helpful Study Material

Clinical Reasoning Notes - these are actually a great resource for your emergency rotation. They give you a good basic differential diagnosis and include the “can't miss” diagnoses.

Podcasts:

- Crack Cast - briefly covers chapters from Rosen's Emergency Medicine textbook
- EM Clerkship - good for the beginning of the rotation as it provides a good and general overview of some hard hitting emerg topics.

Textbooks:

- Rosen's Emergency Medicine
- Tintinalli's Emergency Medicine

PDFs:

- Ottawa's Clerkship Guide to Emergency Medicine First Edition.
- iEM Education Project
- Keep in mind that there is **no NBME for emergency medicine**, so most of the time on this rotation that you have off, you will be studying for the internal medicine NBME.

Family Medicine

Overview (structure of rotation, sites, service etc)

The family medicine rotation consists of six weeks of family medicine. Public health week is no longer present. Now it will be 6 weeks in the community placement.

Prior to the Rotation

In about **6 weeks** prior to the start of the family medicine rotation, your track will receive an email informing you of the available community placements. Available placements are different per track. You and your track-mates will be responsible for **negotiating** with each other on who goes to each placement. Tracks typically achieve this via random draws or discussion. Someone in your track will need to send an email that outlines which student will go to which placement. Some placements are available via application or emailing. You will be emailed further information about placements in **Norway House** or **Churchill**. Bilingual stream students may have available **French-only** placements. Students can request placement in **Winnipeg** for their family medicine rotation, but this is generally only approved for extenuating circumstances. You will need to complete an application form and receive approval if you would like to do your rotation in Winnipeg. Even if you are doing your rotation in a town close to Winnipeg, you are expected to stay at the allocated housing. For instance, if you are doing your rotation in Selkirk, the expectation is that you do not commute from Winnipeg, even if it happens to be a relatively short drive for you. In a few weeks after your track sends who's assigned to each placement, you will be given further information about relevant contact people (including a site contact, and your preceptor), accommodations, travel, and further instructions.

Community Placement (5 weeks):

You will be spending the remainder of the rotation in the community that you have been assigned to. **Accommodation** is provided for you during your stay. A **stipend** that covers for one round trip will also be provided. Your exposure will cover the variety of responsibilities of rural family medicine and differs by community placement.

Everyone will participate in a family medicine clinic. Often you will be seeing various non-urgent complaints, and follow-ups for investigations or chronic disease management. All placements have an **emergency room** where you could have exposures. Some placements will involve seeing **in-patients**. You maybe involved with anesthesia, surgery, and obstetrics if your community placement has these available. It is recommended that you speak with your preceptor(s) if you would like more of certain

exposures. Most placements are accommodating with your preferences. If you are placed in **Winnipeg**, you will be doing some emergency medicine shifts at a peripheral hospital (eg. Grace), and you will mostly be doing clinic.

Everyone is entitled to an **optional 2 days of public health** exposure. Should you choose not to take these 2 days, then they will be distributed to your clinical duties instead. You will be emailed the contact information for the public health contact person. The experience is variable and may include (but not limited to) immunizations, home visits, well child visits, prenatal care, postpartum visits, school health, harm reduction, and preparation of talks or articles. The public health exposure may not take place in your community, and you may need to commute to a nearby community for the exposure.

During the rotation you are expected to participate in **online public health discussions** via **UM Learn**. Details of the requirements will be outlined at your orientation. Each week, a discussion thread will be posted on UM Learn. You are responsible for posting a minimum number of responses to the thread and replies to track-mates' posts. The last Thursday of your rotation will involve a debrief back in the Brodie Campus (or via Zoom during the COVID-19 pandemic). You are also required to complete 5 field notes on patient encounters during this rotation. A template is provided at the start of the rotation and each one includes an evaluation by your preceptor, with one field note being an observed history + physical.

Expectations of Clerks

Dress Code

Business-casual is safe to start. Bring your white coat in case. Clarify with your preceptors about expectations with dress code (if any), but it is usually more flexible.

A Typical Day

Due to the variability of the family medicine rotation experience, it would be difficult to summarize a typical day here. Included in this section are very common settings that you will be a part of across all placements: the clinic, **emergency room**, and in-patients. During the first few days or weeks of the rotation, you may be seeing clinic patients with your preceptor (like shadowing). Eventually, you will be expected to see patients relatively independently.

You will often be working directly with an attending, especially in the smaller community placements. For **new complaints** (eg. sore throat, shortness of breath) take the history of presenting illness as you would normally do (eg. OLDCARTS, OPQRST, etc.). The patient's medical history and medications are usually available to you if the patient has

visited the clinic before. You may opt to clarify some of that information to make sure it is up to date, as it may have been some time since the patient has sought care in your clinic. Some communities may be in the process of transitioning to electronic records, and so previous medical records may not be readily available.

Several of your encounters will also involve **follow-ups** for investigations or treatments. During these encounters, look for the last clinic note to orient yourself to what you will be following up on. Look for relevant lab work, imaging reports and consult notes. It may be more helpful to look for this information prior to bringing the patient into the room, so you can focus your discussion. When you are taking the history, ask how your patient's symptoms have progressed, if they are tolerating the treatment (if given), and how their progress has been with relevant **lifestyle changes** (eg. exercise, smoking cessation).

During each visit, it is worthwhile to consider if your patient meets any **screening guidelines** (eg. does this patient meet criteria for colon cancer screening?).

Documentation for your encounters commonly follows the **SOAP** format. After each encounter, review the case with your preceptor. Often, your preceptor will go into the room with you to conclude the case. It is likely you will spend time in the emergency room of the community. If the community is smaller, you may go between the emergency room and the clinic during the day. In larger communities, you may spend half or full shifts in the emergency room. If you are placed in **Winnipeg** for your family medicine rotation, you will instead do some emergency shifts at one of the peripheral hospitals (eg. Grace Hospital). The **Emergency Medicine** section of the Clerkship Guide has further information and advice regarding working in the emergency room setting. During the morning you may be expected to round on in-patients. The **Internal Medicine** section of the Clerkship Guide has further information and advice regarding in-patient rounds. The expectations for pre-rounding and the schedule for rounds differ by site, so it would be best to clarify those during your rotation. The patients you will encounter in rural hospitalist medicine are typically less complicated and less sick than what you would encounter during your Internal Medicine rotation. If you are placed in Winnipeg for your family medicine rotation, you will likely not be seeing any in-patients.

Call

Call expectations vary from site to site, and you will need to discuss this with your preceptor. It is typically **home call** (ie. you don't have to stay in the hospital, but you are called if you are needed). Commonly, you will be called to assess emergency room patients. Review all cases you see with an attending. At times you may find that the nursing staff do not know you cannot give orders as a med student. If you write down orders, they may be processed without co-signing – be sure to review the patients with your attending physician to ensure this does not happen.

Specifics of the Rotation/Helpful Hints

- Talk to your preceptor about your interests and where you'd like to spend more time in (eg. Emergency, Prenatal Care, Well Child Visits, etc.). Most places are accommodating with your preferences.
- Try and arrange to get your FITER done earlier (around the 2nd last week of the rotation). If you leave it to the last minute, your FITER may end up taking a while to be completed after your rotation, or the preceptor that would normally do your FITER would be unavailable.
- This rotation is good for getting a reference letter since you spend a lot of one-on-one time with a few attendings.
- It is not too difficult to get your observed history and physical for this rotation since you will be spending a lot of time directly with attendings.
- A few ECPs may be more difficult to encounter depending on your community. You may need to be a bit more proactive in finding them: Contraception, Palliative Care, Prenatal Care, Well Baby Care.

Helpful Study Material

- **Case Files Family Medicine** – Good book that covers many common issues encountered in family practice with good detail.
- **Step Up to Medicine** – The Ambulatory Medicine chapter is helpful for this rotation. You likely do not need to read the entirety of this book for this rotation, as it is more helpful for the Internal Medicine rotation.
- **OnlineMedEd** – Good resource if you like videos.
- **American Academy of Family Physicians (AAFP) Website** – Has many practice questions. The questions are tailored to American family medicine residents, but the explanations are good. You need to sign up, but med students can sign up for free. It does take a few days to a week to process your registration.
- **University of Virginia Practice Exam** – A practice exam with 125 questions.

US Preventive Service Task Force (USPSTF) Recommendations – Helpful as a reference for screening guidelines.

- **UWORLD** – there is a setting on UWORLD where you can organize questions into different groups – family medicine being one of them.
- Resources for internal medicine are applicable to the family medicine rotation if you want extra resources.

Surgery

Overview (structure of rotation, sites, services etc)

Your surgery rotation will be made up of 3 weeks of general surgery and 3 weeks of a surgical specialty. This may be changed to 2 weeks for surgical specialty for the Class of 2025.

General Surgery (3 weeks): This part of the rotation will take place at SBGH, HSC or GGH. There are six different general surgery teams you may be assigned to:

- Gold HSC (trauma and acute)
- Green HSC (surgical oncology)
- Orange HSC (hepatobiliary/pancreatic and GI)
- ACSS SBGH (acute)
- A service SBGH (breast, gastrointestinal)
- B service SBGH (colorectal, non-emergent)
- ACSS Grace (acute)

Your overnight call for these three weeks will be with Gold or ACSS based on your site.

Surgical Specialty (3 weeks): This is a highly variable 3 weeks depending on which specialty you are assigned to. In general, the available options are: Cardiac, Thoracic, Vascular, Neurosurg, Pediatrics, Urology, Plastics and ENT. Clinics may be in hospital or off-site (like CancerCare or Tache Clinic). ORs are generally in HSC or SBGH.

Expectations of Clerks

Dress Code

Dress is generally scrubs, which will be available to you on site (DO NOT wear them home, change into them in hospital). If you have days assigned to clinics, they will likely expect business casual dress without a white coat. Although if you are already in scrubs because you were rounding in the morning or whatnot, this may be totally acceptable as well.

A Typical Day: General Surgery

On Gold/ACSS your days will start with patient handover from the previous night, generally at 0600. All services will have patient rounds, generally around 0700 depending on the OR schedule. Depending on the service your team may assign you patients to assess and present or you may round as a team.

Rounding involves documenting post-op day #, reason for admission/ operation,

problems identified overnight by patient/nursing, diet, pain/ analgesia, urine output, GI function (flatus/BM), focused physical exam, new labs/imaging, and the current management plan - at a minimum. You may not get time to finish all notes prior to going to the OR – this is fine! There will be time between cases during the day.

After rounds you will likely be assigned to an OR or clinic. For OR, you must meet every patient prior to their surgery in the recovery room as they are prepared for surgery. You should then follow them into the OR, write your name on the board, attend the safety briefing, then assist with OR preparation as you are able. Always wear a facemask and hair cover in the OR. There may not always be shoe covers available, so wear old shoes or buy OR shoes. First scrub in of the day should always be with the sponge and water. If you are unfamiliar with how to scrub, ask! It also doesn't hurt to watch a Youtube video ahead of time on how to scrub in. If you are keen and attentive you can expect to assist in retraction, skin suturing, making port sites, driving the camera, and other skills as you gain the team's confidence. Always offer to stay with the patient and take them to recovery after surgery. Another way to be helpful is by offering to write the OR note or post op orders after the operation is done.

Consults/Ward issues: In general, the medical student is first to deal with any ward issues or consults from the emergency room during the day. These function as assessments or consults on any service. Be thorough, document everything you do and then review with the team. These things may interrupt your OR time, but OR time is an important and mandatory part of your rotation so advocate for yourself if you aren't getting enough.

Surgical Specialties

Clinics: Like clinics on any rotation, ask the surgeon about their expectations and how they run clinic. The responsibilities, hours and expectations vary widely between specialties. Some are very OR focused while some have significant clinic hours. In general, days will start with rounds on patients in hospital followed by OR/Clinic. Call used to be variable but is now becoming more standardized across specialties.

Call

All call on general surgery is overnight 24 hour call. You may be required to stay up to 26 hours total maximum, with the 2 hours post 24 for patient handover and helping the day resident round on the patients on your service. Do not stay past 26 hours. Alert the rotation director and UGME if you are asked to stay longer or for non-handover activities. You will be on call with ACSS/Gold depending on primary site.

Call consists of managing ward issues overnight, participating in emergent ORs, and

taking consults from the hospital or emergency. Make sure to help the resident update the patient list prior to handover at 6. For Gold call, discuss with night residents where the call room is and the access code. Call room keys can be retrieved from security.

Specifics of the Rotation/Helpful Hints

- It is not expected that you know intricate details of anatomy or surgical procedures while in the OR, but to excel you will need to review the anatomy (especially blood supply) and general details of a procedure. To do this you will need to look ahead in the OR slate and prepare for the cases you will see the following day.
- If a surgeon/resident offers to have you assist in the OR, don't say no! If you feel very uncomfortable or unprepared say yes but ask them to walk you through it or to show you it once first.
- Use appropriate PPE in the OR - protect your eyes, always use a facemask with an eye shield even if your attending/residents are not.

UWorld – Questions are relevant to the NBME and strongly advised

Surgery Case Files – In depth cases, high yield for rotation and exam

De Virgilio's Surgery – A straightforward textbook in case-based question-answer format, in depth and highly useful if you like the format

Pestana Surgery Notes- less in-depth, a great overview. Easy read for the first few days of rotation and again for last few days before the exam.

Anaesthesia

Overview (structure of rotation, sites, services etc)

The Anesthesia rotation has recently been re-structured to include two weeks of Perioperative Medicine/ Anesthesia and 2 weeks of self-study Radiology. The last 2 weeks are made up of the MSK component of the Surgery rotation.

Perioperative medicine: This part of the rotation takes place at either HSC or St.B. This will involve 1-2 half days in each of the following:

- Preop assessment clinic
- Periop patient follow through
- Obstetrical anesthesia
- Thoracic surgery clinic
- Vascular surgery clinic
- Surgical step down unit
- Acute pain service
- Chronic pain clinic
- Ophthalmology

A document will be provided by the department to explain what is involved with each of the locations, as well as appropriate attire for each. The Anesthesia department uses the Equina online scheduling system to assign preceptors for each day and will show you how to log in and access the information. There will be contact information of assigned preceptors on Equina, and you are expected to contact your preceptors the day before to confirm a meeting place and time.

Anesthesia: This segment will take place at HSC, St. B, GGH, VGH or Concordia. You will be in the OR each day. Depending on your site, you may be assigned topics to prepare each day to discuss with your preceptor, or you may be asked to select topics on your own. This allows you to complete all ECPs. Of note, this rotation has now been combined with the 2 week Perioperative Medicine rotation, such that there are a few OR days within the Perioperative Medicine rotation.

MSK: This component of the rotation takes place at HSC, Concordia, Riverview and Pan Am Clinic. This involves:

- Orthopedic trauma clinic
- Orthopedic trauma surgery

- Hip and knee clinic
- Adult hip and knee reconstruction surgical slate
- Physical medicine and rehabilitation EMG clinic
- Pediatric Orthopedics Clinic
- Hand clinic

You will be given contact information for the site you will be at each day. It is a good idea to call the clinics you are working at the night before to confirm their start time, as these will vary. You are also required to do one evening of call until 11:00pm. You will arrange this yourself with the senior resident on call for the night you are hoping to be on call.

Radiology: The radiology component of the rotation had only recently been added to the curriculum and will likely undergo changes as it develops. The course involves online self-study modules and one-hour lectures given by staff radiologists. The self-study modules include topics such as Abdomen, Chest, Cardiology, Pediatrics, and Neuroradiology.

Expectations of Clerks

Dress Code

Periop: The dress code varies depending on which clinic/slate you are on for the day. This information will be provided by the department on orientation day.

Anesthesia: Scrubs

MSK: business casual for clinics

OR Radiology: Self-study at home, pajamas and hot chocolate

A Typical Day

There is no “typical day” for periop and MSK, as each day you will be assigned to a different clinic / or slate.

Anesthesia:

You will show up to the anesthesia lounge/designated meeting place at the assigned start time. Each site will have different OR start times usually range between 0700-0800h depending on the site. You will change into scrubs; a cap and a mask then go to meet your first patient. You will complete a preoperative evaluation and airway assessment to make sure the patient is safe to proceed with surgery.

You will then relay this information to your preceptor and return to see the patient together. Once the patient is taken to the OR you will be able to help draw up medications, bag valve mask and provide spinal anesthesia (you may or may not be allowed to intubate based on COVID-19 guidelines).

While the surgery is occurring, you and your preceptor will discuss the daily topics.

The attending will likely ask you to go assess the next patient once the surgery is winding down. Once the surgery is completed you will help to wake the patient and transfer them to the post op unit.

Anesthesia and surgery share academic days. Every second week will be an academic full day typically beginning at 7am. Much of the teaching in this rotation occurs in the OR around the prepared topics. Grand rounds occur on Wednesday mornings at 7:45am. OR start times are delayed until 9:00am on these days.

Call

There is no call on anesthesia, aside from one MSK call shift until 11:00PM.

Specifics of the Rotation/ Helpful Hints

This is your time to study for the surgery exam, as there is not a lot of time to study during the surgery rotation itself. There is only one call required during the entire 6-week block so take advantage of this time.

Topics to prepare in order to impress attendings: Know about rocuronium vs succinylcholine for intubation, know the physiology of alpha and beta agonists, know your anesthetic/induction agents (propofol, midazolam, volatile gases, opioids, ketamine, etc). There are also assigned readings provided by the department for each day of the anesthesia rotation - these readings are very helpful in preparing for each day of the rotation and will give you something to discuss with your attendings.

Psychiatry

Overview (structure of rotation, sites, services, etc)

You will spend 6 weeks on a specific ward for your Psychiatry Rotation at HSC, St. Boniface or Victoria General Hospital. Typically, you will get an email a few weeks prior to starting your rotation asking you to rank which hospital and service you would prefer.

Besides the regular rotations of General Psychiatry and Consultation Liaison (1 spot) at HSC and General Psychiatry at St. Boniface Hospital, there are also Mood Disorders, Schizophrenia and Intensive Care specific wards at HSC.

On the first day of your rotation, you will have an orientation session led by one of the Psychiatry residents. They will be there to give you an overview of the rotation and the expectations they have of medical students. Typically, they also give a tour of HSC and will show you where to go for your HSC call shifts.

Expectations of Clerks

Dress Code

Dress business-casual for your psychiatry rotation (ie. no jeans!). Typically clerks do not wear white coats on the ward. No scrubs for this rotation.

A Typical Day

Regardless of which site and ward you get, the structure of the rotation is generally the same (with the exception of Consult Liaison at HSC). Typically, the day is from 9am-4pm. Your day will consist of reviewing the notes from the day before and seeing the inpatients you have been assigned to. (Typically, you are assigned ~4-6 patients but this may vary depending on the ward). A good rule of thumb when interviewing psych patients is to always have someone with you, whether it is your preceptor, a resident, a fellow med student, or a nurse. Typically for the first couple of weeks you will see all of your patients with your preceptor and you will be responsible for writing the notes on the patient, including progress notes, history and physicals, and discharge summaries. Depending on your preceptor and your level of comfort you may see patients without your preceptor (but may choose to continue to bring someone else with you). Once your notes are done for the day, you are often able to go home. Throughout your rotation, you will also have some scheduled clinic time, typically 2-3 times a week.

There are also other exposures such as Electroconvulsive Therapy, Family Therapy and CBT group sessions. You will also be expected to attend Grand Rounds and Donut Rounds. Teaching sessions are typically on Wednesday mornings as well as Thursday

afternoons after PDC sessions.

Consult Liaison

This is a very different experience than inpatient psychiatry. Typically only one person is chosen to work on the Consult Liaison service. This service sees consults for inpatients admitted to different wards in the hospital.

You will meet with the team in the morning (around 8:30) and run the list of patients that the team is following. You are assigned new consults and follow ups to do and typically you go off on your own to see the patients. You may see the first new consult with a resident but after that you will see new consults on your own.

There are usually 1-2 new consults per day and the team is often anywhere from 1-4 residents. You may or may not carry the pager. Rounds happen every day from 2-5 pm with the attending and residents where the team goes to see each new consult.

Clerkship students often enjoy this experience. Despite the fact that your hours may be longer than your classmates, you have more responsibility and more of an opportunity to work on your interview skills. You also have the opportunity to see a wide variety of patients.

Call

During the 6-week rotation there are approximately 8-10 call shifts. Previously, students were scheduled to only one site for the shift (e.g. Child and Adolescent, Crisis Response Centre, St. Boniface adult, or HSC adult. Starting July 2020 this has been changed to become a single call group that is responsible for all sites.

For C&A and HSC call shifts you will meet your residents in the Psychiatry room at HSC Emergency. If you are on overnight call for HSC, your resident will typically show you where to find your call room key and how to get to the call room itself. The call rooms are located in the Psych Health Building on the 4th floor. You will need your student card to access these rooms after hours – security will let you in with remote video access.

For CRC, meet your resident at the CRC (down the street from HSC). Ask the front desk at the CRC where to go!

For St. Boniface home call, text or page the resident you are working with that day and ask them to let you know when new consults come in. You only need to go to SBGH if there are patients to see. If you get called to go in, you meet in the Psych room in the SBGH Emergency Department. Ask one of the nurses or doctors which room it is or

ask the resident you are working with to show you.

Specifics of the Rotation/Helpful Hints

Prior to starting your rotation it is a good idea to review the Mental Status Exam- as this is going to be a component of all of the notes you write for your inpatients! There are a handful of Mental Health Act forms that are important to know; usually there is a cabinet at the nursing desk you can go through. Allied Health professionals are a hugely important part of the team, and can help you navigate issues surrounding discharge, finances, housing, etc. Be sure to touch base with them daily to get updates regarding the non-medical aspects of a patient's care and planning.

Helpful Study Material

UWorld – really helpful questions with detailed explanations

Lange Q and A- Extra questions for the exam- Highly recommend

Emma Holliday - Video and slides of high yield material for the NBME. (Note: this is modeled after the DSM4, not DSM5).

Online MedEd

Section VII: Clerkship Evaluations

MITERs and FITERs

The primary methods of evaluation during a rotation are by a midpoint in-training evaluation report (MITER) and final in-training evaluation report (FITER). This is a mandatory component of the rotation. The MITER tends to be less formal and is an opportunity for you and your primary preceptor (and/ or senior resident) to sit down with you and discuss things that have been going well and areas of improvement for the rotation. The MITER includes a survey the student should fill out ahead of time, and which will be available and discussed with the preceptor. The FITER includes an evaluation sheet that you and your preceptor should go over together. It is at this point that you should hear if you have passed, borderline passed, or failed a rotation. (Note: a fail of a rotation should not be a surprise, and the possibility should have been discussed at the MITER meeting!) A borderline pass appears as a 'pass' on your MSPR; a failure appears as a 'failure' until remediated. Note that it is possible to fail a rotation and pass the corresponding NBME exam, and vice-versa; the two are not connected in any way in terms of your records or remediation.

ECPs and Histories/Physicals

All students must complete a list of required essential clinical presentations, or ECPs, during each rotation. These are available to be viewed on Entrada. Each ECP should note the student's role (observed, managed, etc.) as well as a supervising physician. If you are nearing the end of your rotation and still have ECPs to complete, please inform your preceptor and/ or senior resident with enough time for them to find you opportunities – otherwise, you may have to come back after your rotation to finish them all!

Not included in the ECPs but another mandatory component of each rotation is an observed history and physical. These can be done separately, and do not have to be supervised by an attending (ie. a senior resident is accepted). Some of these are more formal and will be arranged by your rotation (eg. Pediatrics) – you will find out in your rotation orientation if this is the case.

NBMEs

Surgery, Pediatrics, Obstetrics/ Gynecology, Internal Medicine, Psychiatry, and Family Medicine all have standardized exams at the end of the rotation (for Surgery and Internal Medicine, these happen at the end of your twelve-week Surgery/ Anesthesia and Internal Medicine/ Emergency Medicine block). These exams are **National Board of Medical Examiner (NBME)** exams, which are American, multiple-choice style exams. Each exam contains 90-110 questions and are usually completed on desktop computers at the Bannatyne Campus. Due to COVID and the need for social distancing, students are currently using their laptops instead, writing the exams from home, with zoom running in the background.

Previously, to pass the NBME, you needed to score at or above the 11th percentile of North American students who wrote the same exam over the past several years. This policy was recently changed so that students now need a set percentage to pass (an “equated percent correct score”). This number varies depending on the exam and currently ranges between 59- 69%. UGME will inform students of the mark needed for each exam at the beginning of each school year.

Should you fail an NBME, your transcript will show ‘pending’ until it is successfully remediated. It’s important to note that failing an NBME is a relatively common thing (~40-50% of students failed at least one exam with the previous system), so don’t stress too much! These exams are different from the MCQ exams we’re used to writing, and do not necessarily reflect a student’s clinical skill or aptitude for a specialty.

Of note, as this is an American exam, all lab values, reference values, and some guidelines follow American rules and notation (see conversion table above). Become comfortable working in American values by using some American study material or resources.

There are a variety of useful references and textbooks available for each exam (see list above). Commonly used reference series include First Aid, Step Up, Case Files, and Blueprints. Of note, UWorld is an online question bank of thousands of questions and answers for all exams except for Family Medicine that many students have found helpful and highly recommended. There’s even a very user-friendly smartphone app!

The NBME website also offers a series of sample exams. Of note, a new feature let’s you organize UWorld questions into different categories, of which family medicine is one of them.

Remediation

As mentioned above, failure can occur at the clinical level (rotation failure) or exam level (NBME failure). Failing a rotation means doing a remedial rotation at a later time. Failing an NBME exam means writing a remedial exam at a later date. If a student fails the same NBME exam twice, they will have to repeat a four-week remedial rotation in that specialty prior to writing their third and final remedial attempt.

The following are situations in which a student may have to repeat a year:

- Failure of two major clerkships in different disciplines (Core Medicine, Surgery, Surgery Selective, Pediatrics, Psychiatry, Family Medicine, and Obstetrics/Gynecology)
- Failure of one major clerkship rotation and one of: i. Its remedial, a Medicine Selective remedial, or the Musculoskeletal course remedial, or: ii. A remedial in any of the assignments integral to either the Professionalism or Population Health courses, or: iii. A Public Health remedial, or: iv. A remedial in the Evidence-Based Medicine Practice Course, or: v. A TTR Selective remedial, or: vi. An Elective remedial.
- Failure of a remedial in two of the following: i. Medicine Selective ii. Musculoskeletal Course iii. Any of the assignments integral to either the Professionalism or Population Health courses iv. Public Health v. The Evidence-Based Medicine Practice course vi. TTR Selective vii. Elective.
- Failures in one or more of the following: a) A single NBME subject examination three (3) times OR b) A total of five (5) NBME EXAMINATIONS or C) The CCE after remediation.

If a remediation period recommended for a student, for whatever cause, requires more than ten (10) weeks, the student will be deemed to have failed the Clerkship Program. An outline of the minimum remediation period for Clerkship is outlined in the Promotion and Failure Policy.

Policies can be found at:

[HTTP://UMANITOBA.CA/FACULTIES/HEALTH_SCIENCES/MEDICINE/EDUCATION/UNDERGRADUATE/POLICIES.HTML#ASSESSMENTEVALUATION](http://umanitoba.ca/faculties/health_sciences/medicine/education/undergraduate/policies.html#assessmentevaluation)

If you are concerned regarding performance and examination, need study tips, or feel that you are struggling, Student Affairs is always available to discuss ways to help you succeed. Your classmates and peers in upper years are also a valuable source of information. Please know that there are many resources and many people who want

you to succeed – don't be afraid to reach out sooner rather than later for help!

CCE

The Comprehensive Clinical Examination (CCE) is an OSCE-style exam at the end of your Clerkship year that tests your knowledge of basic Family Medicine and Emergency Medicine complaints. You will receive more information about this as your year goes on!

MCCQE Part I

The last exam students write is the Medical Council of Canada Qualifying Examination (MCCQE), Part I. Since it is written in part to obtain licensure with the Licensing Medical College of Canada (LMCC), you may also sometimes hear it referred to as the LMCC. This is part one of a two-step process; part 2 is a OSCE-style exam usually completed in spring of R1 or fall of R2, although there has been discussion about permanently cancelling part 2 of this exam. The MCCQE Part 1 consists of 210 multiple choice questions and approximately 38 clinical decision-making questions encompassing everything from medical knowledge to medical ethics and patient safety. This exam is written at the end of April – beginning of May in Med 4. Capstone review courses take place at the end of Med4 and are well-liked by students. Review materials, such as Toronto Notes and the CanadaQBank*, are also used by students to prepare.

***[HTTPS://CANADAQBANK.COM/MCCQE-PART1.PH](https://canadaqbank.com/mccqe-part1.ph)**

Glossary

Abbreviations

WORD	MEANING
1/2NS	half normal saline
AAA	abdominal aortic aneurism
AAT	activity as tolerated
ABG	arterial blood gas
AD	right ear
ad lib	freely, as desired
A/E	air entry
AKA	above knee amputation
ALP	alkaline phosphatase
AMA	against medical advice
AP	antero-posterior
ARM	artificial rupture of membranes
AS	Right ear
ASA	Above sternal angle acetylsalicylic acid
AU	Both ears
AVSS	afebrile, vital signs stable
AXR	abdominal x-ray
BID	twice daily
BKA	below knee amputation
BS	bowel sounds breath sounds
BUN	blood urea nitrogen
CA	cancer

CABG	coronary artery bypass graft
CAD	coronary artery disease
CBD	common bile duct
CF	clear fluids cystic fibrosis
CNS	central nervous system
C/O	complains of
CP	chest pain cerebral palsy
CPAP	continuous positive airway pressure
CVA	cerebral vascular accident
CVD	cardiovascular disease
CVP	central venous pressure
CXR	chest x-ray
C&S	culture and sensitivity
D/C	discharge discontinue dilation and curettage
D5W	dextrose 5% in water
D5 1/2NS	dextrose 5% and half normal saline
D10W	dextrose 10% in water
DAT	diet as tolerated
DKA	diabetic ketoacidosis
DOB	date of birth
DVT	deep vein thrombosis
DNR	do not resuscitate
DTs	delirium tremens
DLD	dyslipidemia
EBL	estimated blood loss
EBM	expressed breast milk
EC	enteric-coated

EDC	estimated date of confinement
EF	ejection fraction
EGD	esophagogastroduodenoscopy
EOM	extra-ocular movements
ERCP	endoscopic retrograde Cholangiopancreatography
GBS	group B strep
GCS	Glasgow Coma Scale
GDM	gestational diabetes mellitus
GERD	gastroesophageal reflux disease
GI	gastrointestinal
GU	genitourinary
HC	head circumference
HCTZ	hydrochlorothiazide
HD	hemodialysis
HEENT	head, eye, ear, nose, throat
HR	heart rate
HS	heart sounds
HTN	hypertension
HOB	head of bed
I&D	incision and drainage
I&O	ins and outs
IUGR	intrauterine growth restriction
IVF	intravenous fluids in vitro fertilization
FHR	fetal heart rate
FBS	fasting blood sugar
FF	full fluids
FFP	fresh frozen plasma

FWB	full weight bear
LBW	low birth weight
ETT	endotracheal tube
L/E	lower extremity
LGIB	lower gastrointestinal bleed
LMP	last menstrual period
LOC	loss of consciousness level of consciousness
LP	lumbar puncture
LR	lactated Ringer's
LSB	left sternal border
MAR	medication administration record
MDI	metered dose inhaler
MSS	maternal serum screen
NAD	no acute distress no abnormalities detected
NG	nasogastric
NKDA	no known drug allergies
NPO	nil per os/ nothing by mouth
NS	normal saline
NSR	normal sinus rhythm
N&V	nausea and vomiting
NWB	non-weight bear
OA	osteoarthritis
OCP	oral contraceptive pill
OD	daily right eye
O/E	on examination
OGD	oesophagogastroduodenoscopy
OGTT	oral glucose tolerance test

O&P	ova and parasites
ORIF	open reduction and internal fixation
OS	left eye
OTC	over the counter
Ox3	oriented x 3 (person, place, time)
PCA	patient controlled analgesia
PE	pulmonary embolus
PEEP	positive end expiratory pressure
PERRLA	pupils equal, round, reactive to light & accommodation
PICC	peripherally inserted central catheter
PIH	pregnancy induced hypertension
PO	per os/ oral
POD	post-operative day
PPP	peripheral pulses present/ palpable
PR	per rectum
PRBC	packed red blood cells
PROM	premature rupture of membranes
PTL	preterm labour
PUD	peptic ulcer disease
PV	per vagina
PVD	peripheral vascular disease
q_	every (time) (eg. qAM)
q_h	every hours
QHS	at bedtime
QID	four times daily
RA	rheumatoid arthritis
RL	

SA	Ringer's lactate
SBO	spontaneous abortion
SEM	small bowel obstruction
SIADH	systolic ejection murmur
SL	syndrome of inappropriate antidiuretic hormone
SLE	sublingual
SOB	systemic lupus erythematosus
SQ, SC	shortness of breath
SR	subcutaneous
SROM	sinus rhythm
SVD	spontaneous rupture of membranes
TA	spontaneous vaginal delivery
T&A	therapeutic abortion
TEE	tonsillectomy and adenoidectomy
TIA	transesophageal echocardiography
TID	transient ischemic attack
TTE	three times daily
Tmax	transthoracic echocardiography
TPN	temperature maximum
TKVO	total parenteral nutrition
TFI	to keep vein open
TM	total fluid intake
UA	tympanic membrane
U/E	urinalysis
UGIB	upper extremity
U/O	upper gastrointestinal bleed
U/S	urine output

UTD	ultrasound
UTI	up to date
VBAC	urinary tract infection
VSR	vaginal birth after Caesarian section
VSS	vital signs routine
WB	vital signs stable
WBAT	weight bear
	weight bearing as tolerated

Definitions

Pre-Rounds

Before rounds with the whole team, some services like their medical students to “pre-round” on their patients. This entails reviewing the patients’ charts to note any important events from overnight (see “How to Read a Chart”), noting their vital signs, noting any other significant findings (this will be service-specific – e.g. PRN medications received overnight, urine/drain outputs, etc), and laying eyes on the patient (time permitting). This will help inform your presentation during rounds.

Rounds (walking vs. table)

During “rounds”, the treatment team gets together to review each patient on the service. This can be done in two ways. On walking rounds, the team physically walks from room to room seeing each patient. On table rounds, the team sits down together in a meeting space to review patients. No matter which type of rounds are being done, team members will present updates on each patient, and the team will decide on the day’s medical plan for that patient, including any new investigations or treatment changes.

Med Rec

A med rec, or medical reconciliation form, is a comprehensive list of all medications taken by a patient, gathered from both the DPIN and directly from speaking with the patient. These are typically done both on admission, and prior to discharge, to ensure that nothing gets missed during these transitions.

DPIN

The **DPIN**, or **drug program information network**, is an online database of prescriptions filled out by patients. It contains the name of the medication, the mg/pill, and the # of pills dispensed. It is NOT always an exhaustive list (it does not include over the counter medications or natural/herbal remedies), which is why Med Recs are so important, but it can be a helpful tool to get a sense of a patient’s medical problems and their medications.

MAR

The **MAR**, or **medication administration record**, is a list kept by the nurses of all of the patient’s most current orders, and of what time and what dosage each medication was given. This is a great place to find out whether patients are taking their medications or not, or how many PRN doses of medication a patient has received.

EPR

EPR, or the **electronic patient record**, is the computerized system used by the WRHA/Shared Health for keeping track of patients going through the hospital/Emergency Room. You will have received a tutorial on how to use EPR, but it is important to note that some hospitals in the city are currently in transition from paper charts to EPR, so make sure to find out (ask a member of your team) which information can be gathered on EPR, and which from a paper chart.



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