UNIVERSITY OF TORONTO
FACULTY OF MEDICINE

SURVIVING CLERKSHIP

A PRACTICAL GUIDE

EIGHTEENTH EDITION 2019

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Dear 2T1 Clinical Clerks,

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- Personal Counselling
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Learn more about us by calling 416-978-2764, emailing ohpsa.reception or looking at our website www.md.utoronto.ca/OHPSA. Stop in or book an appointment with us at http://www.md.utoronto.ca/content/book-appointment.

Our regular office hours are Monday - Friday 9:00am-5:00pm but you can also book after hours appointments at either St. George or Mississauga. Note our new downtown location as of July 1, 2018 is Naylor Building, 3rd floor, 6 Queen's Park Cres (north-west side of University and College)

The OHPSA team

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INTRODUCTION

This booklet is meant to provide you with a concise guide to the clerkship experience, as well as tips and suggestions passed on from previous years.

It is an unofficial student-led guide. We have done our best to ensure that the information in the guide is accurate but may change as the course structure is updated, especially evaluation/call/schedule details.

The useful resources section is meant as a list of resources only. Guideline websites are very useful and are always free. We have included costs and names of a variety of textbooks, however you are NOT, by any means, required to purchase ANY of these books. Each course has official online and/or printed resources, which cover the mandatory topics.

We would like to thank the original creators of this guide, as well as the many people who have provided content since its inception.

We would also like to thank MD Management for generously funding the publication of this booklet.

We wish you the best of luck in clerkship and hope that you find this guide useful in your journey!

- The Surviving Clerkship Team

If you have any questions about clerkship or specific rotations please contact your Clerkship Reps or Course Reps listed below:

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GENERAL TIPS FOR SUCCESS IN CLERKSHIP

1. Always, always be ON TIME – this is the easiest way to impress. Failing to do so is also the easiest way to stand out and annoy everyone who has to wait for you.
2. INTRODUCE yourself. Make sure you always take the opportunity to introduce yourself to all your patients, staff, residents, and allied health professionals. It's very easy to become invisible in clerkship.
3. Always be COURTEOUS to the allied health professionals. Read their notes and learn from them. You'd be surprised where your name pops up and how quickly students can earn a reputation – good or bad. You can make notes of names in your phone.
4. When you get PIMPED by your staff or resident, always go back to first principles and organize your answer in the form of an approach. For example, for acute kidney injury, think about pre-renal, renal and post-renal causes.
5. Show INITIATIVE! If you can look up something on your own, look it up before asking a question. It will show initiative and will save you from asking "dumb" questions (e.g. "What's the operation today?" could be answered by looking in the patient's chart).
6. Be ANTICIPATORY.
    i. Know your patients better than your resident does and keep on top of all their investigations, issues, and discharge planning.
    ii. Begin writing notes before being asked to (e.g. OR notes, chart notes, discharge notes, prescriptions, lab requisitions).
    iii. Take a focused history when you meet a patient.
    iv. In surgery: make sure the field is well lit, have suture scissors ready before being told to cut and suck the smoke/blood.
7. Always carry something to READ in your pocket. Clerkship is busy. Use your downtime during the day to learn and catch up on studying.
8. Create ME time. It's easy to become overwhelmed by clerkship and to give up on things you enjoy in order to catch up with readings,

studying and work. Create time for family, friends and a hobby or two – they'll keep you from burning out.

9. NEVER FUDGE a finding or an answer to a history question. You can endanger patients and you'll lose all trust.
10. NEVER UPSTAGE colleagues (especially at rounds) no matter how good you think you'll look.
11. NEVER TALK about patients (or staff) in public areas. It is unprofessional and you never know who is listening.
12. ASK FOR HELP. You'll be embarking on a journey packed full of new, exciting and challenging experiences. Don't be afraid to ask your colleagues, residents or staff for help when you need it.
13. VITALS – they're called vitals for a reason. Pay attention to them! If the patient appears to be deteriorating (e.g. vitals worsening), call your resident ASAP and ASK FOR HELP! Never be afraid to ask for help.
14. USEFUL RESOURCES FOR ANY CLERKSHIP ROTATION. The following are a list of books that many students find helpful across all the different rotations. You should preview resources before you buy to ensure they fit with your personal learning style. More specific books for each rotation are listed later (also see **APPENDIX C** for more resources).
    - **Toronto Notes**
    - **OnlineMedEd.org**
    - **Tarascon's Pharmacopoeia** (ultimate drug booklet)
    - **Up To Date** –available through U of T Library
    - **DynaMed** – available through OMA as a phone app
    - **BMJ Clinical Evidence** – for therapeutics (evidence based summaries with links to articles/RCTs)

Go to the comprehensive website: **https://meded.utoronto.ca.** It has links to all the courses including lecture notes, announcements, schedules, and resources.

WRITING NOTES

The two most common notes you will write are the "Admission Note" and the "Progress Note". The length and complexity of these notes vary depending on the rotation. As a general rule:

	Admission Note	Progress Note
Medicine	2 – 5 pages	1 page
Surgery	1 – 2 pages	No more than a few lines

A. The Admission Note

The admission note generally follows the same format, although some staff will have their own preferences (e.g. some prefer the PMHx before the HPI). If available, try to look at an old chart before seeing a patient – it will help to speed up your history. See specific rotation sections for sample notes.

Service, Date, Time

Patient ID
No more than 2 sentences, containing name, age, sex, marital/living status and occupation (+ L/R handedness if on neurosurgery/neurology!)

Reason for Referral or Chief Complaint (CC)
Include BOTH the CC (why the patient came in) and RFR (why the emergency staff referred them) when applicable. List in one line the patient's complaints in their own words, including the duration of each of these complaints.

Past Medical History (PMHx)/Problem List
This section is important because it will put the rest of your note into context. For example, back pain in someone with a recent cancer history is far more important than in a healthy person. The problems may be listed in two columns: active and inactive. Try to list the problems in order of importance and relevance to the CC. Most people will put past surgeries

under the inactive problem list. Don't waste a lot of time on exact dates if those surgeries are unrelated to the Chief Complaint. On the other hand, make sure to get the dates for surgeries related to the Chief Complaint.

Medications
Always list their current meds with dosage, frequency and compliance. Ask about "pills," "drops," & "creams". If patients don't know, examine any medication bottles they have with them, or check their old chart. Write down the name and phone number of their pharmacy. The ward pharmacists will have an easier time verifying the medication. Ask women if they are taking the birth control pill or HRT. Also, ask about vitamins, herbal medicines, and over-the-counter drugs.

Allergies
List "allergies", including medications, food, environmental, etc., and describe the type of reaction they had. If they do not have any allergies, write "NKDA" (no known drug allergies).

History of Present Illness (HPI)
Be diligent when taking the history. A good history can often lead to a diagnosis. Most people will use brief sentences, symbols, and acronyms to distil the HPI into a more useable form. A general rule is to provide a brief description of baseline status at the beginning. Next, include pertinent positives. After this, it is always important to list the pertinent negatives to rule out other causes of the patient's complaints. This demonstrates that you are developing a differential diagnosis. Stick to the history; do not put any physical exam findings or lab results in this section unless they are crucial to the story.

LOP^{3}QRSTUVW: Location; Onset; Progression; Palliating; Provoking; Quality; Radiation; Severity; Timing; How has it affected U?; Déja Vu?; What do you think it is?

Family Hx and Social Hx
Should be short – stick to what is pertinent to the patient's immediate management (exceptions include psychiatry, where it will be longer).

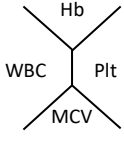
Include IADLs and ADLs if relevant, and any other information that may affect the discharge plan.

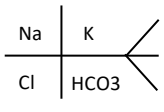
Physical Examination

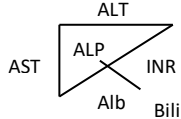
Always begin by listing vital signs (VS): HR, RR, Temp, BP, O_2 Sat. If relevant, include important physical signs from a previous exam in comparison to the findings you elicited on your exam (e.g. an asthma patient's VS taken by the emergency physician prior to receiving salbutamol/ipratropium, and then the VS you take as a medicine clerk afterwards). Begin at the head and work your way down describing your findings by system. Always perform and write out your physical exam in the same way – this will make sure you don't forget anything. An important part of clerkship is learning the screening physical exam. This comes with time as you learn what is and isn't important.

Investigations

Generally, you should divide your "Investigations" section into Labs, Imaging (X-ray, U/S, etc.), and Miscellaneous (e.g. ECG, EEG, etc.). In chart notes, lab values are usually recorded in symbol format. The common formats are listed below (they may differ). To further complicate things, the formats are not written in stone and people will often put the values in different spots. In time you will recognize the range of normal values.







* Based on Sunnybrook & Women's College labs, ALWAYS refer to ranges listed on the specific result you might be looking at.

Assessment and Plan

You may want to leave this section blank until you discuss the patient with your senior resident – but make sure you are at least thinking about what you would write. It is important for you to develop a problem list (if the patient has multiple problems), and a differential diagnosis for each

problem (listed from the 'most likely' to the 'least likely') for each problem. This is the hardest section to come up with on your own, but with time you will develop a sense of what the plan should be – the plan should be a numbered list of actions listed under each problem. This section is where you will have a chance to demonstrate your skills as a clerk so ALWAYS present it, even if you're not sure about your conclusions.

B. The Progress Note

The "**SOAP**" format is the standard outline for both medical and surgical progress notes. Title the note as "CC3 Progress Note" and ALWAYS write the ***date and time.***

Subjective:	How the patient feels (i.e. current symptoms) and what has changed since the previous note.
Objective:	Your findings (what the patient is doing, how they look, physical exam findings, labs, imaging).
Assessment:	What the new findings mean and progress made.
Plan:	Any changes in management, investigations or orders that need to be done.

Medicine: A scaled-down version of the admission note. Use SOAP but also include the current problem list and current meds. Use the problem list as your "agenda" for the day (i.e. what must be done for the patient).

Surgery: Very brief. Usually written very quickly during morning rounds. See the Surgery section for a sample.

WBC	= 4-11 x10^9 Eq/L	Na	= 135-147 mmol/L
Hb	= Male 140-174 g/L	K	= 3.5-5.0 mmol/L
	= Female 115-165 g/L	HCO3	= 22-30 mmol/L
Plt	= 150-400 x 10^9 Eq/L	Cl-	= 96-108 mmol/L
Urea	= 3.0-7.0 mmol/L	Glucose	= 4.0-8.0 mmol/L (random)
		Creat	= Male 62-115 umol/L
			= Female 35-97 umol/L

Always watch for the units given! (e.g. glucose 1 mmol/L = 18.02 mg/dL)

C. The Surgical O.R. Note

You will be required to write an OR note at the end of each surgery. It is the only record of the OR procedure between the operation and when the dictation service finally distributes your consultant's detailed operative note. See the Surgery section for a sample.

D. The Procedure Note

Procedure Notes should be added to the chart after any procedure is performed on the patient (e.g. bone marrow aspiration, thoracentesis, LP). The format is similar to the OR note, but not as detailed.

Sample

Procedure: Abdominal paracentesis
Your Name (CC3) / Dr. Resident
2L of fluid was drained from the abdomen under local anesthetic (list concentration)
No complications. Procedure was well-tolerated.
If a device was added, add a line for lot # and series #
Post-procedure vital signs: BP: 120/60, HR: 72

E. The Discharge Summary

When a patient leaves your service, a discharge summary is written in order to ensure that future medical caregivers have quick access to the information they need. Many hospitals have their own templates or online discharge summaries for you to fill out. You will learn the specific way your particular team prefers to structure discharge summaries. Start these early and update them regularly. After a few middle-of-the-night complex admissions, you will see that a good previous discharge summary can make life a lot easier.

- **Patient Identification:** Name, date of birth, MRN.
- **Recipients:** Make sure that the family doctor and any specialists involved in the patient's care receive a copy.

- **Date of Admission**: Under which service and consultant.
- **Date of Discharge:** Date and length of stay.
- **Admitting Diagnosis**: Working diagnosis.
- **Discharge Diagnosis**: Final diagnosis.
- **Patient Presentation:** Admitting H&P (pertinent details only).
- **Problem List:** List of identified issues.
- **Investigations:** Pertinent lab, radiologic or other findings.
- **Course in Hospital:** The meat of the note. Include treatments, responses, new issues, procedures, and complications. It's a good idea to organize this section into a problem list so it's easy to follow.
- **Disposition:** To home, nursing home, with or without home care.
- **Discharge Medications:** Write which medications are being discontinued, which medications were modified, and new medications. Mistakes are often made by lack of communication.
- **Discharge Instructions:** Be specific about activity level, diet, wound care, symptoms and signs to report or seek care for (e.g. "call Dr. X if …", "go to ER if …"). Anticipate new medication side effects.
- **Follow-ups:** State EXACTLY what you would like the GP to do – phone GP if care has been complex or significant follow-up is needed. *For Appointments*: write out the doctor, specialty, contact info, appointment location, and time. If patient is to schedule the appointment, make sure to include timeframe and method of communication (e.g. "You are to arrange appointment with Dr. X. at Hospital Y in 2 weeks by calling 555-5555").

F. Dictating

As the year progresses, you may be asked to dictate discharge summaries or clinic visit notes. Each hospital has their own dictating system, which usually consists of an extension number and a set of numbers that allow you to pause, rewind, etc. As a clerk, you may not have your own "user code" but staff or residents are usually more than happy to give you theirs so that you can gain experience dictating – a very important skill! Again, there is a lot of variability in how this is done.

Sample Dictation

A general format clinic note dictated as a letter to the family physician:

"This is Clark Kent (spell K-E-N-T), clinical clerk, dictating a general surgery clinic note on patient John Doe (D-O-E), patient # J0995555. Copies to the chart, to Dr. Kryptonite, and to the patient's family physician Dr. Lane of 55 University Avenue, Toronto, Ontario M5G 1X8."

"Dear Dr. Lane...I had the pleasure of seeing Mr. Doe in Dr. Kryptonite's general surgery clinic today (period) As you know (comma) he is a 63-year old gentleman with a history of ....

(Include a concise review of history, assessment, and current management plan)"

"Yours sincerely (comma) Clark Kent (comma) clinical clerk for Dr. Kryptonite FRCP(C).

End of dictation."

Be sure to copy down the reference number somewhere in the chart that is quoted to you at the end of the dictation.

Don't worry about "uhms" and "aahs" in between your text – the dictation service employs trained professionals and they will not include these in the final dictated note. However, you MUST say "period", "comma", "new paragraph" while dictating or your note will be transcribed as one long sentence. When in doubt, spell out your words after saying them (e.g. hiatus [H-I-A-T-U-S] – hernia). Remember you can always pause, rewind, listen to yourself, and correct mistakes (usually by using the phone dial pad) Ask your residents about the dictation dialpad commands. Work in a quiet area, and remember that you are dictating confidential patient information, so make sure you have the appropriate degree of privacy.

HOW TO READ A CHART

Reading a chart may seem like an easy thing to do, but you can get easily bogged down in the details. A good approach to reading a chart can save you a great deal of time and frustration but your approach will depend on the situation.

Inpatient

- Read the admission note first. This will give you a good summary of the patient's status at the time of admission.
- Read the last note made by the most senior person on your service (e.g. medicine, general surgery, etc.). This will give you an idea of the most important issues for your patient from the perspective of the service that you are on.
- If orders are paper-based, read the last orders to give you a better idea of current management.
- Read the last progress note. This will give you an idea of the patient's current status.
- Check the patient's vital signs, medications, intake/output (esp. for surgery services), and scan the nurses' note.

Outpatient (e.g. clinic)

- Most family practice clinics will have a summary sheet for the patient at or near the front of the chart. This will give you a quick summary of the patient's status and past medical history.
- Read the last note made in the chart. Often, patients will be seen for a problem and will be asked to follow up in the clinic at a later date. This gives you a sense of why the patient is in clinic today.

WRITING ORDERS AND PRESCRIPTIONS

One of your common duties as a clerk will be to write orders on your patients. Any patient being admitted to hospital, being transferred to a new service, or having their management changed must have orders. Orders are generally hand-written on the order forms in the chart, although some sites have undergone the transition to electronic order entry. Do NOT forget to sign your name with your rank (i.e. CC3)! Always include the date and time, and try to number your order items. Generally, your orders will not be carried out unless they are co-signed by your resident or staff. Nurses may accept your orders for minor things such as blood work or x-rays, but it is good practice to review ALL orders with an MD.

A. Admission/Transfer Orders

Most people use the "AD DAVIIDD" mnemonic. Some services and hospitals use standardized admission order sheets so you can just check off your orders – verify with your Resident whether this is used.

Standardized order sheets are nice for speed, but they prevent you from learning and getting used to orders. Make sure you study and would be able to write the orders from memory.

It is always a good idea to ask yourself WHY each of the checkboxes exists on the standardized orders. Ask you residents if you are unsure

Admit: Admit to *<your service>* under *<your consultant today>*

(E.g. Admit to D4 Team medicine under Dr. X.)

Diagnosis: This is what you suspect they have (e.g. Acute Renal Failure, Congestive Heart Failure).

Diet: **DAT** – diet as tolerated (no restrictions)
NPO – nothing by mouth (if going for surgery/procedures)
**Don't let patients stay NPO longer than necessary!!!
Sips Only – usually if coming off surgery/bowel obstruction

Clear Fluids – includes ginger-ale, apple juice
Full Fluids – includes pudding, ice cream
Advancing Diet – NPO to sips to clear fluids to full fluids to DAT
Diabetic Diet – also indicate Calories (1800 Kcal, 2200 Kcal)
Cardiac Diet
Dysphagia Diet

Activity: **AAT** – Activity as Tolerated (will use 99% of time)
NWB – Non-Weight bearing (Ortho)
FWB – Full Weight bearing (Ortho)
BR – Bed Rest (OB)
BR with BRP – Bed Rest with Bathroom Privileges (OB)
Others – sedentary patients might have ambulation orders, e.g. "*Up in Chair TID*", "*Ambulate BID*"

Vital Signs: (HR, RR, BP, O_2 Saturation, Temperature)
Ask yourself if all vitals need to be done and how frequently?
VSR – Vital Signs Routine (q 8-12 hours, i.e. q shift)
Others – more frequent if patient v. sick (vs q6h, etc.)
– Special parameters (e.g. postural VS, neuro vitals q1h)
Monitor (not really vitals, but a good place for this)
– Accurate Ins & Outs (surgery, volume status pts.)
– Daily weights (e.g. renal failure, edema, infants)

Investigations: This is the largest section you will write. A simple approach is to remember that there are five basic areas of investigation: Imaging, Consults, Cells (Hematology/Cytology), Bugs (Microbiology) and Biochemistry. For each investigation start from the head and work down keeping in mind your patient's disease. Avoid standing orders and if you need daily investigations specify number of days (e.g. "daily CBC x3 days").

- **Imaging**: X-ray, CT, MRI, ultrasound, nuclear, echo, ECG
- **Consults**: Social Work, SLP, PT, OT, neurology, etc.
- **Cells:** CBC + diff, PTT/INR, immunology, cytology, CSF cell count

- **Bugs**: For this section remember all the things you can culture: blood, urine, feces, saliva, CSF, pus from wounds; urine R&M/C&S, gram stain for CSF
- **Biochemistry**: Electrolytes (Na^+, K^+, Cl^-, HCO_3^-), Urea, Creatinine, Ca^{2+}, Mg^{2+}, PO_4^-, glucose, CSF protein and glucose

IVs: Solution (D5W, 2/3+1/3, NS, Ringers), Rate (cc/hr), Additives (e.g. KCl)

Drugs: This is also a big section. A simple approach is "Past, Present & Future". Begin by ordering all the medications the patient is already on ('the Past'). Exercise judgment as to which ones the patient still needs. For example, a bleeding patient doesn't need aspirin or warfarin. For the Present, think about what the patient needs right now. They will likely need an IV but may also need antibiotics, diuretics, anti-arrhythmics and so on. For the Future try to anticipate what the patient might need. Think about DVT prophylaxis, sleeplessness, nausea and pain.

Diabetics and DVTs: Accu-cheks, sliding scales, and heparin!

- Mnemonic: Make sure you've addressed the **"10 Patient P's"**
  Problem specific medical issues
  Pain: analgesia
  Pus: antimicrobials
  Puke: anti-emetics, prokinetics, antacids
  Pee: IV fluids, diuretics, electrolytes
  Poop: bowel routine
  Pillow: sedation
  PE anticoagulation (e.g. heparin 5000 units sc bid)
  Psych: don't forget about the DTs (delirium tremens) when on medicine!
  Previous Meds
- Alternatively, think of the **"7 A's"**

Analgesics	Anti-emetics
Antibiotics	Anti-inflammatory
Anti-coagulants	Autologous (own meds from before admission)
Anti-constipation (laxatives)	

Sample Order

To demonstrate a typical set of orders let's assume we have a 70 y.o. M with bright red blood per rectum. This is only an example as different hospitals and individual staff will have their own specific preferences.

1. Admit to Medicine (14 Cardinal Carter Wing) under Dr. X
2. Dx: Lower GI Bleed
3. NPO (may take PO meds with sips), AAT, VSR
4. Foley Catheter
5. Accurate Ins & Outs
6. Alert MD if U/O < 90cc over 3 hrs
7. Daily Labs x 3 days: CBC, BUN/Cr, lytes, PTT, INR
8. ECG, 3 views of the abdomen
9. GI consult in am
10. Standard bowel prep
11. 2 large bore IV's (14 or 16 gauge)
12. 1st IV: NS with 20 mEq KCl/L @ 125 cc/hr
13. Saline lock second IV
14. Transfuse 2 units of cross-matched PRBC over 2 hrs with 20 mg furosemide between 1st & 2nd unit
15. ECASA 325mg PO daily (HOLD)
16. Ranitidine 150 mg PO BID
17. Ativan 0.5mg SL QHS PRN
18. Tylenol plain 1-2 tabs q6h PRN

B. Common Order Pitfalls

1. **Name, Hospital #**: Always remember to write the patient's name in the upper right-hand corner of the order sheet or stamp that corner with the patient's hospital card. Nurses cannot carry out orders unless the patient is properly identified.
2. **Date and Time:** Needed to carry out the orders and helps clarify the sequence in which care is delivered to patients.
3. **Allergies**: Always remember to write in the allergies or NKDA on EVERY page!
4. **Write Clearly**: Hours of work (interviewing, examining, reviewing, and counselling) can be undone in the few seconds it takes to write an illegible order that is misinterpreted. Dosing mistakes usually result from bad penmanship and improper short forms.
   - Always use prefix zeros but never use unnecessary or trailing zeroes, i.e. ".1 mg" (bad), "0.1 mg" (better). "10.0 mg" (bad), "10 mg" (better). Use "mcg" for microgram doses.
   - Try to avoid abbreviations, e.g. OD means "once daily" and also means, "right eye".
5. **Remember to think ahead:** Anticipate problems with regards to pain, sleeplessness and hydration. It may be worthwhile to order prn meds for pain, constipation, nausea, and sleepiness at the time of admission. A simple order written at admission can save you or someone else a call at 2 am.
6. **Press hard on the order sheets**: You are making a carbon copy that will be used by pharmacy. Pharmacy will catch your mistakes more than anyone else so do them a favour.
7. **Sign the orders** with your name, rank, and pager number so that orders can be clarified if necessary.
8. If the orders are important, ensure they are seen by the ward clerk or nurse right away. Regardless, always remember to pull up the "Doctor's Orders" flag in the chart.
9. Don't abuse words like "now" or "stat" – check with your resident.
10. If you are unsure about your orders in any way, make sure to ask someone.

C. Ordering Medications

Format and Nomenclature

Drug	Dose	Route	Frequency	Duration/Amt
Lasix	40 mg	IV	q12h	
Clarithromycin	500mg	PO	BID	X 10 days
Ativan	0.5 mg	SL	qhs prn	20 tablets
Tylenol #3	1-2 tablets	PO	q6h prn	15 tablets

These doses and routes are for illustration only, so check them before writing orders. You cannot possibly know every drug dose, but you will come to know those that are commonly used. It is extremely helpful to have a pocket book with drug dosages. See Useful Resources for Clerkship.

Common Medication Abbreviations

PO	By Mouth	**od**	Once Daily	**Q_h**	Every _ Hours
IV	Intravenous	**daily**	Once Daily	**PRN**	As Needed
SC	Subcutaneous	**BID**	2x Daily	**qhs**	At Bedtime
SL	Sublingual	**TID**	3x Daily	**ac**	Before Meals
PR	Per Rectum	**QID**	4x Daily	**qw**	Every Week
IM	Intramuscular				

D. Writing Prescriptions

Prescriptions for outside the hospital use the same abbreviations, but with a slightly different format. Formal prescriptions have the following structure:

Date

Patient name and Address and/or Date of Birth

- Write out or stamp directly with patient's hospital card (do not use stamped stickers)
- Script should have two pieces of information identifying the patient (patient's name + address or DOB)

Inscription (Rx is short for "recipe" or "take thou")

- Also called the body of the prescription
- Provide the drug name, dosage, route and if relevant the formulation/dosage form (e.g. suspension, syrup, tablet, etc.)

Subscription (Instructions to the pharmacist)

- Specify the quantity to be dispensed and any special information
- The abbreviation M: (Mitte = "dispense") is often used here
- For narcotics, write out the amount to be dispensed, *e.g. "30 (thirty)"*

Signature (Instructions to the patient)

- What you want written on the bottle, to clarify the inscription
- The abbreviation S: (Sig, Signa = "write") is often used here *(e.g. "apply sparingly to affected area QID")*

Refill Information (# refills, or NO repeats...ALWAYS remember this)

Prescriber's Signature
(Your signature AND a co-signature from your resident/staff)

***Benzodiazepines and Narcotics**
If you are prescribing a benzodiazepine or a narcotic (which are now controlled substances) you must include a patient ID number (such as an OHIP number) as well as the physician's CPSO number. Ask for help if you're not sure what you need to do, so that the pharmacy doesn't have to call you later to let you know that the prescription was invalid.

Sample Prescription

Date: September 1, 2004
Patient: Mr. John Doe
Address: 1 King's College Circle
(1) Lasix 40mg PO daily
M: 14 tablets, NO repeats
(2) Fucidin Ointment
M: 30 g, NO repeats
Sig: Apply sparingly to affected area TID

Dr. Ian Taylor

All prescriptions require a doctor's signature! If you write a script, sign your name but then remember to have your resident/staff CO-SIGN it.

For all prescriptions, put a line through any blank space at the bottom so that the patient cannot add their own medications to the list

REQUESTING A CONSULTATION

Consults are arranged when your team needs an expert opinion (e.g. a patient admitted under medicine develops acute abdominal pain and a general surgery consult is requested to find out if it's a surgical problem).

The details of requesting a consult will vary slightly, but here is a quick, general approach. Remember to write the order for a consult in the chart and **call it in yourself** (check with your resident or staff the first time, as some services do not permit/expect clerks to request consults).

- Page the RESIDENT on-call that day for the service you need
- Introduce yourself and let them know that you would appreciate a consultation on your patient
- Give the consultant a brief history of the patient
- **Always have a question.** Clearly state **WHY** the consultation is being requested i.e. *"Please assess for condition X / please rule out condition X"* OR *"Please advise on the management of condition X"*
- State the level of urgency
- **Have the chart handy** so that you can answer questions regarding blood work, specific dates, hospital number, etc.
- You may want to ask the consultant to page you once they have seen the patient or you can communicate through the chart
- You may choose to write a brief consult request note on the CONSULT sheets

Sample Consult: (if verbal, BE BRIEF & TO THE POINT)

ID: name, age, service admitted under, floor & bed #.

RA: Admitted to service for the following: _____

Reason for Consult:

(1) To answer the following questions: _____

(2) To help manage the following medical conditions or findings: _____

PMH: list of the **relevant** history.

HPI: This HPI has to do with the reason for the consult. For example, the patient may have been admitted for pyelonephritis, and on investigation, was found to have an incidental finding of an adrenal mass. Tell the consultant the HPI of the adrenal mass. Include relevant symptoms, labs, etc.

FH, Social Hx: If relevant to the consultant

ANAESTHESIA

Outline of Rotation

- 2-week rotation
- 2 simulation days at Sunnybrook (usually Day 2 and Day 9)
- 8 mandatory e-modules (two simulation day modules must be completed before the corresponding sessions)

Useful Resources

- Course manual on Elentra
- *Anaesthesia for Medical Students* is a comprehensive companion to the emails (copy available on Elentra)
- *Ottawa Anesthesia Primer* – for those wishing further reading at a medical student level

Preparation before the Rotation

- Read the course manual on Elentra!
- Review basic cardiac and respiratory physiology, and narcotic equivalencies
- Learn about:
- Preoperative assessment (ASA scoring system & Mallampati scoring system)
- Drugs and common dosages, different types of lines, epidural vs. spinal
- Basic induction, maintenance, and emergence
- Basic airway management (including airway assessment, which you should complete on each patient)
- Pain management
- If you are interested in specific areas of anaesthesia (i.e. IV insertion, OB, pain management, etc.) and if they are available at your assigned hospital, contact your site coordinator early so they can organize specific ORs for you

Typical Day

- Ensure that you arrive at the OR on time – typically 07:30

- Assist in the OR throughout the day – typically there will be 2-6 cases depending on the type of cases
- Patients are typically outside the OR, or in the preoperative area prior to the start of the case – try to help complete the preoperative assessment sheet and the physical exam before the patient is brought into the OR
- Post-op, assist in transfer of patient to PACU and record post-op vitals on arrival at PACU
- May have a day rotation on the Pain Service or Preadmission Clinic

Call

- Generally, NO CALL, but some evening shifts optional depending on your hospital. Volunteer to be on call with the site lead if you are gunning for anesthesia. You also learn a lot on call.
- Evening shifts = ER cases and L&D

General Tips

- Review Pre-operative Assessment and Airway Management in the Anaesthesia Clerkship Manual on Elentra prior to starting – really helps!
- On Day 1 – familiarize yourself with the drugs that your particular hospital uses (take stickers!)
- Let your preceptor know if you are just starting your rotation, they will often teach your basic skills (setting up a saline bag, piggy-backing a second bag, etc.) and useful tips!
- Know basic OR protocol
- Check the OR schedule the day before and familiarize yourself with the cases (you will be assigned to an OR)
- Always introduce yourself to the patient outside the OR or before induction of anesthesia
- Always introduce yourself to the nurses – they are critical to a positive rotation
- Take the initiative to fill out the anaesthesia record

- There will be downtime in the OR so go in prepared with questions
- Be proactive – ask to prepare meds, push meds, place lines, and do intubations
- Purchase a comfortable pair of shoes – these will be handy for other rotations too (Surgery, Ob/Gyn). Ideally water proof.
- Dress code is scrubs for the OR. If you are cold, ask a nurse for an OR gown. Do not bring your own sweater into the OR or wear full sleeve shirts under the scrubs.
- Do not bring personal bags or handbags into the OR, you are welcome to bring a notebook or an iPad into the OR.
- All valuables should be kept on one's person. Everything else should be placed in secure lockers where provided.

Examination

- MCQ
- Short answer questions
- Key concept questions (choose 4 from a list of approx. 10 options)
- Review "topics for discussions", e-modules and course manual
- Only need to know drug dosing for ACLS medications

Evaluation

- Written evaluation – 60% [1.5h exam - 40% MCQ, 60% SAQ]
- Clinical evaluation – 40%

Contact Information

- 2T1 Anaesthesia Representative (Dong An)

DERMATOLOGY

Outline of Rotation

- Four elements comprise the rotation, all during TTC:
- 1) Patient viewing day – a full day consisting of 12 patient, clinical or procedural stations, each 12 min, facilitated by staff dermatologists or senior dermatology residents
- 2) Online modules – 2 orientation modules and 10 clinical modules with 3 short questions after each module
- 3) Clinical note – one of the stations during patient viewing day will require a focused H&P for a patient who comes in for a skin check. The following station will be a rest station to provide time to edit/complete a clinical note, which is submitted at the end of the day. Note: This station is done as a group, but each member must submit a separate note.
- 4) Written exam – 40 MCQ, 1-hour exam, includes photos

Useful Resources

- Dermatology syllabus on Elentra
- Online atlas (link on Elentra)
- Optional modules on Elentra
- http://dermnetnz.org

Preparation before the Rotation

- Review the course material from Dermatology week in pre-clerkship
- Review the course website on Elentra
- Review taking a dermatological history and performing a full skin exam

Call

- No call

Sample Note

- ID: age, gender, ethnicity, occupation, +/- drug plan

- HPI: **OPPQRST** – **O**nset; **P**osition (location), **P**ersistent vs. intermittent; **Q**ualifying factors – pruritus, pain, burning; **R**elieving and aggravating factors; **S**ystemic symptoms – fever, weight loss, arthralgias, GI symptoms; **T**reatments – prior investigations and/or treatment(s)
- Past medical history and family history of dermatologic (and other medical) problems, medications, allergies, exposures
- Physical exam: **P-SCALLDA** - Skin **P**hototype; **S**ize of lesion(s); **C**olour of lesion(s); **A**rrangement of lesion(s); **L**ocation of lesion(s); **L**esion morphology – primary and secondary; **D**istribution; **A**lways check nails, hair, mucous membranes, intertriginous regions

General Tips

- Do not spend an excessive amount of time taking a history prior to the physical exam as some symptoms may be better elucidated after seeing the lesion
- This rotation is very short! Stay engaged during patient viewing day and use it as an opportunity to ask your station preceptors questions
- Go into this rotation with the mindset that dermatology is relevant to your learning and WILL come up on family medicine, pediatrics, internal medicine, etc.

Examination

- Written exam – 1h x 40 MCQ (80%)
- Clinical note – completed during patient viewing day (20%)
- When studying, refer to the mandatory modules on Elentra (HIGH YIELD), online atlas (link provided in Elentra) in addition to the course syllabus – you will need to be able to recognize the common dermatological presentations; pictures are often on the exam

Contact Information

2T1 Dermatology Representative (Matt Ladda)

EMERGENCY MEDICINE

Emergency Medicine is an extremely broad specialty and one that will be applicable to your career regardless of what path you choose. Whether you are receiving a consult or advising a patient to go to the emergency department, being familiar with what is and is not possible in the emergency department is key. Emergency Medicine is fun and emergency physicians are some of the most interesting, funny and accomplished people you will meet – so make the most of this rotation!

Outline of Rotation

- Starts with a 3-day intensive crash course that includes interactive seminars and hands-on workshops on airways, chest pain, cardiac dysrhythmias, ED radiology, wound care, toxicology, trauma, and splinting
- Subsequently, you will have 3.5 weeks of clinical time
- Expect to work two weekends and up to three night shifts during the rotation
- You will be scheduled for approximately 14 shifts and it is expected that missed shifts be rescheduled
- Each clerk is assigned 1-2 preceptors for at least 50% of their shifts
- You will be working with a variety of staff physicians during your rotation, all of whom play a role in your evaluation

Useful Resources

- Course Manual: The ABCs of Emergency Medicine
- Tintinalli, Judith. Emergency Medicine: A Comprehensive Study Guide. ~ $230
- Dubin, Dale. Rapid Interpretation of EKGs. ~$50

Preparation before the Rotation

- Since Emergency Medicine is such a broad field, your reading needs to be equally broad

- Before you get overwhelmed, remember that the goal for you is not to nail the diagnosis every time but to have a good approach to the common presenting complaints and to have a healthy differential diagnosis:

  Step 1: Download the course manual, *The ABCs of Emergency Medicine*, from Elentra

- Reading this manual will provide you with practical information for managing ER patients and will function as a useful reference. Exam questions are taken directly from the manual and the seminar material.
- The book has a couple of chapters on the "The Symptom Pursuit Approach". Try to thoroughly review these chapters before starting your clinical work. That way you won't be lost on your first day.

Step 2: Buy a pocket book

- Keep track of the patients you've seen, and what investigations/treatments are pending before their discharge
- Keep track of things you want to read up on.
- Write down summary answers in the pocketbook. That way if you see the same case again, you don't have to run around trying to find a free computer.

Step 3: Other common things you should learn (that will make you look like a superstar)

- Familiarize yourself with the resuscitation chapters with a focus on knowing how to clear a C-Spine and the common C-Spine Precautions
  - Canadian CT Head Rules
  - The Ottawa Foot, Ankle and Knee Rules
  - Know how to do simple interrupted sutures
  - Know how to read ECGs (especially for MI, WPW, Afib, etc.)
  - Basic chest X-ray interpretations
  - Common meds for common problems (e.g. STI, CHF, asthma)
- Other great resources:

- See the Emergency Medicine course page on Elentra where you will find contact info, seminar schedules/notes, and the clerkship handbook which contains course info and a list of objectives

Typical Day

- The schedule varies – you may work the day, afternoon, or night shift (generally 8 hour shifts at most hospitals)
- You will be linked with several nurses
- With the assistance/supervision of a nurse, you should perform the following procedures: IVs, venipunctures, Foley catheters, NG tubes, and ECGs
- You may perform other procedures under the supervision of RTs or the orthopaedic technicians, as available

Call

- No call

Sample Case Presentation

An Emergency Medicine case presentation is very different from an Internal Medicine or Family Medicine case presentation. From experience, most physicians have recommended the following order:

- Patient's Name, Age, and Sex (e.g. Mr. Al Capone, 67M)
- **Chief Complaint** (e.g. Chest pain)
- **PMHx:** State the PMHx before the HPI only if it is relevant to the current presentation (e.g. Hx. of MI x 2, DMII and CAD)
- **HPI:** State the relevant positives supporting your diagnosis first (e.g. 8/10 retrosternal chest pain with radiation to the left shoulder and associated with nausea, vomiting, dyspnea and diaphoresis), then state the pertinent negatives (e.g. I don't think this patient has a PE because there was no calf swelling or tenderness, hemoptysis, or risk factors)
- **Physical exam:** ALWAYS present the vitals and the general state of the patient first, followed by the relevant physical exams – in the ER, you have to learn to be focused so do NOT do a knee exam on someone

who presents with chest pain as it does not matter if they have arthritis!

- **Pertinent labs and imaging:** in the ER, nurses will often order blood work even before you see the patient, so be aware of these results
- **Your Impression, Working Diagnosis, and Differential** (e.g. M.I. or less likely causes such as pericarditis, aortic dissection or PE)
- **Assessment and Plans:** Summarize what you think is the working diagnosis and any investigations which may help to narrow the differential
- NOTE: If the patient has presented to the hospital before, review their old notes before presenting as this can add significant value to your presentation

General Tips

- The most appropriate dress code is scrubs, though white coats can be worn over scrubs or business casual dress if desired
- Try to find your supervisor and ask him or her if it's okay for you to start seeing patients – this may not always be possible if the staff is with a patient
- You will see many different presentations during this rotation and you are not expected to know how to approach each one specifically – it is recommended that you have a good approach to the following "bread and butter" scenarios: "dizziness", failure to cope in the elderly, fall, headache, chest pain, shortness of breath, abdominal pain (male/female specific), vaginal bleeding in pregnancy, altered level of consciousness, allergic reaction, seizure, and shock
- You will be seeing some sick patients – if you are worried about a patient or a person's condition deteriorates during your assessment, find your staff physician immediately
- Ask your staff how long they expect you to spend with each patient and how they want you to present the patient – staff can have very different expectations and knowing this beforehand can make life much easier for both of you

- When approaching a diagnosis, it is important to think in broad categories (e.g. GI, GU, CVS, MSK), and have a systematic approach so you do not miss important findings
- Vitals are called vitals for a reason
    - Before seeing the patient, ensure that you review all the patient's vitals since they first were seen by medical personnel
    - If any vital signs are unstable, let your staff know immediately before you assess the patient – immediate intervention may be needed
    - If there are non-urgent abnormalities, record them in your assessment and circle them so you remember to discuss them with staff – all abnormal vitals should be repeated when you see the patient
    - Remember that there are 5 vital signs: BP, HR, RR, T, SaO_2
    - Have a general idea of how to interpret ECGs – ER docs are asked to review these constantly
    - Have a plan in place for your patient after you see them:
    - Investigations you want ordered
    - The differential diagnosis
    - The patient's disposition (home versus admission). Who would you refer them to?
    - Are there programs in the hospital that could help this patient at home (e.g. CCAC, Geriatric Outreach Team)?
    - Reading around cases is important in Emergency Medicine – if you have Internet access, use eMedicine or UpToDate to further your understanding on the topic while you are between patients
    - Some ERs have a computerized method to track the time a patient waits to be seen by specific people – ask your supervisor whether or not they want you to help keep track of this information
    - Learn how to do simple interrupted stitches and instrument tie reasonably well before or during the rotation

- Remember to ask to eat if you are hungry – ER shifts can be very busy, and you need to take care of yourself
- Be very nice to the Emergency Nurses – they can really help you if you're interested in doing simple procedures like starting IVs, obtaining blood samples, bandaging wounds, etc.

Examination

- 1-hour written exam. MCQ, short answers and key feature questions based on content of course manual and seminars

Evaluation

- Written exam (50%)
- Clinical evaluation (50%)
- Shift evaluation forms filled out by the staff supervisor at the end of each shift – in total there should be ~13 shift cards
- Observed history and physical
- Your preceptor will provide mid-rotation feedback and should review your Case Logs progress at the same time

Contact Information

2T1 Emergency Medicine Representative (David Wiercigroch)

FAMILY MEDICINE

Outline of Rotation

- 6-week rotation
- The first two days consists of centralized core seminars downtown.
- The six weeks are spent at your assigned Family Medicine clinic. You may have seminars with the other students at your site during these weeks. You will have mandatory e-modules to complete, which cover core topics in Family Medicine.

Useful Resources

- American Family Physician Website: very good practice guidelines for classic Family Medicine problems (access through U of T library).
- Canadian Practice Guidelines: http://www.cma.ca/cpgs/
- Canadian Task Force on Preventive Health Care: practice guidelines on medical screening (www.canadiantaskforce.ca/)
- DFCM Open: one-page primers on common presentations (www.dfcmopen.com)
- The Hub: created by Dr. Azi Moaveni, useful resources for common Family Medicine topics (http://thehub.utoronto.ca/family/)

Preparation before the Rotation

- Scan the Family Medicine chapter in Toronto Notes.
- Get comfortable with general approaches to common issues: e.g. Hypertension, common infections, diabetes management, chest pain, abdominal pain, back pain, etc.
- Review your head-to-toe physical exam skills.
- Be familiar with up to date screening guidelines (breast/colon/cervical cancer, lipids, diabetes, etc.) and immunization schedules.

Typical Day

- Generally, clinics begin at 9:00 am and finish by 5:00 pm (varies by site). You will typically be assigned to 2-3 preceptors, depending on your site. You will see patients throughout the day, taking histories, performing physicals, and assisting with procedures.

- Occasionally, you may have shifts during the evening or on weekends depending on your preceptor's schedule.
- Some preceptors may also work in other specialty clinics (e.g. sports medicine, geriatrics, etc.) or do Obstetrics/Emergency shifts.

Call

- Varies by site: some sites have mandatory ER or Obstetrics shifts.

Sample Note

- "SOAP" note: see page 8 for details.

General Tips

- On your first day, ask your preceptor to explain the charting system they use in the office. With electronic records, it is often helpful to learn how to use time saving functions like inserting standardized forms (e.g. Rourke, annual health exam form) or stamps.
- Most charts have a cumulative patient profile (CPP). Before you see a patient for the first time, scan the CPP quickly for an overview of their medical problems, meds, FHx, SHx, and screening exams.
- Every time you see a patient, try to write the "assessment" and "plan" part of your SOAP note before you review with your staff. This is great practice and forces you to create a clear management strategy on your own.
- Try and see as many different patient problems as you can. In academic centres, the staff physicians may have more narrow scopes of practice, so try and work with a few different preceptors to get exposure to a larger spectrum of patients and issues.
- Do as many procedures as you can (pelvic exams, Paps, immunizations, ear syringing, cryotherapy, punch biopsies, etc.). If you express an interest in doing these things, your preceptor is more likely to let you try!
- Ask your preceptor to let you write the requisitions and the prescriptions. It is good practice and it will save your preceptor time.
- Know the practice guidelines published by the CMAJ on common clinical presentations. Decision making in Family Medicine largely relies on these evidence-based guidelines.

- Use periodic health exams as an opportunity to practice different physical examination skills (e.g. fundoscopy). The more "normal" findings that you're exposed to will help you better recognize abnormal pathology in the future.
- Also take the opportunity to practice counselling patients on a variety of health topics (e.g. exercise, smoking, diet, etc.)
- For Periodic Health Exams:
  - Ask about changes in their typical symptoms for their chronic condition(s).
  - Record full functional inquiry and focus on education and health promotion (sun safety, seatbelt use, water safety)
  - ALWAYS ask about new meds or changes in chronic meds. Ask about over the counter (OTC) meds and herbals also.
  - Some EMR systems have stamps for Periodic Health Exams – if yours does, this can be useful for guiding your history and physical.
- During well child/well baby visits, record developmental milestones. Use the Rourke record and/or Nipissing checklist.
- Start thinking about your academic project topic sooner rather than later. Basing your presentation on a clinical encounter you had will make the whole process easier.

Examination

- Written exam is during the last week of the rotation.
- Make sure you study the seminar material from the first week, review topics of the Hub and topics taught in your hospital-based seminars.

Evaluation

- Clinical Evaluation - 35%
- Evidence-Based or Advocacy Project [presentation and write-up] - 15%
- Written exam – 34% [SAQ + key features]
- Clinical Evaluation Exercises (FM-CEX) [4 observed H&Ps] - 16%

FM-CEX

- Each FM-CEX is an observed history and physical by your preceptor that is graded using a standard evaluation form; you have to do one per week in weeks 2-5 (each worth 4%). You will see all of your CEX marks at your final evaluation with the Hospital Program Director.

Contact Information

- 2T1 Family Medicine Representatives (Alicia Roy & Shivani Patel)

MEDICINE

Outline of Rotation

- See Elantra for full details on scheduling, evaluations, and to find the *Orange Book* with suggested study topics.
- 8 weeks of Team Medicine with 4-6 ambulatory half days scheduled between weeks 2 and 7 (site-specific with a fair bit of variation between sites, pre-assigned, and covering 2-3 sub-specialties).
- The rotation starts with 2 days of didactic teaching on common topics in Internal Medicine. These are high-yield topics that you will see many times on the wards.
- Each site will also have site-specific longitudinal seminar series, ECG reading and radiology seminars over the course of the rotation.
- Typically, each hospital has 4 teams, each with a staff internist, senior resident (PGY-2 or PGY-3), 2-3 interns (PGY-1), 3rd year clerk(s), +/- elective students. Additionally, there is usually a fifth (Hospitalist) team that does not include clerks, whose purpose is to consult in the ER during the daytime hours, so the other teams do not have to.
- Each student is assigned a preceptor to provide informal feedback and teaching, and to observe your evaluated H&P.

Useful Resources

- Official textbook: Cecil Essentials of Medicine by Andreoli – ~$80
- Useful resources:
- Pocket Medicine: The Massachusetts General Hospital Handbook of Internal Medicine – ~$65
- Approach to Internal Medicine by Hui (similar to Pocket Medicine, but Canadian)

Preparation before the Rotation

- Look through the course website and the *Orange Book* manual on Elentra
- Read about the approaches to common presenting complaints: chest pain, cough, shortness of breath, decreased level of consciousness, weakness and abdominal pain. Other important common problems are listed in the curriculum outline in the *Orange Book*.
- Develop an approach to interpreting common investigations: CXR, ECG, PFT, ABG, joint aspirate, CSF, urinalysis/microscopy, CBC/lytes
- Come prepared (instruments, scrubs)! You will be assigned patients on the first day and may be on-call the first night.

Typical Day

- **8–9 am Morning Report (some sites have this later in the day, a few times a week, or do not have it at all):** The clerk or intern presents an interesting/challenging case and the staff poses questions to the students to facilitate learning/solving the case.
- **Rounds with staff:** How often and how long depends on staff. Also round on the new patients received on-call previous night.
- **Bullet rounds:** Rounds with interdisciplinary team (PT/OT/Pharmacy/SW/RN/RD/CCAC). Management/discharge planning is discussed during these rounds
- **Clinical care**: See patients in order from most sick > those needing discharge > least sick
- Relevant Hx and P/E (ask staff or resident how to focus)
- Write progress note (SOAP format)
- Order/follow up on labs/imaging/consults
- Review plan with senior resident
- **Lunchtime rounds:** Daily presentations on various topics. All teaching, including lunchtime rounds, will vary be site. Site directors will inform you of your teaching schedule.

- **Teaching:** Site and team dependent. The afternoon is also often used to round on patients or provide clinical care.
- Typically leave by 5:30 - 6:30 pm
- There is gradually increased responsibility on the ward with students being expected to care for more patients each week of their rotation.

Call

- Approximately 1 in 4 (including alternating weekends). The pattern for call days is: Mon-Fri-Sun-Thu-Tue-Sat-Wed (repeating depending on your start date).
- Students will take overnight call taking consults from the ER (typically 1-3 per night). There is gradually increasing responsibility (e.g., covering ward issues typically in week 4) as the rotation progresses.
- For any consult, find out from your resident the location of the patient and whether the patient is stable or not. Go eyeball the patient to double check that the patient is still stable (e.g. vitals ok, on a monitor), and review previous records (e.g. old d/c notes, EM note, and already-ordered labs) before formally going to see the patient.
- Write a full admission note (see example below) and review it with the senior resident upon completion. Time to review varies, so use it productively (e.g., study/read around case/create a management plan).
- Formal presentation to staff/team in the morning followed by rounding on all new admits. The post call day ends at 10 am. Maximum time in hospital on call is 26hrs.

Sample Admission Note

1. **ID:** Age, sex, came from home/institution/street, arrived by EMS/walk-in/cab. If neuro case, include handedness. Note any limitations in collecting information (i.e. non-reliable historian).
2. **CC and RFR:** Include BOTH the CC (why the patient came in) and RFR (why the emergency staff referred them to Internal Medicine).

3. **PMHx:** Present the most pertinent part of the PMHx first. Number PMHx items from most to least important and report in that order. Flesh out directly relevant PMHx, including signs/symptoms, any previous W/U (work-up), disease course, major events, Rx, compliance to Rx, recent changes in Rx, complications, and F/U including date last seen by F/U MD.
4. **Meds:** from patient, family, pharmacist, FamMD or Electronic Health Record (MiSYS, Soarian, etc.). Rx, dose, route, compliance and when prescribed.
5. **Allergies:** include patient reaction
6. **HPI:** OP3QR2ST2 for all presenting complaints. Begin with onset of symptoms and proceed chronologically (e.g., course in ER). Discuss pertinent positives, pertinent negatives, risk factors, constitutional symptoms. Calculate risk scores where relevant (e.g., PORT, TIMI, Well's etc.).
7. **SocHx: ADL, iADL, Smoke** (how long, how much) / **EtOH** (how much, what, how long) / **Drugs** (IV or not), immigration hx, sexual history, education & work hx, home & home care.
8. Code Status: Including details on interventions (e.g. chest compressions, intubation, ICU admission).
9. **FamHx:** where relevant. Ask about health issues in parents, siblings, and kids. Ask about FamHx of cancer, CAD, DM, and autoimmune as appropriate.
10. **(ROS):** Non-pertinent ROS not listed in the HPI. Often non-relevant ROS is simply stated as: additional ROS unremarkable.
11. **ER Management**: Include vitals at triage to the ER, and what was done for management before medicine was consulted
12. **Physical Exam**
    General Appearance: well or unwell + conditions (i.e. O2 mask, IV w/ meds, etc.).
    Other possible descriptors: obtunded, agitated, respiratory distress, disheveled.
    VS: BP (both arms if cardiac pt.), HR (note regular/irregular etc.), RR, Temp, O2 Sat, pain and pain control. If indicated: orthostatic VS. GCS. All vitals should be when you visited the patient, not at triage.

Cardio: JVP, apex, heart sounds (S1-S4), murmurs. If indicated: bruits, peripheral swelling.
Resp: inspection (obvious abnormalities), auscultation. If indicated: percussion, palpation, clubbing.
Abdo: bowel sounds, percussion, palpation, peritoneal signs. If indicated: organomegaly, CVA tenderness, signs of liver disease, DRE.
Other as indicated: Neuro, MMSE, PVE, MSK, Derm, Ascites, HEENT, Thyroid, etc.

13. **Ix:** CBC, lytes, extended lytes (Total calcium, albumin, phosphate and magnesium), other blood/biochem, ECG, then imaging. If there are any abnormalities in the CBC, report the MCV and WBC differential. If current abnormal lab value, make reference to baseline lab values if available. Circle abnormal results in your notes.
14. **Impression:** 3-4 summarizing statements including ID, CC, pertinent findings on Hx, P/E, and Ix. Include working DDx and rationalization. This section can be organized into issues.
15. **Plan:** Should address specific issues in impression. Come up with a problem list. Always remember to include discharge/disposition in the plan. e.g.:
    1) Acute renal failure – DDx, Ix, Tx
    2) L knee pain – DDx, Ix, Tx, PT/OT to see
    3) Disposition – home when ambulating and Cr stabilized. CCAC to see.

General Tips

- You should know your patients best. Stay up to date with their status, concerns, investigation/results, allied health, and discharge planning.
- Speak up! Make sure you advocate for your patients at interdisciplinary and team rounds.
- Create an issue/problem list for each patient and a list of things to do for each patient daily (templates available for download, e.g. 'Medfools').
- Update the team list daily and ask on the first day where the team list can be edited/printed from (e.g. in EPR).

- When you admit a patient, stamp 2 stickers with the patient's hospital card – for your staff and senior resident.
- If your patient needs other services (allied health, consults, imaging, etc.), try to get this arranged as early as possible. All consults should be made in the morning to ensure the patient is seen on that day.
- "ALC" means "Alternate Level of Care", these patients are awaiting placement and therefore, by definition, should not have daily blood work or investigations for you to follow. Try to see these patients briefly every day and do a formal assessment every 2-3 days.
- When taking over an already-admitted patient, READ THE CHART! The admission note is usually the most helpful place to start. Never take what's in the chart for granted – if you're not convinced the diagnosis or management plan is adequate, consider starting a new workup yourself and ask your resident about it.
- Check medication orders daily – you'll be surprised at what doesn't get done, despite things being ordered. If you suspect that there was a medication error, check the Medication Administration Record (MAR) to assess what your patient has been given.
- Consider whether your patients require blood work for the next day and ensure that you place orders before you leave the hospital.
- A few things to consider on a daily basis that can improve patient comfort: Need for Foley? D/C if possible; current diet – can it be advanced or should they stay NPO, etc.
- Discharge planning should start on the day of admission. D/C summaries should be started early and updated regularly.
- If someone else will be taking over the care of your patient, write a 'Transfer of Care Note' in the chart on the patient's course in hospital. This allows a more seamless transfer of care to the next team member.

- Your approach can be based on any categorization scheme (e.g. anatomy, organ system) – just be systematic!
- Read around topics listed in Appendices 1 and 2 in the Internal Medicine clerkship curriculum outline (orange manual).
- You will pick up a LOT of random information and clinical pearls during your rotation. DO NOT try to chase around all of these clinical pearl tidbits that you hear about every day, just file them away on a notepad reserved for clinical pearls. Incorporate them when you come across reading about relevant examinable topics.

Examination

- Written Exam – 2.5h MCQ, SAQ covering all subspecialties in IM (30%)
- Clinical Ward performance (30%)
- Ambulatory Clinic evaluation (10%)
- Observed Hx & Px (*formative*)
- Patient Centered Care Assignment (*formative)*
- EBM Presentation (5%)
- OSCE - 8 stations (25%)
- 3 standardized patients (Hx only, PEx only, or both)
- 3 clinical vignette stations (one-on-one with a staff, as you go through a case and outline history, physical exam, DDx, investigations, management, etc.)
- 2 written stations (CXR and ECG interpretation)

Evaluation

Measure	Timing	Contribution to Mark
Observed Hx and Px	By end of Week 3	Credit / No Credit
Written Exam	Week 6	30%
EBM Assignment	Week 7/8	5%
PCC Assignment	Week 8	Credit/No Credit
OSCE	Week 8	25%
Ward Evaluation	Ongoing	30%
Ambulatory Clinics	Ongoing	10%

Case Logs / Professionalism	Ongoing	Credit/ No Credit

- *Anticipate the marking scheme to change slightly as this has not been confirmed yet!
- You must pass both the OSCE and written exam individually to pass the course.

Contact Information

2T1 Medicine Representatives (Jeff Smallbone & Sofia Solar-Cafaggi)

OBSTETRICS AND GYNECOLOGY

Outline of Rotation

- 6-week rotation
- Site-specific seminars (each day covers a syllabus topic)

Useful Resources

- Course Syllabus – large compilation of articles and staff-generated summaries. Very detailed, highly applicable information.
- Essentials of Obstetrics & Gynecology by Hacker & Moore. ~$80
    - A must-have for Ob/Gyn keeners, used for the LMCC questions and highly recommended by the teaching staff.
    - Easy to read and great for understanding concepts.
    - Also found at hospital libraries.
- Toronto Notes

Preparation before the Rotation

Read at minimum:

- Hx & PE sections (Toronto Notes, Clinical Exam Handbook)
- Progress of Normal Labour, Fetal Heart Tracing in case you are on call on your first day (Toronto Notes is sufficient)
- Review the course website on Elentra

Typical Day

Gyne

- Round at 7:00 am with Gyne team on in-patients
- Arrive ~15-20 minutes earlier to set up the charts and write down all vitals (with time taken), urine output, most recent bloodwork
- Arrange for necessary consults
- Check imaging and blood work on each patient and then inform the senior resident
- OR +/- academic rounds for the rest of the day
- Usually finish around 5:00 pm

Labour & Delivery

- Rounding on all complicated vaginal/C-section deliveries (exact time depends on the site)
- Go to L&D floor, do admissions, triage, follow patients through L&D
- Usually finish by 5:30 (on-call clerk arrives at 5:00 pm)

Clinics

- Staff dependent, usually start between 8:30-9:00 am (after seminar).
- Some clinics are outside the main hospital building. Ask site supervisor or check CPSO for locations.

Seminars

- usually every day from 7:30-8:30 or 8:00-9:00 am depending on site. These are mandatory to attend unless you are post-call.

Call

- 1 in 4-6 overnight call
- Responsible for L&D admissions, deliveries, ER consults, and ward problems
- Prepare charts (vitals, hgb) for postpartum rounds and help round
- Go home after handover (8 am on weekdays, 9 am on the weekend)

TRIAGE/ADMISSION NOTE TO L&D – Sample

A condensed list to consider when assessing all OB patients, especially in triage:

1. Fetal Movements
2. Per Vaginal (PV) blood loss (amount and pain, Rh?)
3. Contractions
4. Ruptured membranes?
5. Infectious symptoms (fever, pain) & GBS status
6. Complications in pregnancy (bleeding, u/s abnormalities, infections, GDM, HTN)

Date and Time

ID: age, GxPx, GA, EDC, GBS, Rh status

CC: contractions, bleeding, leaking fluid, ↓ fetal movement

HPI: ctx time, leaking fluid, bleeding, fetal movement

Hx of pregnancy: antenatal screening (bloodwork inc. blood type/Rh status and serology, genetic screening, anatomy U/S and other U/Ss, GDM test, GBS result), twins, HTN, infection
OBHx: outcomes of each pregnancy (SA, TA, term/premature, vaginal/C/S, size of babies, length of labours, complications)
PMHx: routine problem list; HTN, DM, asthma
PSHx: surgeries
Meds: dose and route of admin
Allergies: include reaction
O/E: FHR assessment (baseline FHR, variability, accels/decels, tocometer contractions)
Position of baby | palpable contractions?
Sterile speculum exam *(with resident):* nitrazine test, pooling amniotic fluid, ferning, fetal fibronectin
Vaginal exam *(with resident)*: membrane status | cervix (effacement, dilatation, position, presentation)
Other relevant features depending upon chief complaint
Investigations:
SROM? (nitrazine, ferning)
Preterm Labour? (fetal fibronectin, cervical length on US),
Fetal status? (U/S BPP)
Impression:
Primip or multip in active labour (or not in active labour) for admission (or discharge). Try to decide if the pt is in labour BEFORE you go to the resident.
Plan:
Discharge or admit (if admitting, consider: ARM, oxytocin, epidural, GBS prophylaxis)

L&D ADMISSION ORDERS – Sample

Date and Time
Admission to L&D under Dr. _____
Diagnosis: Active vs. latent phase labour, antenatal hemorrhage, etc.
Diet – usually as tolerated, but beware of other circumstances
Activity – same as diet

Vitals – VSR and fetal heart rate monitoring (if concerned about well-being, use continuous; otherwise intermittent is sufficient)
IV solution – Ringer's Lactate/Normal Saline @ 125 cc/hr
Oxytocin (if required) as per hospital policy
Investigations: CBC, group and screen, others if necessary
Drugs: ?Epidural + ? Abx if GBS+

OB PROGRESS NOTE (L & D) – Sample

Date and Time
Subjective: Analgesia: epidural?
Coping?
Contractions – frequency, strength
Oxytocin? Dose?
Exam: FHR assessment (baseline, variability, accels/decels, tocometer contractions) Cervix (effacement, dilatation, station, presentation) Fluid quality
Impression: Progress or not, reassuring fetal status or not
Plan: Continue monitoring progress + FHR, ↑ Oxytocin, call for epidural

DELIVERY NOTE (L & D) – Sample

Date and Time
Type of delivery: SVD, vacuum, forceps, C/S
Obstetrician
Assistants
Anaesthesia: epidural, local
Placenta: spontaneous or manual removal, intact, 3 vessels
Laceration/Episiotomy: degree, repaired with XX suture
Infant: live-born male/female child, birth-weight, APGARs
Blood Loss
Counts correct

POSTPARTUM PROGRESS NOTE (Post-Delivery Days 1 & 2 etc.)

Date, Time and Postpartum Day # (PPD)
Type of delivery (SVD, forceps, vacuum, C/S), provide reason for C/S (repeat, breech, dystocia, non-reassuring FH tracing)
Vitals: "VSS, afeb"

Subjective:
lochia (normal is like a period or less, increased, clots), pain control, voiding, flatus, BM, breastfeeding (Y/N), diet (fluids, DAT), ambulating

Objective:
Abdo exam – fundus firm at umbilicus
Incision – clean & dry / discharge / drains (amt draining, quality)
Periphery – calves tender, swollen, etc.
Chest exam – prn only (i.e. having chest pain, etc.)
Labs - HgB, WBC

Assessment: Well (or differential diagnosis if problem exists)

Plan: Discharge plan, HgB, mobilize, advance diet
Special tests: CBC, CXR, US, CT, leg Dopplers

GYNE OR Note – Sample

Date + PPP SAFE DISC + Disposition

Date and Time
Procedure
Pre-op diagnosis
Post-op diagnosis ("same" if same as pre-op Dx)
Surgeon, Assistants (residents, clerks)
Anesthesia
Findings → you will learn how to fill this section out with experience, ask your resident/staff the first few times you do it
Estimated blood loss (EBL)
Drains → do they have any? (Chest tube, Foley, Peritoneal Drain)
Ins and Outs: Total Urine Output (UO) and Fluid through IV (usually RL or NS)
Specimen: Whatever was sent to pathology (if anything)
Complications**/**Counts correct?
Disposition → usually "Stable, to PACU"

GYNE PROGRESS NOTE (ward note) – Sample

Date and Time

Post-op Day (POD) # (or Hospital Day # if not post-op)

Procedure or diagnosis

Subjective:

Pain (controlled? Via PCA or po analgesia, what dose?)
Diet (NPO, fluids, DAT)
Flatus
Voiding (spontaneously, or to Foley) – urine output
Vaginal bleeding: pads count, clots (if appropriate)
Symptoms of hypovolemia (dizzy, lightheaded, SOB, chest pain)
Screen for DVT/PE (CP, SOB, unilateral leg pain)

Objective:

Vitals: "VSS, afeb" i.e. < 38.0
Chest: lungs clear (or not…)
Abdo exam: soft, guarding, tender
Incision: clean & dry / discharge / drains in place (amt draining, quality of fluid)
Periphery: calves tender, swollen
Labs: HgB, WBC

Assessment: Well POD # (or differential diagnosis if problem exists)

Plan: Advance diet, ambulate, d/c Foley, home
Special tests: CBC, CXR, US, CT, leg Doppler's

ER CONSULT NOTE - Sample

Date and time	
Reason for Referral	
ID:	XX year old gravida X para XX
HPI	**OP^{3}Q^{2}R^{2}ST^2** - briefly describe main symptom
Past Gyne Hx:	**LMP** (cycle length - e.g. 28days) | **contraception | surgeries** | **similar problem** in past (menarche is not very relevant in ER)
Past ObHx:	outcome of all pregnancies (SVD or C/S), including complications (may omit if irrelevant)

PMHx:	Routine problem list. Remember to get details on serious medical problems if patient is elderly (see Internal Medicine notes).
PSHx:	**surgeries**, esp. previous abdo surgery.
Meds:	**Dose and route**
Allergies:	**note what reaction occurs with allergy**
Last Meal:	**(if pt may go to OR)**
SocHx/FamHx:	**FamHx of gyne problems or cancers.** Others as indicated.
O/E:	**Vitals -** (postural if bleeding may be an issue – e.g. ectopic, DUB) **Abdo -** soft | tender | guarding | peritoneal signs | scars **Chest** - lungs | heart sounds | murmurs? **Pelvic** - speculum and bimanual *(only to be done with resident)*
Investigations:	**CBC** | PTT/INR | Cross & Type | **beta-HCG** (R/O pregnancy) | Imaging: Ultrasound / CT (as indicated)
Assessment:	**Differential Diagnosis and working Dx.**
Plan:	**Enumerated list:** more investigations, home, admit, refer, treatment etc.

GYNE CLINIC NOTE – Sample and Common Scenarios

ID: __ year old gravida ___ para ___

CC:

HPI: OPQRST+UVW + associated symptoms:

- If **amenorrhea**, primary or secondary? Ask about nutritional deprivation/increased exercise, double vision/headache, sense of smell, nipple discharge, short stature/webbed neck, signs of virilization, hx of radiation/chemotherapy, etc.
- If abnormal uterine bleeding (AUB), ask about signs of hyperandrogenism (hirsutism, acne), signs of perimenopause (hot flashes, insomnia, urogenital atrophy, mood disturbance), hx of blood dyscrasia (vWD, platelet abnormality), hx of thyroid abnormality? etc.

- If dysmenorrhea, ask about dyschezia, dyspareunia (when is it painful – at insertion, midvaginal or deep?), dysuria, hx of intrauterine procedures, hx of PID, IUD, etc.
- If infertility, ask about prior reproductive function of each partner, menstrual cyclicity, coital technique, hx of PID/endometriosis/surgery, hx of undescended testes/varicocele/hernia repair, etc.
- If **pelvic pain/mass**, first r/o pregnancy, then acute vs. chronic? Ask **about sinister** symptoms (weight loss, increase abdo girth, constitutional symptoms, bowel/bladder symptoms), dyspareunia, symptoms of STI (fevers, chills, discharge?), hx of previous sexual abuse/assault, hx of uterine prolapse?
- If vaginal discharge/pruritus, ask about discharge (colour, amount, nature, odour), irritating symptoms, dysuria/dyspareunia, skin lesions, product use (soaps, tampons, recent Abx)?

Past Gyn Hx:	**LMP** (certain, regular, cycle length), contraception **Sexual Hx** (as indicated): number of partners, men/women/both, new partners, unprotected sex **Age of menarche**/ thelarche/ adrenarche/ menopause **Last pap** (hx of abn results?) → colposcopy, LEEP, etc. **Hx of STI** or STI symptoms STI (cervicitis, PID → any Rx?) **Hx of hormone replacement** (unopposed estrogen?) **Previous gyne procedures** or abdominal surgeries
Past Ob Hx:	outcome of pregnancy, complications
PMHx/PSHx:	problem list / surgeries
Fam/SocHx:	hx of ovarian/breast cancer | known BRCA? | Abuse screen (as indicated)
Meds:	**Dose and route**
Allergies:	**Allergen and reaction.**
O/E:	**Vitals** (postural if concern of major bleeding) Chest: lungs | heart sounds | murmurs? **Abdo:** soft | tender | guarding | peritoneal signs | scars

Pelvic *(only to be done with resident or staff)*
Speculum: ***external genitalia | vaginal walls | cervix (d/c, lesions)***
Bimanual Exam → cervical motion tenderness | uterus (shape, size, orientation, tenderness, mobility) | adnexal mass

Investigations:

- CBC | PTT/INR | beta-HCG (Cross & Type if major bleed)
- W/U for abnormal bleeding: TSH, PRL, FSH, LH, 17-OH prog., DHEA
- W/U for postmenopausal bleeding: pap smear, vaginal/cervical biopsy, endometrial biopsy +/- hysteroscopy and D&C, pelvic US (Abn > 5mm)
- W/U for dysmenorrhea: pelvic US, CT
- W/U for infertility: day 3 FSH (N < 10), prolactin, TSH, PCOS workup, US for ovarian reserve, tests of tubal patency (HSG), semen analysis
- W/U for pelvic mass: pelvic US, CT

Assessment: Differential Diagnosis and working Dx.
Plan: More investigations, home, admit, refer, Rx, etc.

Rotation Specific Do's & Don'ts:

General Tips

- Anytime you start with a service, ASK your resident/staff about what your responsibilities are.
- Be very nice to the nurses. They can TEACH you a lot on this service.
- Volunteer to take blood and put in IVs - this rotation can be a good opportunity to practice these skills.
- Eat, sit and sleep when you can.
- When on L&D, introduce yourself to every patient that is covered by your team so that if you have the opportunity to assist in their delivery, you will be prepared.
- Bring food when on-call. Not many food outlets are open at 3 am.

- Seminars are at your hospital and are very well done. Exam topics come from these seminars, but extra details in the syllabus are sometimes testable. Try to read the syllabus chapter the night before.
- Do a little reading most nights and you will be fine for the exams. Practice talking aloud in preparation for the oral exam.
- Never complete a pelvic exam without supervision.

OR Tips

- Introduce yourself to the staff and residents when you enter the OR if you come late (which you often are after morning seminar). Write your name and level (CC3) on the whiteboard.
- Read the chart before meeting the patient if possible. Otherwise, read it before scrubbing in. Know the case - focus on *anatomy* (including vascular supply) and the specific condition; general principles of the surgery are important but less so.
- Meet the patient before they go to the OR. Ensure that permission has been obtained regarding any examinations that may be conducted on the patient while under GA. If in doubt, ask their permission yourself. Explain that a pelvic exam might be conducted in order to help improve your future care of patients. Thank them in advance for their part in helping make you a better doctor (because that is what they are doing!).
- Often during elective C-sections, the partner (or support person) is just waiting to be admitted to the procedure room. If you have the time, it's appreciated when you take a few moments to introduce yourself and talk with him/her.
- Determine if you are scrubbing in. If so, let the OR nurses know and find your correct glove size and an extra gown if needed.
- Wear easy to clean shoes (e.g. Crocs) OR shoe covers.
- Write the OR note and post-op orders. Ask your resident to co-sign your orders.
- Practice knot tying and suturing – ask for sutures from the OR to practice with.
- Volunteer to clean up and transfer the patient at the end of the case.

Labour & Delivery Tips

- Introduce yourself to the patient as soon as you get to the floor (the earlier in labour the better).
- Introduce yourself to the nurse in charge of patient. Put your name & pager # alongside the patient and the staff's name on the main board. Ask the nurse to page you when the patient starts pushing or hang around the nurse's station when you have a free moment
- Go with your resident for the reassessments of the patient. Try to be there for the entire 'pushing' stage of active labour.
- Assess the fetal monitoring yourself for practice.
- You should be doing most of the delivery of the baby and placenta (with guidance from the resident/staff). If you aren't doing this, ASK to do more with each delivery.
- ASK to get practice at examining for cervical dilation & effacement, help with the assessments of patients who have epidurals. Once you are better at it and can do it faster, the resident may then have you assess patients not on epidurals. It is very important to learn this skill!
- When taking cord blood make sure you:
    - Clamp the cord proximally before withdrawing the needle to avoid blood spurting from the cord
    - Keep your fingers on the side of the cord to avoid a needle stick injury
    - Know if it's the artery or vein! Label appropriately.
- Help the nurses clean up.
- Don't reveal the sex of the baby unless the parents wish to know.
- Don't talk about 'bad medical stuff' in front of patients. They may become worried you are talking about them!
- Always ask how the family members are related (congratulating the new grandmother when she's actually a new aunt is avoidable).
    - If patient comes in with vaginal bleeding, make sure you ask about recent cervical exams and sexual intercourse.

Ward (Gyne, High Risk) Tips

- Ask the resident what your responsibilities are.

- To get the most out of the ward experience, read the chart on each of the patients and know their current status – it makes for a good learning experience. If you can follow a few patients it is even better.
- Do all the admissions (write the admission notes and orders).
- Don't just leave if there is nothing going on – tell your resident that you have finished the work and ask if you can help with anything else. Inform him/her where you are going if there isn't anything else to do at the moment. Page him/her at the end of the day to say you are done your work and going home if he/she hasn't told you to do so already.

Examination

- Written exam, MCQ and short answer
  - Based exclusively on content found in the syllabus provided
- Structured oral exam
  - 4 case-scenarios; you are asked about assessment and management of typical cases (e.g. pre-eclampsia, post-partum hemorrhage, ectopic pregnancy, etc.) Generally, 2 OB topics and 2 Gyne topics.

Evaluation

- Clinical evaluation (33%) - At least 10 daily encounter forms (7-8 by staff and 2-3 by residents) that you work with in clinic, OR or on-call. 3-4 forms should be submitted by the midterm evaluation. Try to get an encounter form from every significant interaction. All of the forms are used for the final clinical evaluation.
- Written exam (33%)
  - As long as you know the manual well you should be set for this exam.
- Oral exam (33%)
- Observed H&P Form (CR/NC)
- Case Logs Requirements (CR/NC)
- Professionalism Evaluation (CR/NC)

Contact Information

- 2T1 Ob/Gyn Representatives (Julia Hollingsworth & Tommy Hana)

OPHTHALMOLOGY

Outline of the Rotation

- 1-week rotation, consisting of half/full-day clinics and 1 half-day of OR
- The Ophthalmology course has mostly online lectures. Pediatric Ophthalmology will take place on the Friday (or Thursday if it is the week of the exam) at the Hospital for Sick Children

Useful Resources

- Course syllabus
- Elentra
- Harper, R.A. (ed). *Basic Ophthalmology*. American Academy of Ophthalmology. 9th Edition. ~$50. This is a very basic review text geared towards general practice and other non-ophthalmologic specialties.

Preparation before the Rotation

- Start reviewing the material on Elentra before your clinics. This will give you a head start on the terminology
- Direct fundoscopy (using direct ophthalmoscope)
    - To gain confidence with this skill, make sure you start by examining a *dilated* pupil
    - A few basic points on how to get a good view of the optic disc: angle of approach (15 degrees temporal), match the eye you are looking at (e.g. your right eye to patient's right eye), make sure the patient is focusing on a point at the distance and you aren't obstructing their view, and get close. Otherwise, it's all about practice
- Slit Lamp Exam (anterior segment exam)
    - Know the eye anatomy in cross section – this guides you when you are focusing your slit lamp for various parts of the eye
- Be familiar with the notations for clinic notes (Toronto Notes Ophthalmology section)

Typical Day

- Clinics start around 9 am, usually finish by 5-6 pm
- Clinical time split between private offices and hospital clinics, depending on academy
    - Some clinics tend to be more of a shadowing experience if you are not proactive about asking to participate! Try to use the ophthalmoscope/slit lamp with as many patients as you can
    - Hospitals will have teaching scopes which are very helpful for getting feedback
    - If clerks are interested in taking call or spending time in the OR, they can arrange this with their site coordinator

No call – unless you're interested. If so, then ask the residents!

General Tips

- Take advantage of practice time in clinic & become familiar with the **slit lamp, the direct ophthalmoscope, lid eversion, and eye patching**. These are the critical skills to be learned during the rotation - they apply to general practice and will definitely show up on the exam!
- Some sites recommend that you bring an ophthalmoscope. Try to borrow one if you don't have one and need it for clinic. Be sure to charge it beforehand!

Examination

- Written exam on the same day as OHNS and Anaesthesia at the end of Week 4 of the Anes/OHNS/Ophtho/ER block.
- MCQs and short answers – know the online cases notes well
- There will likely be a few images to be identified on the exam. These will be taken from the online notes

Evaluation

- Clinical evaluation (35%)
- Written exam (65%) – 1h duration

Contact Information

2T1 Ophthalmology Representative (Ruben Kalaichandran)

OTOLARYNGOLOGY – HEAD AND NECK SURGERY

Outline of the Rotation

- 1-week rotation
- Depending on the order of your grab bag rotations, a Friday afternoon of your 2-week ENT/Ophtho block is reserved for teaching at Sick Kids and will consist of:
  - Paediatric seminars – 1 hour
  - Audiology Lecture – 1 hour
  - OtoSIM seminar session – 1 hour

Useful Resources

- CPC2 notes
- Course lecture notes and eCases on Elentra, sample exam questions placed on Elentra. Recap of the Head and Neck Exams: http://www.entnet.org/EducationAndResearch/The-ENT-EXAM.cfm
- Site specific clerkship handbooks: http://www.otolaryngology.utoronto.ca/undergraduate/clerkship1/clekship_handbooks.htm
- Otic reference library: www.hawkelibrary.com
- Baylor College of Medicine: http://www.bcm.edu/oto/gr-archive
- Otolaryngology Houston: http://www.ghorayeb.com/pictures.html
- Martindale's The "Virtual" Medical Centre: http://www.martindalecenter.com/MedicalAudio_2_C.html
- Canadian Society of Otolaryngology - Head and Neck Surgery website: www.entcanada.org and follow the link for 'Undergraduate Education'.
- Lee, KJ (ed). *Essential Otolaryngology*: head & neck surgery, and Pasha, R. *Otolaryngology: head & neck surgery: clinical reference guide.* Both useful as references and are available from the U of T libraries (Gerstein and Sunnybrook, respectively).
- Toronto Notes

Preparation before the Rotation

- Reading ahead the preceding weekend or reviewing your CPC2 notes will help you get the most out of this experience. Reviewing the physical exam from ICE (or the link above is recommended).
- The syllabus has been thoroughly updated to include notes on Elentra that can be reviewed before the start of the rotation.
- Visit the course website on Elentra for useful case studies and other course information.
- Students will get an email from the Department of Otolaryngology – Head & Neck Surgery regarding their assigned hospital that will provide details as to where and when to meet on the first day and the schedule for the week.

Typical Day

- Clinics begin at 8-9 am depending on your site. A few sites will require you to round on patients on the ward with the residents (typically start at 7 am).
- The Department of Otolaryngology has put considerable effort into ensuring that most students are placed in the community. Refer to Elentra/departmental website (see link above) for the clerkship site handbook with information about each site including TTC and driving directions, office locations and contact information.
- Every effort is made to get clerks time in the OR. Speak to your residents/staff as early as possible if you would like this opportunity and it has not been scheduled for you.

Call

- No call.

General Tips

- **Take advantage** of practice time in clinic and become familiar with nose packing, otoscopy and simple examination instruments. OtoSim, an otoscopy simulation system, should be available at all sites.
- Exam questions are from the online lecture notes and the audiology lecture given on Friday. Make sure you focus on these!

Examination

- 1.5 hour written exam (55 MCQs). Questions are taken directly from notes. Learn general statistics and risk factors (e.g. most common thyroid cancer), common things, “what a family doctor would be expected to know”. Sample questions can be found on Elentra.

Evaluation

- Clinical Evaluation (20%)
- Written Exam (80%) – 1.5h x 55 MCQ
- Case logs: A completed case log summary is required and must be submitted to the invigilator at the written examination on the last day of the rotation.

Contact Information

- 2T1 Otolaryngology Representative (Gianluca Sampieri)

PAEDIATRICS

Outline of Rotation

- 6 weeks at community hospital OR 3 weeks at SickKids (Ward or Emerg) + 3 weeks at a community office
- 2 days of interactive seminars in the first week
- Depending on site, there are neonatal seminars scheduled.

Useful Resources

- Paeds On-The-Go Handbook: condensed, pocket-sized version of the syllabus. Provided to students. Everything in it is testable. Great study guide!
- Course Syllabus: Available on Elentra. Good source of information for reading around your cases. Don't feel like you need to know everything – intended to supplement your clinical experience.
- CLIPP cases: Online interactive paediatrics cases. Each takes 40min-1hr to complete. A great study resource with printable summaries. All 31 together cover most curriculum requirements. Very high yield for the exams!
  - You must complete 15 CLIPP cases to pass the rotation.
- **Textbooks**:
  - Nelson's Textbook of Pediatrics: Good source for paeds to read around cases.
  - Goldbloom's Pediatric Clinical Skills: Physical exam only. Excellent newborn, ophtho, neuro exams and developmental milestones chart.
- **Handbooks**: useful for DDx, when on-call/ER
  - Paeds On-The-Go Handbook of Paediatric Essentials
  - Mosby's Care of Pediatric Patient
  - Paediatric Emergency Care
  - Prasad Pocket Pediatrics
  - HSC Formulary

Preparation before the Rotation

- ICE handbook, Pre-Clerkship notes

- Review pediatric physical exams
- Review immunization schedule

Typical Day

HSC ward (7D, 7B, or short-stay/Streamlined Care Unit) –
brief orientation on the first day

- Start at 7:30 – get handover/new patients from the on-call team.
- Responsible for around 3-4 patients. Daily patient care assigned by staff/senior resident. Includes seeing patients, writing progress notes, arranging consults, reviewing labs, etc.
- Family-centred rounds on all patients with the team, then put in computer orders that need to be done (don't forget to have written orders co-signed) and write progress notes on your patients. Update ward list during the day.
- Start discharge summary soon after the patient is admitted. Be sure the patient is removed from active patient list once discharged. Arrange to review your progress notes with your senior resident.
- Various 1-hour educational rounds during day (schedule will be given out at start of rotation).
- All teams have hand-over @ 5 pm to on-call team.
- Home by 6 pm when not on-call.
- Three overnight call shifts (Thursday + Saturday or Friday + Sunday of one weekend + one other weeknight) during the three weeks @ HSC.

Computer system: (1) KIDCARE – the computer system used @ HSC for all orders, labs, and investigations. (2) PACS – the imaging system where reports & images are viewed. Passwords/training are obtained during your first week.

Community hospital

- Very dependent on different sites and supervisors
- Some sites have ER call or after-hours clinics to attend

Emergency at HSC

- Shift work (some overnight)

- Separate ER teaching seminars (Thursday morning 8 am - 1 pm, even if post-shift), includes mock codes at simulation centre (525 University Ave.)
- There is an orientation for students starting in the ER to learn how to use the EPR and ER online patient list system (EDIS)
- Brief history (as opposed to detailed Pediatric ward history) to be documented. Focus primarily on CC/HPI bringing in relevant past medical history, meds/allergies, social history, and family history. A detailed developmental, pregnancy/birth, immunization, or feeding/dietary history may not be needed (unless relevant).
- Brief physical exam to be documented on the ER chart. Given the case presentation, ensure that the most necessary exams are performed first whereas others may be left for later or omitted.

Call

- Site dependent
- No more than 1 in 4

PAEDIATRICS ADMISSION NOTE – Sample

ID:	18-month-old male, previously healthy & normal development
CC:	fever x 8 days
HPI:	May 4: onset of fever (38.5 C) May 5: onset of bilateral, non-purulent conjunctivitis and generalized erythematous rash; visit to family MD —> prescribed Amoxil for ?scarlet fever May 6-10: continued fever, increasing irritability, decreased appetite, decreased fluid intake, conjunctivitis resolved today: bilateral hand and foot swelling, feet > hands (mother unable to put patient's shoes on) Ø diarrhea Ø vomiting Ø cough Ø recent travel Ø sick contacts
PMHx:	previously healthy
Meds: Ø	**Allergies**: NKDA

Perinatal Hx: uncomplicated pregnancy
SVD at term
8 lbs. 4 oz.
Apgars 8/9
Ø resus or antibiotics necessary
Ø significant jaundice
discharged home with mom after 36 hrs. in hosp.

Development: appropriate; more advanced compared to siblings

Immunization Hx: UTD (up to date); MMR given March 14

Feeding Hx: 8 to 12 oz. homo milk by cup per day; good intake of all other foods incl. meats, fruits and vegetables

FHx: Paternal aunt: congenital deafness
Maternal grandfather: osteogenesis imperfecta

SHx: lives in Oshawa with mom, dad and two sisters
mom stays at home with children
dad works as computer programmer
lots of family supports
Ø financial concerns

O/E: VS: T = 39.2 C ax, HR 140, RR 36/min, BP 70/P irritable, Ø toxic
W:10.8 kg (50th %ile); L:83 cm (75th %ile); HC:47 cm (50th %ile)
HEENT: ant. Fontanelle closed, N TM's, + red reflex, Ø conjunctivitis, lips and tongue swollen/ erythematous, Ø ulcers, generalized cervical lymphadenopathy, neck supple
CVS: N S1S2, Ø S3 S4, PPP, cap. refill < 2 sec., well perfused
RESP: good A/E bilaterally, Ø crackles, Ø wheezes
ABDO: +BS, soft, non-tender, Ø HSM, Ø masses
GU: normal external genitalia
DERM: generalized erythematous maculopapular rash, esp. in groin; palmar and pedal erythema bilaterally, Ø peeling of fingertips
MSK: generalized non-pitting edema of feet > hands, Ø dactylitis
NEURO: PERRL, reflexes symmetrical, 2+ bilaterally

Ix:	Na: 126	Hb: 126	Polys: 9.8	ALP 430
	K: 4.2	WBC: 16.4	Lymphs: 4.3	AST 86

Cl:32 Plt: 486 Monos: 0.8 ALT 42
EKG: N sinus rhythm, Ø ST changes

Imp: 18 mo male previously well, presents with 8-day Hx of fever and 4/5 criteria for Kawasaki disease

Plan: 1. Admit to ward __ under Dr. Staff
2. IV 2/3 1/3 with 20 mEq KCl/L @ 50 cc/hr
3. High dose ASA
4. IV Ig
5. Rheumatology consult
6. Echocardiogram tomorrow

Note: The SOAP format used for both medical and surgical **progress notes** is used for paediatric progress notes.

General Tips

- Don't need a paediatric stethoscope
- Have a small (cleanable!) toy that you can attach to your stethoscope to distract kids or bring stickers to give away
- If a child looks sick, tell someone right away – they can deteriorate quickly!
- Kids are not just little adults – this can affect case presentation, DDx, and treatment
- Age of child – tailor your approach (e.g. infant, pre-school/school-aged child, adolescent)
- Pay attention to medication dosing by weight – have your calculator handy
- Earning trust – you are a stranger in a strange environment so take time for your patient to become comfortable with you
- Parent and child – patient history will often have to be obtained from parents depending on the patient age; keep in mind privacy issues at all ages and confidentiality in older patients

Tips for presenting a case to staff on ER:

- Prior to meeting with staff, organize H+P into a brief 1-2 minute snapshot to present, including only the relevant details (not a medicine case presentation).
- Consider relevant tests (if needed) and treatments.

- After discussion, typically the staff will review the patient with you at the bedside and talk with the parent(s).
- Complete all necessary notation on the chart and begin to prepare discharge sheet (with documented diagnosis, discharge meds, discharge instructions, and follow-up instructions) to eliminate added paperwork at the end of shift.

Examination

- On last Friday of rotation
- MCQ, short answer and key feature
- Review seminars, Paeds On-The-Go Handbook, CLIPP cases
- MCQs are based on CLIPP cases

Evaluation

- Clinical evaluation (50%)
    - Ward/Community: done by staff (with resident input)
    - HSC ER – Cards filled out by each supervisor at shift – averaged by site supervisor
    - Written exam (50%)
    - Case Log (credit/no credit): review with staff at midway point (completed form)
- Observed H&P (credit/no credit)
- CLIPP cases (credit/ no credit): 10 in total must be completed

Contact Information

- 2T1 Paediatrics Course Representatives
  (Kimberly Young & Linlei Ye)

PSYCHIATRY

Outline of Rotation

- Two 3-week blocks in different areas of psychiatry – Inpatient, Consult Liaison/Medical Psychiatry, ACT team/Emergency Psychiatry, Geriatric Psychiatry.
- For each block you will be assigned a preceptor. You will work closely with this preceptor and any resident on the team. Ask your preceptor what your role is, as a clerk, at the beginning of the block. You will often see the patient first and then present the case to the resident or staff.
- Each hospital will have a Personality Disorders Course run by residents and Interviewing Skills sessions on site. These are very useful for your everyday duties and are also high yield for the exam and OSCE!
- One day of core seminars take place in the 1st week. PLUS, you will have 2 hours per week for "guided" self study over the first 5 weeks of the rotation
- The OSCE and written exam are on the same day in the final week at a centralized site.
- You will be responsible for writing up a narrative medicine assignment. Your first preceptor will grade it. It is due at the end of the rotation.
- There will be 2-3 Child Psychiatry half-days over the rotation, which may be off-site (e.g. CAMH, HSC, Hincks-Dellcrest Centre).

Useful Resources

- Psychiatry Handbook: compiled and provided by the undergraduate committee. Available for free on Elantra.
- Black D.W & Andreasen, N.C. *Introductory Textbook of Psychiatry*. Sixth Edition, 2014. (**REQUIRED TEXT**)
- Best resource to study from, exam questions are based on information from this book. Contains descriptions of psychiatric disorders and DSM-V diagnostic criteria

- Zimmerman, M. Interview Guide for Evaluating DSM-V Psychiatric Disorders and the Mental Status Examination.
- Pocket book, useful to develop clinical/interviewing skills ~$11
- Diagnostic Criteria from DSM-V Pocket version of DSM-V ~$20
- Goldbloom, D. (ed) *Psychiatric Clinical Skills* – focusing on clinical assessment, user-friendly with good teaching pearls ~$54

Preparation before the Rotation

- Read Interviewing and Assessment (Chap 2) of Andreasen text
- Review Mental Status Exam (MSE)
- Review the course website on Elentra

Typical Day

- Inpatient Psychiatry
- Morning report (review patients and management plans with inter-professional team) – starts around 8-9 am
- Round on patients (interview patients and write progress notes) – either alone or with resident/staff
- Day ends by around 5-6 pm
- Emergency
- Morning report from 8-9 am
- Assess patients as they are referred to Psych ER (complete history and MSE, then review with staff)
- Meet with clerk crisis clinic patient – if applicable
- Hand-over to on-call team at 5 pm (review current patients)
- Consultation Liaison (CL)/Medical Psychiatry
- Meet with preceptor – usually at 8:30 or 9:00 am
- Round on patients being followed (on non-psych wards)
- Complete new consults (history and MSE), and review with staff
- Day ends by around 4-6 pm

Call

- Depends on your site, primarily in Psychiatric Emergency Room.
- Starts at 5 pm, officially ends at 11:00 pm.
- Return for morning report/hand-over the next day (8-9 am).

- You will be expected to stay the full day post-call.

Psychiatric Assessment (Overview)

1. **ID:** name | age | marital status | living situation | source of income | reliability of patient as a historian
2. **CC/RFR:** patient's subjective complaint and duration (or the specific reason for the consult)
3. **HPI:** onset | duration | time course | symptoms | previous episodes | stressors/triggers | supports | relevant ψ functional inquiry
4. **Ψ Functional Inquiry**
    - Mood: **Depression: MSIGECAPS**
        - Has there been a period of 2 weeks or more when you've been feeling down, depressed or hopeless? Have you lost interest in things that usually give you pleasure?
        - **Mania: GSTPAID**
        - Have you had a period of a week or more when you felt the opposite of depressed? When your mood was abnormally good, where you were extremely talkative, had a lot of energy and didn't need to sleep but still felt rested?
    - Anxiety: **BESKIM** (GAD)**, STUDENTS fear the 3Cs** (Panic Disorder)**, TRAUMA** (PTSD)
        - Do you consider yourself a worrier? Do you worry more days than not? Do you experience sudden attacks of anxiety accompanied by physical symptoms?
    - Psychosis:
        - Do you ever hear things that other people can't hear?
        - Do you ever see things that other people can't see?
        - Do you think that some people are out to hurt you?
        - Do you feel as if you have any special powers or abilities?
        - Does the TV, radio or newspaper carry messages that are intended directly for you?

- Organic**:** substances (see below), dementia (MMSE/MOCA)

5. **PψHx:** psychiatric hospitalizations | psychiatric contacts | psychiatric medications | forensic history
6. **Safety:** suicidal/homicidal ideation | previous attempts | suicide plan | lethality | supports | children in the home
7. **Substances:** substance abuse/dependence | last used | known complications (e.g. DTs, seizures) | HIV, hepatitis | IV drug use
8. **Meds:** current and previous psychiatric medications | effectiveness | compliance | all other medications
9. **Allergies:** allergens and reactions
10. **FHx:** psychiatric family history (include age and effective medications) | general medical FHx
11. **PMHx:** problem list of general medical conditions
12. **Past Personal History:** education | occupation | relationships | supports
13. **MSE:** see below
14. **Impression:** summary, risk (SI/HI), need for hospitalization, certifiability, capacity for Rx
15. **Multi-axial Assessment:** (no longer part of DSM but still used)
    Axis I – DSM-V clinical disorders
    Axis II – personality disorders and developmental disability
    Axis III – general medical conditions that are relevant to the current mental state
    Axis IV – psychosocial and environmental issues relevant to presentation
    Axis V – global assessment of functioning (GAF 0-100)
16. **Plan:** add or alter medication | behavioural interventions | admit | discharge. **ALWAYS** make a plan (even if you're not sure), **ALWAYS** include risk assessment and rationale for admit/discharge

Inpatient Assessments & Notes

- When you first meet the patient, you may be required to do a full psychiatric history. After that you can use the SOAP method:

ID age **|** admitting diagnosis if applicable

Subjective	what the patient reports they are experiencing **	** thoughts **	** perceptions	psychiatric functional inquiry
Objective	MSE
Assessment	impression	multi-axial assessment	interventions that have been attempted	effectiveness of Rx	
Plan	add or alter medication	behavioural interventions	discharge planning

Mental Status Examination (MSE)

The MSE is essentially the physical exam for psychiatry. The included mnemonics are useful for remembering components of the MSE.

Appearance & Behaviour	age (chronological/appeared)	alertness	cooperativeness	dress	grooming	distinguishing features	eye contact	abnormal movements
Speech	rate	rhythm	volume	spontaneity
Mood	patient's report (subjective, use their exact words)	quantify (/10)
Affect	examiner's report (objective)	quality	range (full, restricted, blunted, flat)	appropriateness to thought content	intensity
Thought	suicidal/homicidal

ASEPTIC

Appearance and behaviour
Speech
Emotion (affect and mood)
Perception
Thought content and process
Insight and judgment
Cognition

Content	ideation | ideas/themes | preoccupations, ruminations | obsessions | magical thinking | ideas of reference | overvalued ideas | first rank symptoms (TW/TI/TB) | delusions
Thought Process	logic | coherence stream (goal-directed, tangential, circumstantial, loosening of associations, flight of ideas, word salad)
Perception	hallucinations | illusions | depersonalization/ derealisation
Insight	patient's awareness and understanding of their illness (give an example e.g. insight poor- believes delusions and hallucinations are due to breathing problem)
Judgment	patient's ability to understand the outcome of their behaviour and act accordingly (give an example e.g. judgment poor- stopped taking medications despite acknowledging their beneficial effects)
Cognition	MMSE or MOCA (if applicable) | alertness and orientation to time, place, and person

ABC STAMP
LICKER

Appearance
Behaviour
Cooperation

Speech
Thought content, thought process
Affect
Mood
Perception

Level of consciousness
Insight
Cognition
Knowledge base
Endings (suicidal/homicidal)
Reliability

FOLSTEIN MINI-MENTAL STATUS EXAM

Name:_____ Date:_____
Age:____ LOC: alert/drowsy/stupor/coma Examiner:_____

1. Orientation
Year /1 Country /1

Season	/1	Province	/1
Month	/1	City	/1
Day	/1	Hospital	/1
Date	/1	Floor/Ward	/1
	/5		/5

2. Immediate Recall: Repeat: Car, Ball, Tree /3
trials until learned: ___ (remind them you'll ask them to repeat it later)

3. Attention/Concentration

Serial 7s	100	or	spell "WORLD" backwards
	93		/1
	86		/1
	79		/1
	72		/1
	65		/1
			/5

5. Delayed Recall: Car, Ball, Tree /3

6. Language

Repeat "No ifs, ands, or buts"	/1
Name watch & pen	/2
Read "Close your eyes" and do what it says	/1
Write a complete sentence	/1
Copy design (intersecting pentagons)	/1
Take paper with right hand,	/1
…fold in half,	/1
…and place it on the table	/1
	/9

TOTAL /30

Psychiatry Discharge Summary

- Ask your staff/resident for a discharge summary template
- Keep it brief, objective, and factual
- Focus on course in hospital and disposition planning

Clinical Resources

- Most inpatient units and psychiatry emergency services have a social worker that works as a discharge planner. The social worker has comprehensive knowledge of all the services available in the area for patients with mental health issues.
- Toronto has a book similar to a phone book called: *The Blue Book: Directory of Community Services in Toronto.* Dial 2-1-1 and a counsellor will answer the phone 24 hours a day, 7 days a week. Also see 211toronto.ca.
- Additional community/clinical support programs are often hospital and regional specific – ask your residents if you need to contact a specific service.

General Tips

- Interview patients on your own to prepare for the OSCE. Be proactive - let the residents know you want to take responsibility.
- Always ask about suicidal/homicidal ideation/safety.
- Memorize the common drugs, the basics of the mechanisms by which they work, and the common and serious side effects. When interviewing patients, ask about drug side effects and whether medication is making a difference to specific symptoms.
- When writing notes in ER, include the patient's social situation and how they presented in the identifying data (e.g. 23 y.o. male, patient of Dr. X, brought to ER by girlfriend, accounting student at U of T, lives with parents).
- Mental Health Forms (e.g. Form 1) can be printed from http://www.health.gov.on.ca/en/public/forms/mental_fm.aspx
- Be familiar with all components of the MSE.
- Memorize the Folstein MMSE. Introduce it tactfully; e.g. "I'm now going to ask you some questions to give me an idea of how your memory and concentration are today." Another useful test is the Montreal Cognitive Assessment or MOCA (http://www.mocatest.org/).

- **Remember that your own safety is your number one priority.** Don't be afraid to ask for help. You can always leave the room and go back later when the patient is more cooperative.
- Start reading in the first week and follow the course outline. For example, the first week is on mood disorders, so read the chapter(s) on mood disorders.
- Keep on top of your observed history taking! You must complete 6 observed histories through the rotation, half of which have to be with staff (which can be hard to get done on short notice due to time constraints).
- Start the narrative medicine assignment early. You will have a seminar within the first few weeks that goes into what will be expected in it. This seminar is also a component of the assignment.

Examination

- Find someone who you can practice timed interviews with. The OSCE is very different from any other rotation and the best way to prepare is practice, practice, and practice!
- Practice redirecting and interrupting difficult patients - you may need to interrupt, using their name, and remind them what you're there to accomplish and why it's important. This skill has been commonly tested on the OSCE.
- For the OSCE and in general, empathy is extremely important. You may want to use techniques such as summarizing and paraphrasing to convey to your patient that you have heard what they have said.
- READ THE TEXTBOOK! A few of the questions on the exam may ask for even more detail than the handbook provides.
- Study the syllabus and lecture notes, as exam questions may be taken from this information as well.

OSCE Tips

- The OSCE consists of 4 x 15-minute stations. Three stations are typically 11 minutes with the patient, followed by 4 minutes of a post-encounter probe with the examiner. There is one modified OSCE station where you spend 15 minutes with the examiner only.

- Read the scenario carefully and make sure you do what it asks. You have 2 minutes to read the stem before you enter the room – write down important points, DDx, important things to ask (e.g. SI, HI, safety, MSIGECAPS, other useful acronyms). Do an MMSE if indicated (e.g. suspected dementia, cognitive impairment from a medical condition, such as HIV).
- When you enter the room, give the examiner your stickers, wash your hands, and greet your patient.
- Introduce yourself and your level of education to the patient.
- Do not speak to the examiner – they are not allowed to speak to you during the interview.
- Look at the patient and comment on unusual things they are wearing or holding. This shows the patient that you are interested in their interests, and it may help guide your interview and diagnosis.
- You may wish to jot down brief notes to remind you of what you've covered. Do not write too much as it will slow down the interview.
- Use lay terms when speaking with patients. Save the medical lingo for the examiner if they ask you for a differential after the encounter.
- Introduce new parts of the interview - this will help you to organize your thoughts and let the patient and examiner to know where you are going (e.g. "Now, I would like to learn more about your social situation.")
- Folstein MMSE - Some patients may feel that certain questions are patronizing. You may wish to introduce it with, "I am now going to ask you some questions that I ask everyone who comes into the hospital."
- In children screen for ADHD, ODD, CD, psychosomatic illness, milestones, abuse, and ask who disciplines the child. Say that you'd like to interview the parents and teachers for collateral information.
- For geriatric patients, screen for dementia, delirium, and depression.
- Pay attention to your patient's emotions, behaviour and responses throughout the interview – they can guide you to be more empathetic.
- If you feel that you are getting stuck, move on. In a brief focused interview, it is better to touch on many topics than to explore few.

- If the patient wants to leave the room do not physically restrain them; remain calm and ask them if they will return. Tell them that if they do not return, and it is indicated, you will be required to complete a Form 1 that will require them to remain in hospital for up to 72 hours for evaluation.
- If the patient has active suicidal or homicidal ideation, admission should be seriously considered.
- Use the last minute to conclude the interview. This is more important than trying to fill in small details that you may have missed. If you finish the interview early, try not to sit in silence - ask more questions.
- The marker will have a long checklist to score your performance on content and process. Do not get worried if the marker is not checking things off – they may just do so at the end of the encounter.

Content (the content checklists vary in length/detail)
Process: a) Nonverbal communication /5
b) Verbal communication /5
c) Organization /5
d) Empathy /5

Evaluation

- Clinical evaluation (40%)
- Collaboration between supervisors from your 2 blocks (including input from residents and allied health)
- Narrative reflective competence (10%)
- OSCE (25%) - 3 OSCEs + 1 Modified OSCE
- Written exam (25%) - done the day of the OSCE at a centralized location
- 40 MCQs and 5 short answer
- Feedback on exam performance is provided on the last day of week 6

Contact Information

- 2T1 Psychiatry Representatives
  (Jimmy Tan & Shaoyuan (Randi) Wang)

SURGERY

Outline of Rotation

- 8-week rotation that is organized as follows:
  - The first week is "Prelude to Surgery" where you will receive hands-on seminars and problem-based learning sessions on core surgical topics and an introduction to surgical skills. Based on clerkship committee meetings, for the 2T1s this week has been revamped based on student feedback with more emphasis on hands-on training in person (and didactic learning independently).
  - The last week includes one day of paediatric seminars and the remainder, for written and oral exam preparation. Attendance is **mandatory** for both weeks.
  - The 6 weeks in between are divided into 2 blocks, each 3 weeks. One of which must be General Surgery, the other based on student ranking and matching.
- Each student is assigned to a staff surgeon preceptor for each block for supervision and evaluation.
- Keep in mind that every academy has a Surgical Education Office that is there to assist you and guide you through the rotation.

Useful Resources

- NMS Surgery Text & Handbook: Each student is provided a copy to borrow free of charge from the Surgery coordinators. It is very helpful for the written exam.
- Pestana, C. *Dr. Pestana's surgery notes – Top 180 vignettes for the surgical wards.* Kaplan medical. Very helpful for the exam.
- Kao, L and Lee, T. *Surgery Pre-Test*. ~ $32 (A good study aid for the written exam.)
- Blackbourne, Lorne H. *Surgical Recall*. ~ $50 (This is a book of "quiz questions" common in the surgical setting. Useful for studying.)
- Doherty, Gerard M. *Current Surgical Diagnosis & Treatment*. ~ $92 (A good general reference for all surgical specialties.)

- Textbook/atlas/app of medical anatomy (Netter's, Grant's, etc.)
- Sherris, DA, and Kern, EB. *Essential Surgical Skills*. ~ $55 (Picture book on basic surgical skills such as draping, suturing, and knot tying.)
- Toy, Liu & Campbell. Case Files: Surgery. ~$35 (Contains common cases in many surgical specialities; great for the oral exam.)

Preparation before the Rotation

- Read the applicable section to your sub-rotation in the provided NMS textbook and handbook the weekend before you start that sub-rotation.
- Check out the surgical clerkship webpage on Elentra.
- Read the Technical Skills information on the website prior to starting the "Crash Course in Surgery".
- Buy a pocket notebook that can be written in on the run!
- Contact the staff / chief resident / administrative assistant a few days before the start of each sub rotation to introduce yourself and ask where and what time to meet on your first day.

Typical Day

- Start at 6:15-7:00 am to round on your team's ward/ICU patients.
    - Arrive 5-15 min early and get patient charts ready. Print out patient lists for each member of your team. Check the notes for anything that happened overnight. Check labs, vitals, ins/outs, new orders. Only if your resident asks you to, record this in each chart and set up a SOAP note for rounding.
    - This is typical for General Surgery but may not apply on other services; check with your resident.
    - Take turns writing SOAP notes in charts with other clerks on your team to help your team round quickly. Be aware of team dynamics (i.e. each clerk should able to contribute equally, regardless of interest in the field).
    - Quick progress notes are written as you round – be ready to write down whatever your senior says.
    - On some services, you may be asked to round independently on patients and review later. Always ask if you're not sure.

- You will need to return to the floor later in the day (or even several times per day) to deal with any outstanding ward issues or developments.
- You may or may not be directly responsible for specific patients like on Internal Medicine. Most commonly the collective team takes care of all the team's patients on the floor and ICU. Therefore, make sure you know all of the patients admitted under your service/team well.

- After morning rounds, you will go to one of several places, typically the OR, teaching rounds, clinic, etc. Usually the schedule changes frequently and it's best to ask your resident or site admin person.
  - In the OR, your role will vary. You should always try to help out with preparatory work for the patient (e.g. moving them to the OR table, helping residents with draping, foley insertion, etc.). Write your name on the board and your glove size(s). If you know which residents and staff are in the room, do the same for them.
  - If you are not sure how to do something, ASK. The last thing you want to do is "wing it" and have it be wrong, only for everyone else to have to re-do it. The same goes for after the case ends.
  - During the operation, your role will vary as well. Make it known that you are interested in participating and your staff will try to accommodate you as appropriate. Be aware that the residents and fellows are also there to learn (albeit to learn skills of a different level).
  - Staff and residents often ask you questions during the operation. The most common questions are anatomy-related, so know this in advance. They will also often ask about the procedure being done. To help prepare for this, check the OR desk for the next day's procedures before you go home each night. Some staff may not ask you questions or engage as much. If you want to show interest, ask intelligent questions,

timed correctly that show you are following the procedure and can anticipate next steps.
    - Always try your hand at writing the post-op note. Even just setting up the headings and filling in what you know will help out the residents.
    - In clinic, you will see patients and review with your staff. It is to your advantage to learn to dictate well, succinctly, and clearly during clinic.
    - In any surgical case, if you can demonstrate that you are able to perform some skill, people will be more inclined to let you do more and more. Bon the staff and resident you have, and if it is okay, ask the scrub nurse for instruments before they are needed (i.e. picking up scissors while the surgeon is tying a knot). Always ask the nurse for instruments and do not take them directly from the tray, even if it is right in front of you.
- Your (non-call) days end after whatever afternoon activity you are doing ends. For OR days, they typically end before 5 pm. However, you are expected to remain with the residents and deal with any outstanding post-op or ward issues, etc. Clinic days vary depending on scheduling. Never head home without checking with your resident.
- Staff are aware that duty hours apply: maximum 12hrs/day or 26hrs consecutive if on call. They often do not know your call schedule or when you arrived in the morning. If you are approaching your duty hours, let a resident or staff know. This can be extremely difficult given the power dynamic: if your duty hours are not being respected you can tell the site lead and ask them to send a message to all preceptors for anonymity (they are on your side)!
- Clinics (new patients and outpatient follow-ups) often start at 8 or 9 am; OR's start at anywhere from 7:30-8 am – be on time to meet the patient prior to them entering the OR and so that you don't miss opportunities to practice technical skills! (i.e. Foley insertion)
- Sometimes you round with staff in the afternoon.
- Usually finish between 4:30 and 6:00 pm.

Call

- Usually 1 day in 4 (including 1 weekend day per rotation, so 2 weekend days per month).
- While on-call: consults in ER (after a consult, take 2 stickers with you for the staff and write when you saw the patient and name of referring physician), assist in OR on emergency cases, assessment in trauma cases (SMH/SBK/Sick Kids).
- Home after morning rounds and helping team wrap up any loose ends (discharge summaries, ordering consults, etc.).
- Some sites will allow you to set your own call schedule with the residents. If possible, it would be best if you did your call when your staff is also on call, to get more exposure to him/her.
- Be aware that call nights, particularly at busier sites, are a great opportunity to get more hands-on experience, as there are fewer residents/fellows/etc. around overnight to do any emergency cases or other urgent work.
- At some sites, you may be listed as first call. Always confirm with your on-call resident regarding how the call shift will be run. The resident may choose to page you with consults from the ER or other floors, which you will see yourself and then review with your resident. It is also possible that you will be expected to field calls first and then touch base with your supervising resident to determine who will deal with each issue as they arise. Be prepared to check in with the OR desk to see when your next case will run if there are cases pending, and if you are at SMH/SBK/Sick Kids, make sure you inform your resident/TTL (Trauma Team Leader) to call you for the trauma cases in the OR and trauma room.

Sample Post-op OR Note – write in patient's chart after each surgery
*Keep in mind that some staff/residents may ask you to document it differently. Not all headings below apply to every surgery.

Sept 1/11, 23:00	<u>OR Note</u>
Surgeon:	Dr. (staff)
Assistants:	Dr. (resident) PGY _/ (clerk) CC_
Anesthesia:	General Anaesthesia by ETT, Dr. (anaesthetist)

Pre-op Dx:	appendicitis
Post-op Dx:	perforated appendicitis
Procedure:	laparoscopic appendectomy
Estimated Blood Loss (EBL):	150cc (check suction container/ask anaesthesia)
Findings:	none
Specimens:	appendix
Complications:	none
Counts:	correct
Drains:	none (i.e. JP, Foley, NG, etc.)
Disposition:	to recovery room (PACU) in stable condition

Sample Post-Op Orders (Use "AD DAVIIID" mnemonic)

Sept 1/11, 13:00	Post-Op Orders
Admit:	to Ortho Ward 7C under Dr. (staff)
Diagnosis:	post-op hip replacement
Diet:	sips to ice chips to DAT (Diet As Tolerated)
Activity:	AAT (Activity As Tolerated), up in chair, etc.
Vitals:	Vital Signs Routine (VSR)/q2h if more concerned
I.V.*:	2/3 D5W + 1/3 NS + 20 mEq KCl/L @ 100cc/hr
Ins and Outs:	Please measure precise in's and out's
Investigations:	CBC, lytes, BUN, Cr. Accuchecks if diabetic.
Drugs:	Analgesia: Morphine 5-10 mg SC q3h prn Tylenol #3 1-2 tabs PO q4h prn Antibiotic: Ancef 1g IV q8h x24hr Anticoagulation: Enoxaparin 40mg SC OD Bowel routine: Colace 100 mg BID with DAT Antiemetic: Gravol 25-50 mg PO/IV q4h prn Anti-inflammatory Patient's own meds from before admission

* Use the "4-2-1 rule": 4cc/kg 1st 10kg, 2cc/kg next 10kg, 1cc/kg after
Ask resident for specifics regarding orders for their specialty.

Sample Surgery Progress Note (SOAP note)

ID: 78 yr male POD *(post op day)* #2 - right hemicolectomy

S/	*(subjective assessment)* good pain control with PCA (Patient Controlled Analgesia) + flatus, Ø BM yet post-op; feels hungry
O/	*(objective assessment)* AVSS (T_{max} = 37.2) (Afebrile, Vital Signs Stable i.e. BP, HR, RR) good U/O (Urine Output) / suprapubic catheter drained 1200cc incision ✓ (incision is clean)/ wound CDI (clean, dry, intact) BS+, abdo soft, Ø distended
A/P	*(assessment and plan)* - stable - advance to clear fluids - D/C PCA and switch to Tylenol #3 1-2 tabs q4-6h prn - family meeting today re: disposition

Sample Consult Note

ID: 40yr male construction worker previously well

CC/RFR: Abdo pain ?appendicitis or hepatitis

HPI:

a. pain—use OPQRSTUVW from ICE
b. nausea/vomiting, last meal, character of vomitus
c. gas/bowel movements
d. bleeding?
e. fever/chills/sweats/weight loss, other constitutional symptoms
f. pruritis/jaundice/dark urine/pale stools/etc.

Past medical/surgical Hx

Meds

Allergies

Physical exam:

a. vitals—specific numbers, not just AVSS here
b. focused exam, including quick cardio and resp exams

Labs, imaging

Impression and plan: come up with something and review with the resident. Don't worry if you're wrong – the residents are there to teach you too!

Sample Admission orders: similar to post-op orders

Sept 1/11, 13:00	Admission Orders
Admit:	to (Surgical service) under Dr. (staff)
Diagnosis:	e.g. appendicitis, septic arthritis of R knee
Diet:	(NPO if need surgery soon)
Activity:	AAT (Activity As Tolerated), up in chair, etc.
Vitals:	Vital Signs: specify frequency
I.V.*:	2/3 D5W + 1/3 NS + 20 mEq KCl/L @ 100cc/hr
Ins and Outs:	Please measure precise in's and out's
Investigations:	CBC, lytes, BUN, Cr. Accuchecks if diabetic.
Drugs:	Analgesia: Morphine 5-10 mg SC q3h prn
	Tylenol #3 1-2 tabs PO q4h prn
	Antibiotic: Ancef 1g IV q8h x24hr
	Anticoagulation: Enoxaparin 40mg SC OD
	Bowel routine: Colace 100 mg BID with DAT
	Antiemetic: Gravol 25-50 mg PO/IV q4h prn
	Anti-inflammatory
	Patient's own meds from before admission

* Use the "4-2-1 rule": 4cc/kg 1st 10kg, 2cc/kg next 10kg, 1cc/kg after
Ask resident for specifics regarding orders for their specialty.

General Tips

- ALWAYS BE FIVE MINUTES EARLY FOR EVERYTHING! Surgery teams are very busy, and scheduling is very tight. This will have an impact on both your experience and your evaluations.
- Try to attend as many of your supervising surgeon's OR's and clinics as possible, so they can get to know you, assess your progress, and tailor your experience to your interests. If you need to be away, be sure to inform your supervisor ahead of time. Seek feedback from them and more importantly, realize when they are giving you non-formative feedback. Keeping the above in mind, don't be afraid to 'drop-in' on other OR's and clinics (if there is room) to explore the specialty and areas of interest. This is best organized with the help of

your senior resident. Getting the most out of your surgery rotation is on you – be proactive in arranging clinics and ORs.

- While you are in a patient room during morning rounds, read the chart of the next patient on the list so that you will be able to quickly comment on the vital signs, in's & out's, etc.
- Volunteer to be the scribe of daily ward rounds notes and pay careful attention to what your resident evaluates each morning.
- Check the next day's OR schedule and try to review the procedure, the anatomy involved, possible complications, etc., so that you can anticipate the next moves and be able to answer questions.
- Ask your resident(s) early on if you're not sure of how things work at your site. Often there is already an established role for the clerk at morning rounds and it's best for everyone if you learn this fast.
- Be proactive; ask to learn procedures and do things. People are usually happy to try to accommodate you if the situation permits. You will gain a lot more from your rotation this way.
- Work with the residents and the other clerks to divide up work and experiences fairly; expect to help out with some of the "Scut."

Common ward work and general tips:

- Requesting consults from other services, checking lab work and imaging, dealing with ward issues, and writing discharge summaries.
- ER consults and patient assessments when you are on-call.

- Get enough sleep, wear comfortable shoes, and always carry food.
- If residents, fellows, or staff offer you a break or tell you to go home, DO IT. Likewise, if there are too many learners in an OR, don't be afraid to ask to step out and study – but stay nearby and available!
- Be respectful and courteous to nurses and all healthcare workers in the OR and on the wards:
    - Introduce yourself and write your name/level of training/glove size on the OR whiteboard.
    - Pull out your gloves for the RN in the OR, offer to put in Foley catheters (once comfortable doing so), etc.

    - Clean up after your procedures. Never leave sharps out!
- If you feel ill or too tired to contribute or be safe in the OR, tell your supervisor and step out.
- NEVER fake/lie about a finding; it's always best to be honest and admit when you don't know something
- Cooperate with the other clerks on your team to ensure equal access to scrubbing-in, etc. Make sure you don't try to 'out do' them by showing up earlier than them, etc. You will only make yourself look bad! Agree on a clerk start time and stick to it.
- When doing a physical or a procedure, make sure that both YOU and the PATIENT are comfortable with the arrangement and setting.
- Practice tying one-handed knots when you can; all you need is thread. You'll learn how to do so during the Crash course. If you're scrubbed and not doing much, ask for a tie and practice tying knots (just make sure you're still following the operation and not in the way). Competency in this will certainly impress and incline others to let you do more.

Receiving requests from the wards (e.g. from RNs)

- On the phone:
    - Patient name/MRN/location
    - What is the issue?
    - Current vitals – ask for it if not available
- When you go see the patient:
    - Reason for admission
    - What procedure was done, if any
    - What was the condition at AM rounds?
    - Eyeball the patient: stable or not?
    - If unstable, get help and ABCs
    - Take BRIEF history of the new complaint
    - Do a BRIEF and FOCUSED physical exam + vitals
    - Make a plan and review with your resident

Preparation for OR days – know these BEFORE going into the OR

- What procedure and why? You can find an OR list the night before from:
  - The surgical ward nursing station
  - The OR front desk
  - Your supervisor's office
- Past medical history
- Possible complications
- Patient allergies

In the OR

- You must wear: Mask, cap, scrubs, OR-appropriate shoes (closed toe, ideally waterproof) or shoe covers. Optional (but recommended): eye protection (face shield, goggles etc.)
  - NO lab coats past the OR front desk
  - NO extra bags etc. in the OR. Avoid bringing things you can't fit in your pockets.
- Bring a pen to write notes and orders.
- Scrub-in only after you have ASKED the STAFF if it is okay to do so. Sometimes it is better to not scrub to see more; this is your staff's discretion.
  - Ensure the RNs have a gown for you and your gloves ready
  - Scrub properly – they will show you during lecture week
  - Don't forget to "turn yourself" to tie the waist-cord on the gown
- Most common clerk tasks: adjust lighting; cutting sutures; suctioning; retracting; suturing/stapling/other wound closure; maintaining sterile technique.
- You are encouraged to ask questions WHEN APPROPRIATE. Use your judgement, e.g. if there is a nicked aorta that is bleeding profusely and everyone is scrambling to deal with it, do not ask questions then!

In Clinic

- New patients: <10 minutes

    - Read the referral note – what is the chief complaint, and what investigations have been done?
    - Take a brief and focused history
    - Do a focused physical exam
    - Come up with a differential diagnosis and plan
    - Review with your staff: keep this CONCISE. They will ask you questions if you are missing something, and they will fill in remaining gaps with the patient themselves. Surgeons do NOT want case presentations the way internists and psychiatrists do!
- Post-op follow-up patients (very quick visit):
    - Read the chart and find out what happened and when
    - Review pathology findings
    - Review most recent clinic visit
    - Take a brief interim history
    - Do a brief focused physical exam, paying attention to possible post-op complications
    - Write a SOAP note and present to your staff CONCISELY.

Consults

- On the phone, get the following:
    - Patient name/MRN/location/gender
    - Reason for referral
    - Stable or not? Most recent vitals. Is this urgent?
- Think of a plan.

- Consider AMPLE history if urgent OR:
    - Allergies
    - Meds
    - PMHx
    - Last meal
    - Events leading up to current problem (i.e. focused)
- If in the ER: read emergency notes and past records.

Examination

- Common things are common; know common complaints. Some are covered in the seminar series, but this is not complete. Treat it as an introduction.
    - You are expected to read beyond the material given.
    - The material on the website may not be the same as what lecturers present; however, the content will be similar. Faculty are encouraged to go through cases in their lectures.
    - Major topics are General Surgery, Urology, Neurosurgery, Orthopaedic, Thoracic, Cardiac, Vascular and Plastic Surgery.
    - Start EARLY as there is a lot of material to know.
    - Use the NMS study guide and casebook provided by the faculty for your exam.
    - Use clinic visits and consults as practice for your oral exam.
    - For the exam, read Pestana's first, then read "Surgery, a case-based approach" by De Virgilio and do pre-test questions last.

Evaluation

- Final grade is based on the written exam, structured oral exam, and clinical/ward evaluation. Each component is weighted equally (33%)
- Mastery Exercise – 50-75 questions over 2h
- Oral exam – 2 stations, 20 minutes each (not necessarily in consecutive order). Part 1 will be a focused H&P relevant to the patient's primary problem and then present a summary of your findings to the examiner. Part 2 will be 3 structured oral exam questions
- To pass the course, you must pass both the oral and written exam and receive a passing grade (60%) on the ward evaluation.
- You will also have centralized OSCEs that will include surgical stations among other disciplines as part of your overall clerkship

Contact Information

- 2T1 Surgery Representatives (Lucshman Raveendran & Saly Halawa)

APPENDIX A: OTHER USEFUL STUFF

The Doctor's Letter of Condolence

The New England Journal of Medicine, April 12, 2001 Vol. 344, No. 15

A letter of condolence from a doctor may have a special meaning for a family in mourning. It may help the family as they move through the natural phases of grief. It may also help to alleviate some of the physician's personal feelings of grief or distress about the event. A letter of condolence appears to be more effective than a telephone call, for it enables the family to reread your words at their own leisure. Obviously, the condolence letter is meant to be genuine, and so the purpose of the following outline is merely to assist you in your writing.

- Avoid superficial attempts such as "it was meant to be", or "I know how you feel".
- To avoid the issue of legal liability, the letter should focus on the sadness of the death, rather than revisit the clinical details of the illness.
- Begin the letter with a direct expression of sorrow, such as: "I am writing to send you my condolences on the death of your husband."
- Try to include a personal memory of the patient and something about the patient's family or work, such as devotion to family, courage during the illness, or speak of the patient's character traits that left an impression on you. This will help to bring the letter to life.
- Explain that it was a privilege to participate in the patient's care
- Point out the comfort the patient received from the family's love.
- Conclude with a few words of support to let the family know your thoughts are with them.

"After a patient dies, when we all feel helpless, the best care we can provide is our expression of concern and sympathy in a letter of condolence"

– Susanna E. Bedell, NEJM 2001

APPENDIX B: FREQUENTLY USED ABBREVIATIONS

A	
AAT	Activity as Tolerated
ABG	Arterial Blood Gas
A/E	Air Entry
AGUS	Atypical Glandular Epithelium of Undetermined Significance
AKA	Above Knee Amputation
ALP	Alkaline Phosphatase
AMA	Against Medical Advice
AP	Antero-Posterior
ARM	Artificial Rupture of Membranes
ASA	Above Sternal Angle
ASCUS	Atypical Squamous Cells of Undetermined Significance
AVSS	Afebrile, Vital Signs Stable
AXR	Abdominal X-Ray
B	
BCP	Birth Control Pill
BE	Barium Enema
BKA	Below Knee Amputation
BRBPR	Bright Red Blood Per Rectum
BRwBRP	Bed Rest with Bathroom Privileges
BS	Bowel Sounds, Breath Sounds, Blood Sugar
BUN	Blood Urea Nitrogen
C	
CABG	Coronary Artery Bypass Graft
CAD	Coronary Artery Disease
CBD	Common Bile Duct
CF	Clear Fluids
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	
D/C	Discharge / Discontinue
D5W	Dextrose 5% in Water
D10W	Dextrose 10% in Water
DAT	Diet As Tolerated
DKA	Diabetic Ketoacidosis
DVT	Deep Venous Thrombosis
DNR	Do Not Resuscitate

DT's	Delirium Tremens
E	
EBL	Estimated Blood Loss
EBM	Expressed Breast Milk
EDC	Estimated Date of Confinement (Due Date)
ECASA	Enteric Coated Acetylsalicylic Acid
EF	Ejection Fraction
EGD	Esophagogastro-duodenoscopy
EOM	Extra-ocular Movements
ERCP	Endoscopic Retrograde Cholangio-Pancreatography
ETT	Endotracheal Tube
F	
FF	Full Fluids
FHR	Fetal Heart Rate
FFP	Fresh Frozen Plasma
FWB	Featherweight Bearing
G	
GA	General Anaesthesia
GBS	Group B Strep
GCS	Glasgow Coma Scale
GDM	Gestational Diabetes Mellitus
H	
HC	Head Circumference
HBD	Had Been Drinking
HS	Heart Sounds
HSIL	High-grade Squamous Intraepithelial Lesion
I	
I & D	Incision and Drainage
I & O	Ins and Outs
IUGR	Intrauterine Growth Retardation
IVF	Intravenous Fluids
L	
L/E	Lower Extremity
LAT	Lateral
LBW	Low Birth Weight
LGIB	Lower Gastrointestinal Bleed
LOC	Loss of Consciousness / Level of Consciousness
LP	Lumbar Puncture
LR	Lactated Ringer's
LSB	Left Sternal Border
LSIL	Low-Grade Squamous Intraepithelial Lesion
M	
MAR	Medication Administration Record
MSS	Maternal Serum Screen
N	
NAD	No Apparent/Acute Distress; No abnormality detected
NG	Nasogastric
NKDA	No Known Drug Allergies

NPO	Nil Per Os (nothing by mouth)
NS	Normal Saline (0.9%)
NSR	Normal Sinus Rhythm
N & V	Nausea and Vomiting
NWB	Non-Weight Bearing

O

OA	Osteoarthritis
OB	Occult Blood
OCP	Oral Contraceptive Pill
OD	Right Eye (don't use for "once daily" – write "daily" or "qd")
O/E	On Examination
OGD	Oesophago-gastroduodenoscopy
O&P	Ova and Parasites
ORIF	Open Reduction and Internal Fixation
OS	Left Eye
O x3	Oriented to (1) Person (2) Time and (3) Place

P

PCA	Patient Controlled Anaesthesia
PE	Pulmonary Embolus
PEEP	Positive End Expiratory Pressure
PERRLA	Pupils Equal, Round and Reactive to Light & Accommodation
PICC	Peripherally Inserted Central Catheter
PIH	Pregnancy Induced Hypertension
PO	Per Os
POD	Post-Operative Day
PPP	Peripheral Pulses Present/Palpable
PR	Per Rectum
PRBC	Packed Red Blood Cells
PROM	Premature Rupture of Membranes
PTA	Prior to Admission
PTL	Preterm Labour
PTCA	Percutaneous Transluminal Coronary Angioplasty
PUD	Peptic Ulcer Disease
PVD	Peripheral Vascular Disease

R

RA	Rheumatoid Arthritis
RFA	Reason for Assessment
RFC	Reason for Consultation
RFR	Reason for Referral
RL	Ringer's Lactate
R & M	Routine and Microscopy

S

SA	Spontaneous Abortion
SBO	Small Bowel Obstruction
SEM	Systolic Ejection Murmur

SIADH	Syndrome of Inappropriate Antidiuretic Hormone
SLE	Systemic Lupus Erythematosus
SOB	Shortness of Breath
SOBOE	Shortness of Breath on Exertion
SR	Sinus Rhythm
SROM	Spontaneous Rupture of Membranes
SVD	Spontaneous Vaginal Delivery

T

TA	Therapeutic Abortion
T & A	Tonsillectomy and Adenoidectomy
TEE	Transesophageal Echocardiography
TTE	Transthoracic Echocardiography
Tmax	Maximum Temperature
TPN	Total Parenteral Nutrition
TKVO	To Keep Vein Open
TFI	Total Fluid Intake

U

UA	Urinalysis
U/E	Upper Extremity
UGIB	Upper Gastrointestinal Bleed
U/O	Urine Output
U/S	Ultrasound
UTD	Up To Date
UTI	Urinary Tract Infection

V

VBAC	Vaginal Birth After Caesarian section
VSR	Vital Signs Routine
VSS	Vitals Signs Stable

W

WDW	When Drinking Well

APPENDIX C: USEFUL RESOURCES FOR CLERKSHIP

The decision of what books to buy in Clerkship is a controversial one. Different people have different learning styles, and your learning style should guide the resources you use. The following is by no means a comprehensive list. The books you buy will be strongly influenced by the specialty you decide to enter. It is advisable to tailor your purchases/acquisitions to the amount of time you will actually spend (all good intentions aside) reading during your clerkship, as well as your method of studying. In addition, each rotation will present you with a list of their own departmental recommendations – some good, some not so good.

Recommended Books:

- The Toronto Notes, $95 if purchased directly from UofT, $135 if purchased at the UofT Bookstore.
- Tarascon Pocket Pharmacopeia (Updated Yearly), ~$15
  - Contains almost all the drugs you will be ordering, their indications, and their dosages.
  - Smartphone users may substitute Medscape or Epocrates (may not have all the Canadian drugs), Lexicomp, or the mobile version of the Tarascon book.
  - Make a point of knowing where to find the nearest CPS on each rotation for the few drugs that are not listed.
- A pocket book for Medicine, such as the Massachusetts General Hospital Handbook of Internal Medicine (very useful beyond your Medicine rotation).

Other Useful Books

- On-Call: Principles & Protocols ~$50
- On-Call: Surgery, or Medicine ~$50
- U of T's Essentials of Clinical Examination Handbook
- Clinical Examination by Talley & O'Connor
- The Sanford Guide to Antimicrobial Therapy ~ $15
- The Recall Series (Surgery Recall, Medicine Recall, etc.) ~$40ea.

- The Lange Series of Books, by specialty
- NMS Review Series, by specialty
- Cecil's Essentials of Internal Medicine, ~ $90
- Harrison's Principles of Internal Medicine, ~ $190

**One of the best resources for finding really good books is your residents or 4th year clerks. See what they suggest. Try to get your hands on a physical copy of the publication before you buying to ensure it's both at your level and something you will actually have the time/inclination to read.

Online Resources

Most of your clerkship will be spent in centers with readily available Internet access. Frequently, this can act as a surrogate textbook in lieu of carrying your entire medical library with you in your lab coat. Being able to access online information quickly is a good skill to have, and you will find it even more useful in clinical practice than in the pre-clinical years. Some useful sites for this include:

- Up to Date
  - Available to UofT students through the Library
  - Excellent resource – many residents use it!
- American Academy of Family Physicians – www.aafp.org
  - Quick search of a large library of handy review articles
- Medscape – www.medscape.com
  - Medical news, articles, and medical student section
- eMedicine – www.emedicine.com
  - Free, reliable, online textbooks for medical professionals
- The Merck Manual Online – www.merck.com
  - Full text of the handy Merck Manual available online
- New England Journal of Medicine www.nejm.com
  - Free full text articles with login
- Useful forms, such as for Psychiatry –
  - www.gov.on.ca/health/english/forms/forms_cat.html

APPENDIX D: FITZGERALD ACADEMY

St. Michael's Hospital (SMH)

Frequently Called Numbers

Main 416-864-6060
Locating x5431
Switchboard 0
Locating x5431
Core Lab x5082
  Hematology x5125
  Biochemistry x2459
  Microbiology x5381
  Cytology x5850
Film Library x5662
CT Scan x5663
Student Centre x5700

Department Locations

- B2-Cardinal Carter: Radiology (MRI)
- 2-Queen: Haematology/Oncology
- 4-Queen: Palliative Care
- 6-Queen: Respirology
- 3-Cardinal Carter: Radiology (film library, X-ray, CT scan)
- 4-Cardinal Carter: Med/Surg ICU, CVICU, ambulatory clinics
- 5-Cardinal Carter: ORs, Cystoscopy
- 7-Cardinal Carter: Cardiology/CV Surg
- 8-Cardinal Carter: ENT, Nephrology/Urology
- 9-Cardinal Carter: Orthopedics, TNICU
- 14-Cardinal Carter: Medicine
- 15-Cardinal Carter: Gyne/Post-partum ward, L&D
- 16-Cardinal Carter: Plastics/Gen Surg/GI
- 17-Cardinal Carter: Psychiatry

Call Rooms

- Medicine and Surgery (8 Bond)
  - The easiest way to get to 8-Bond is to go through 7-CC and follow the signs to the CCU. Just before you get to the door for the CCU there will be a door for a staircase that only goes up one flight, to the 8th floor. This will take you to the call rooms
  - Obtain card access from security (Cardinal Carter lobby) after 5 pm during your call. Each call room has a bed, desk, and telephone
  - Bathrooms with shower, computer, kitchen are shared
  - Call rooms 42 and 43 are for medicine clerks only
- Ob/Gyn
  - Separate call room on 15-Cardinal Carter
  - No booking necessary

Telephones

- Dial "9" for an outside line, including when paging
- Dial direct with 4-digit extension number
- If you are paged to a 4-digit extension number and are not in the hospital, dial 416-864-xxxx
- Call locating (x5431) if you need to page someone
- Call switchboard (0) for a direct extension of a dept/office

Miscellaneous

- Access the Li Ka Shing (LKS) building from the main hospital via the underground tunnel or the above ground walkway at 3-Shuter
- Get replacement pager batteries from IT (4 Shuter) or Med Ed (LKS 5th floor)
- Student Lounge is located on 6 Shuter, accessible via Shuter North elevators only
- Clerks have a reserved set of lockers in the general locker room in the LKS
- Printing is available at the Health Sciences Library (LKS 3rd floor)
- Student centre website for any queries: studencentre.smh.ca

APPENDIX E: MISSISSAUGA ACADEMY OF MEDICINE

Credit Valley Hospital (CVH)

Frequently Called Extension Numbers

Locating x4466
Security x3974
Phone for deaf in ER x4476
Outpatient Specimen Collection x5441
Medical Imaging x4517
Film Library x2685
Emergency x4141
Pharmacy x1614
Laboratory x2696
Library x2411
Medical Education x4365
Ethicist x4482

Call Rooms

- Rooms located on 1C
- Access the rooms with your hospital ID badge
- Call rooms available on a first-come, first-served basis

Student Lounge: 1st floor, C-wing; use hospital ID badge (ASCM lounge) Printer available here.

Medical Education Offices: 1F

Scrub Machines: one in the ER (near diagnostic imaging) and one outside the ORs on 3G (across from 3C). There is also another machine on the L&D floor (3A), but only really accessible during OBGYN rotation.

Parking: Monthly student passes should be bought at Trillium and security at CVH will activate for site access. As of 2018, this was the cheapest method of obtaining parking at all sites.

Intranet

The iCare homepage has many useful resources including:

- SCM (vitals, investigations, clinical documents, med reconciliation)
- Meditech (investigations, old notes and mox)
- UptoDate
- ECGs
- Impax (radiology)
- Order sets and clinical protocols
- PRO and REACH viewers (records from other hospitals)
- ChartMaxx (scanned documents from previous visits)

Mississauga Hospital (M Site)

Frequently Called Extension Numbers

Main Switchboard x7533
Locating x7557/2222
Security x7394
Medical Imaging (Bookings) x7384
CT x3860
Film Library x7296/7285
Emergency (Main desk) x7600/7613
ER Admitting x2241
Pharmacy x7475
Laboratory (Office) x7297
Library x7394
Blood Bank x7520
Pathology x7297
Ethicist x3083

Call Rooms

- Rooms located on ground floor of the J Wing – behind the parking 'pay-station'
- Access the rooms with your hospital ID badge

- Call rooms available on a first-come, first-served basis
- Please use the 'occupied' signage when using the room

Scrub Machines: Outside surgery on 2nd floor; another one in the CT hallway beside emerg on main floor

Student Lounge: 7th floor, Clinical Administration (CA) **Building (ASCM lounge)**
Medical Education Offices: 7th floor CA building

Parking: Monthly student passes can be bought at the parking office located in the North end of the parking structure at M site. This pass will also work in the North Staff parking lot at Q site.

Intranet
The iCare homepage has many useful resources including:

- SCM (vitals, investigations, clinical documents, med reconciliation)
- Meditech (investigations, old notes and mox)
- UptoDate
- ECGs
- Impax (radiology)
- Order sets and clinical protocols
- PRO and REACH viewers (records from other hospitals)
- ChartMaxx (scanned documents from previous visits)

Queensway Health Centre (Q Site)

Frequently Called Extension Numbers
Main Switchboard x7533
Locating x7557/2222
Security x7394

Parking
Monthly student passes can be bought at the parking office located in the North end of the parking structure at M site. This pass will also work in the North Staff parking lot at Q site.

Scrub Machines
In the day surgery area on the main floor

Changerooms and Lockers
Basement below the ORs

Travelling Between Sites - Shuttle Bus Services

You can pick up a copy of the bus schedule at the main lobby information desks at each location. Or find it online at:
http://trilliumhealthpartners.ca/ineed/directions/Pages/default.aspx

Designated Shuttle Bus Stops:

- Mississauga Hospital:
  1. Main entrance
  2. West wing entrance
  3. Emergency/Family Care entrance
- Queensway Health Centre:
  1. Urgent Care Centre
  2. Appleton 160 building
- Credit Valley Hospital:
  1. Main Entrance
  2. PRCC entrance

APPENDIX F: PETERS-BOYD ACADEMY

Sunnybrook Health Sciences Centre

Sunnybrook Hospital Campus (2075 Bayview Av.)

Frequently Called Extension Numbers

Main Switchboard 416-480-6100
Locating x4244
Paging
- From inside the hospital x744
- From outside the hospital 416-480-5744

Cardiac Arrest x5555
Security Office
- Secretary x4601
- Security Officer x4589

Occupational Health x4175
Medical Education Office
- Margaret Chung (E313a) x4273
- Sonya Boston (E313b) x4274
- Norma Armas-Lewis x5962

Admitting x4407
Biochemistry x4646
Blood Bank x4051
Cardiac Cath Lab x4880
CT Scan Booking x4343
MRI Scan Booking x6177
Ultrasound Booking x6130
Medical Imaging x7515
Emergency x4207
Endoscopy Suite x4005
Family Practice Unit x4930
MacDonald Library (EG-29) x4562
OR Reception x4239
Pathology x4600
Social Work x4477
Thromboembolic Team x8170

Department Locations

- BG Emergency (Zones: green, blue, purple, orange)
- A1-20 Family Practice
- M1-202 Ophthalmology
- M1-102 Otolaryngology
- FG-46 Psychiatry
- H1-71 General Surgery

Photo ID Badges: Badges issued in first year are valid until graduation. Contact Norma (E319) for more information.

Call Rooms

- Surgery (H367-H369): key safe mounted outside the rooms, the code will be changed and provided at the start of each rotation.
- Medicine
  - H303: Key safe codes provided to registered students by Margaret (E3-13a)
- OB/GYN: access managed by department (obgyn@sunnybrook.ca)

Student Lounge: 3rd floor, E-wing, E3-09

Lockers: Assigned during orientation. Locker room (JG02)

Pagers & SunnyCare access: Information provided during orientation. Access is valid until graduation. Contact Margaret (E313) with questions.

Food: M1 Second Cup is open 24/7, M1 cafeteria is open until 7:00pm every day. Check Sunnybrook website for other locations/hours.

Transportation

- TTC (2 routes): bus #11 to/from Davisville station OR bus #124 to/from Lawrence station
- Driving: monthly and weekly parking passes available for medical students (Parking office CG-01). Need photo ID badge to purchase a pass.
- Shuttle: Sunnybrook-CNIB-Holland Orthopedic-Women's College
  - Shuttles run Monday – Friday only
  - Main stop located outside H Wing

	Southbound			Northbound	
Bus	**Bayview**	**HOAC**	**WCH**	**HOAC**	**Bayview**
2	5:30am	5:50	6:00	6:05	6:30
1	5:45	6:05	6:15	6:20	6:45
2	6:30	6:50	7:00	7:05	7:30
1	6:45	7:05	7:15	7:20	7:50
2	7:30	7:50	8:00	8:05	8:25
1	8:00	8:20	8:30	8:35	9:00
2	8:25	8:50	9:00 - 9:15	9:20	9:45
1	9:15	9:35	9:45	9:50	10:15
2	9:45	10:05	10:15	10:20	10:45
1	10:15	10:35	10:45	10:50	11:15
2	10:45	11:05	11:15	11:20	11:45
1	11:15	11:35	11:45	11:50	12:15
2	11:45	12:05	12:15	12:20	12:45
1	12:15	12:35	12:45	12:50	1:15
2	12:45	1:05	1:15	1:20	1:45
1	1:15	1:35	1:45	1:50	2:15
2	1:45	2:05	2:15	2:20	2:45
1	2:15	2:35	2:45	2:50	3:15
2	2:45	3:05	3:15 - 3:35	3:40	4:05
1	3:35	4:00	4:10	4:15	4:50
2	4:05	4:35	4:45	4:50	5:35
1	4:50	5:20	5:30	5:35	6:15
2	5:35	6:10	6:20	6:25	7:00
1	6:15	6:40	6:50	6:55	7:30
2	7:00	7:25	7:30	7:35	8:00pm

*This schedule does not include CNIB stop times (between Bayview & HOAC in both directions).

Women's College Hospital

Frequently Called Extension Numbers

Main Switchboard	416-323-6400
Locating	x4141
Cardiac Arrest	x5555
Security	x6090
Medical Education Office	416-323-6044
Admitting	x6075
Biochemistry	x6289
Blood Bank	x6294
Ultrasound booking	x6160
Film Library	x6081
Emergency	x6300
Family Practice Unit	x6060
Homecare	x6199
Medical Library	416-323-6036
Pathology	x6140
Social Work	x6150

Photo ID Badge: Security office located in main lobby.

Computer Access: Apply for a user ID with Med Ed (Room 2438 within Education Suite 2406).

North York General Hospital

Frequently Called Extension Numbers

Main Switchboard	416-756-6000
Locating	x6002
Security	x6049
Medical Education Office	x6929
Ultrasound booking	x6176
Emergency	x6001
Family Practice Unit	x6980

Photo ID Badges: Obtained from Centre For Education (6N-630) at the start of your rotation. Must be returned at the end of rotation or you will be charged a fee.

Call Rooms: Room 6N-629

Student Lounge: Room 6N-629

Lockers: Located within room 6N-629. To be assigned for the duration of rotations at NYGH.

Pagers: Obtained from Centre For Education (6N-630), batteries available during office hours (7AM-4PM). Pagers from other sites can also be used, contact Locating at ext. 6002.

Food: Tim Hortons on 1st floor, West lobby is open 24/7. Check NYGH website for other locations/hours.

Transportation

- TTC: Take Line 4 to Leslie Station, follow signs on platform for Hospital. Turn right when exiting on Leslie St. and hospital will be across the street.
- Driving: Staff parking rate is available to clerks, contact the parking office in the parking garage.

APPENDIX G: WIGHTMAN-BERRIS ACADEMY

To call another WB hospital the following prefix is used before the extension:

Mt Sinai 17
TWH.....13
TGH.....14
PMH.....16
MaRS 18

Mt. Sinai (MSH)

Frequently Called Extension Numbers

Main 416-586-4800
Switchboard.....0
Locating.....x5133
Medical Imaging x4411
Med Ed Office x5989/8389

Department Locations

- 12, 17 (ward) Medicine
- 5 Radiology (film library, X-ray, CT scan)
- 18 Med/Surg ICU
- 16 CCU
- 14 General Surgery
- 10 Post-partum ward
- 11 Gynaecology
- 7 Labour & Delivery, High Risk In-Patient OB
- 5 OR
- 4 Ophthalmology
- 4/11 ENT
- 11 Orthopaedics

Call Rooms

- General Surgery – 5th floor (OR area), code given

- OB/Gyne – 16th floor, code given
- Medicine – 15th floor, code given

Computer Systems

- POWERCHART: Check results (labs, micro, imaging reports), orders can be entered but must be co-signed by MD.
- E-FILM: Medical imaging & reports (XR, CT, MRI, etc.). All imaging should be on the system.
- FetL Link: Obstetrics monitoring system for documenting the progress of labour and fetal health.

University Health Network

Frequently Called Extension Numbers

	Toronto General	Toronto Western
Main	416-340-4800	416-603-2581
Switchboard	0	0
Locating	x3155	x5111
Medical Imaging	x3365	x5871
Med Ed Office	x4162	x5924/6403

Computer Systems

EPR

- ID, password, course required (can do in Sept, same as with TWH)
- Orders (labs, investigations), results (labs, imaging reports)

E-film: Medical imaging. Reports can be found on E-film and EPR.

Toronto General Hospital Site Specific Information

Department Locations

- 13&14 Eaton Medicine
- 1 Radiology (film library, X-ray, CT scan)
- 10 NCSB Med/Surg ICU
- 2 CCU
- 9 Eaton General Surgery
- 8 Eaton Psych

- 2 NCSB OR
- 7 ENT
- 3 NCSB Uniform exchange

Call Rooms

- General Surgery – 5th floor NCSB, code given
- Medicine – 5th floor NCSB, key to be signed found in binder by 13 Eaton nursing station

Toronto Western Hospital Site Specific Information

Department Locations

- 8 Medicine
- 3 Radiology (film library, X-ray, CT scan)
- 5 Med/Surg ICU
- 3 CCU
- 8 General Surgery
- 2 OR
- 6/7 Ophthalmology
- 2/5 Neurosurgery/Neurosurgery &Trauma ICU, Orthopaedics

Call Rooms

- Medicine/Neurosurgery – 8th floor, code given
- All others – basement, key given by department

General Info for WB Academy

Telephones

- Dial "9" to get an outside line, including when paging someone
- Dial direct with 4-digit extension number
- Call locating if you need to page someone
- Call switchboard (0) if you need a direct extension for a dept/office

Pagers: Replace your pager batteries from Med Ed offices

MRN numbers: This is patient identification number. ALWAYS have this number with you when retrieving lab work from the computer, when requesting films from the film library, or when arranging for a consult

Photocopy Cards: Pick up from your home hospital library (500 free copies). Accepted by all three hospitals.

Hints on Finding X-rays and CT films

- First check on the E-Film system. If not found, call the film library (MRN # handy) and determine if hardcopy available
- If a film is not in the film library, check the following places:
- Radiology reading rooms, CT scanner room, ED, wards

UHN Shuttle Bus Service

Daily shuttle bus service between TGH and TWH is available M-F

Leaving From TWH: Leonard Street Entrance			
0630h	0700h	0730h	0800h
0815h and every 15 minutes until 1700h			
1730h and every 30 minutes until last bus at 2000h			
Leaving From TGH: 585 University Avenue Entrance			
0645h	0715h	0745h	0815h
0830h and every 15 minutes until 1715h			
1745h and every 30 minutes until last bus at 2015h			

Late-night bites:

TGH: Tim Horton's (Open until midnight on weekdays), Subway (open until 11 pm), Mega Wraps and Hero Burger (Open until 10 pm)

TWH: Druxy's (9 pm), Tim Horton's (10 pm), McDonald's and Tim Horton's at Bathurst and Dundas (24 hrs)

Refer to WB website for the full list of restaurant options within UHN and in the area.

APPENDIX H: FREQUENTLY USED CONVERSIONS

Remember:

100 mL = 1 dL 1 mcg/L = 1 ng/mL 1 mmol/L = 1 mEq/L for electrolytes

Lab Value	convert from	conversion factor	convert to
Albumin	g/L	x 0.1	g/dL
Ammonia	µmol/L	x 1.703	µg/dL
Bilirubin	µmol/L	x 0.0585	mg/dL
Calcium	mmol/L	x 4.008	mg/dL
Cholesterol	mmol/L	x 38.66	mg/dL
Copper	µmol/L	x 6.354	µg/dL
Creatinine	mmol/L	x 11.3	mg/dL
Cyanide	µmol/mL	x 0.026	µg/mL
Glucose	mmol/L	x 18.02	mg/dL
Iron	µmol/L	x 5.585	µg/dL
Lactate	mmol/L	x 8.904	mg/dL
Lead	µmol/L	x 20.72	µg/dL
Lipase	µkat/L	x 60	IU/L
Magnesium	mmol/L	x 2.432	mg/dL
Osmolality	mmol/kg	x 1	mOsm/kg•H_2O
pCO2	mm	x 0.1317	kPa
Phosphate	mmol/L	x 3.098	mg/dL
pO2	mm	X 0.1317	0.1317
Thyroxine	nmol/L	x 0.078	µg/dL
Urea	mmol/L	x 6.006	mg/dL
Uric acid	mmol/L	x 16.81	mg/dL
Zinc	µmol/L	x 6.538	µg/dL

NOTES