CLERKSHIP SURVIVAL GUIDE

ROTATION STUDY TIPS | NAVIGATE KGH/HDH

A GUIDE FROM PREVIOUS MEDICAL STUDENTS

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1. Foreword

Welcome to the Queen's University Clerkship Survival Guide for medical students! This book was put together by clerks in the class of 2022. A general acknowledgement that this book is not endorsed by the school of medicine and has not been validated by any of the clerkship course directors. It's also important to note that some details for rotation formats/assessment strategies may need to be updated. Check with your clerkship council if this booklet has been updated for your year!

The information presented here is based on the personal experiences of clerks who have completed these rotations. The goal is to provide you with the resources to guide your preparation and navigate the logistical challenges of each rotation, allowing you to focus on your personal learning and get the most out of each block.

We have organized the tips & tricks for each block into a general format:

1. The rotation format (length, need-to-know locations, exam)
2. Expectations for clerks (including staff you are working with, hours, procedural skills, how to write a consult, etc.)
3. Assessments (and how to complete these)
4. How to prepare for the rotation (studying strategies & resources)
5. Previous Clerks to Contact - Past clerks who are willing to speak about their experiences

We hope that this guide will be helpful to you during your clerkship years. We hope to see you around the hospital!

If you have any questions or feedback on making this document better, please contact Daniel Shi (dshi@qmed.ca) or Ken Choi (kchoi@qmed.ca), class of 2022.

Huge thanks to all of the contributors: Tyeren Deacon, Sarah Gomes, Salman Surangiwala, Cara van der Merwe, Kim Yuen, Parsa Mehraban Far, Mehras Motamed, Jennifer Payandeh, Alessia Di Carlo, Hamza Asif, Julia Robson, Marika Moskalyk, Stephanie Jiang, and Paul Bullock from the class of 2022.

We'd also like to thank the residents who reviewed this document: Leah Allen (PGY1, EM) and Sherwin Wong (PGY3, IM).

2. Getting around KGH/HDH – Entrances, Exits, Scrub Machines, Locker Rooms, Cafeterias

The two main hospitals that you will be working in are the Kingston General (KGH) and Hotel Dieu (HDH). There are a few need-to-know locations in each one.

KGH

The **KGH staff entrance** is located on the intersection of Stuart & George Street and will take you to the Watkins 2 area of the hospital. To enter, make sure to bring your hospital ID badge. You will be able to swap your mask with a hospital-provided one at this entrance, before proceeding to the staff sign-in. A picture of the entrance is below.

Note: During COVID-19 times, you will NOT be able

to enter or exit through the main entrance at 76 Stuart Street (tip for ordering food as well during your call days!).

If you want to store a bicycle, the **caged bicycle storage area** is located on George Street. To get there, go past the physician on-call parking and turn into the GIDRU parking lot area. Go to the end of the parking lot and you will see a caged lock up area. You will need KGH security to give your hospital ID badge access to scan into the secured storage site.

To gain access, email HospitalID@kingstonhsc.ca and provide them with the following information:

1. Bike Make
2. Bike Model
3. Colour
4. Serial #

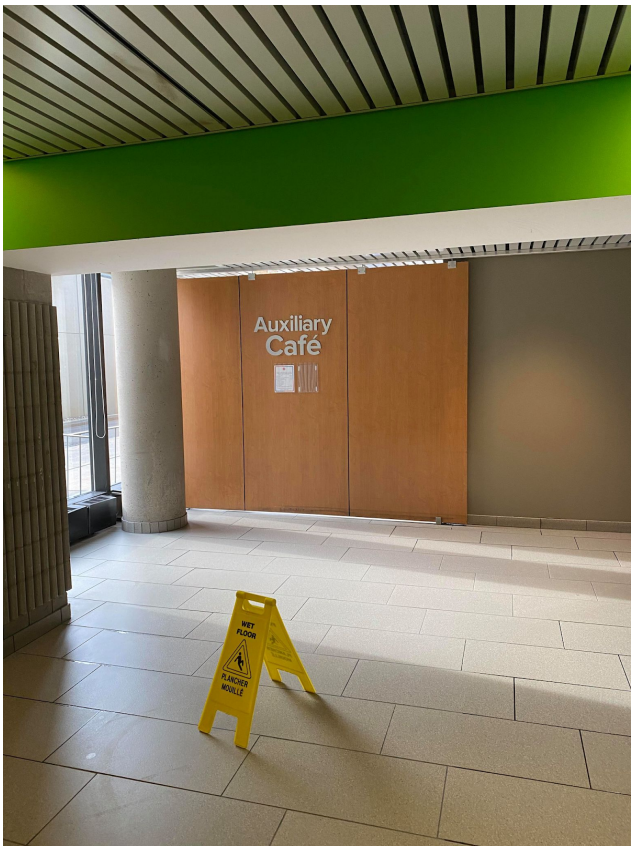
To find the **locker rooms**, you will need to head over to Burr 1. Once you go in through the staff entrance on Watkins (which is the second floor), follow the main hallway. Before you enter the “Anesthesia department”, look left and you will see a staircase. Head down the stairs to level one and walk toward the Burr hallway on your left (it will be blue). You will see the men’s and women’s change rooms on your right.

These lockers are set up for the medical students at KGH. There are lots of empty lockers, and your class president will typically post about how to sign up for these on your class Facebook page.

To find the **call rooms**, you will need to head up to Kidd 6. Once you leave the elevator, the entrance to the call rooms should be right in front of you. You will need your KGH ID badge to get through the door. The ones set up for clerks and for your specific rotation are labelled.

The KGH **scrub machines** are located on the second floor, on Connell 2 (left picture). To get there from the staff entrance, follow the main hallway and turn right before you enter the “Anesthesia department”. Make sure you have your staff ID badge, as you will **tap it** to the machine to check out scrubs. Do NOT swipe your card (this will not work!). Every student will have up to 5 tops/pants that they can check out at one time. The return station for used scrubs is in the same hallway on Connell 2 and is located by the windows across from day surgery (middle picture). To find the **Operating Rooms**, continue down the hallway with the scrub machine and there will be a set of double doors on your left (right picture). It should not be too far from the scrub machine. Note: There is a second scrub machine right beside the elevators on Connell 5, in case the scrub machine does not have your available size on Connell 2.

The **Auxiliary cafeteria** is located to the right of the main entrance (76 Stuart Street). There is a small place that serves sandwiches + coffee on the first floor. If you head down the stairs to level 0, there is a second cafeteria that has a daily special (although they usually only run 11:30AM-3PM), along with a Tim Hortons. Be sure to bring food for any night shifts, as the Tim Hortons is usually the last thing open (closes 11 PM).

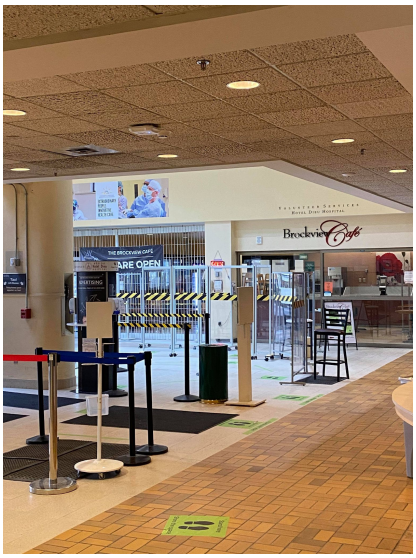


HDH

The **HDH staff entrance** is located on Sydenham street, by the intersection of Brock and Sydenham (left picture). Make sure to bring your hospital badge to open the door and sign-in at the staff entrance. One thing to note is that sometimes this staff entrance gets closed for construction purposes, so there is a second entrance on Johnson street (right picture).

To get to the main lobby from the Sydenham entrance, you will want to take a left and follow the main hallway for a **long** time. You will eventually reach the Jeanne Mance Wing and you will see a sign that says day surgery. Before you hit that, take a left toward the patient seating area and you should see the **scrub machines** on the left. The return station is located right next to the scrub machines.

There will be a staircase that you can take down to the main lobby on the first floor. The **cafeteria** will also be in the main lobby.



3a. Periop/Acute Care 1 (Anesthesia)

Rotation Format

- Periop 1 is a 4-week block. It is divided into two 2-week rotations.
    - Everyone will have 2 weeks of anesthesia.
    - The remaining 2 weeks will be allocated for your **surgical subspecialty**.
    - These two rotations can take place in any order.
- Shifts will be at either KGH OR, or the HDH OR.
- Contact Info:
    - Course Director - Dr. Yuri Koumpan: yuri.koumpan@kingstonhsc.ca
    - Program Coordinator - Saulina Almeida: Saulina.Almeida@kingstonhsc.ca
    - Department Telephone: (613) 548-7827
    - Department Location: Victory 2 - Submit your case assignments here
- You will receive your orientation package via email from Saulina, as well as a date/time to arrive for orientation at KGH and subsequent simulation session in the Med Building (Sim Lab Floor 2)
- **Your schedule can be found here under the "Clerk weekly schedule" link:** https://anesthesiology.queensu.ca/academics/undergraduate
- Essentially, you will be rotating through a number of different days while on anesthesia. A general breakdown of each labelled day is below:
    - 1. HDH OR: Check the OR schedule on the KGH Intranet link, either when you are at hospital or at home through Citrix, and you will be able to see the OR # and anesthesiologist you will be working with at HDH. You will be asked to complete the Anesthetic Record and assess each patient that is coming for surgery. Other tasks can include setting up the OR room, drawing up medications, putting ECG + O2 sat leads/monitors on as well as the blood pressure cuff, bag mask ventilation (a very important skill!), intubating, and charting vitals. Note that you will be with a different staff everyday, and some may ask you to do less than others
    - 2. KGH OR: Similar tasks and expectations to the HDH OR days. If you are ever confused on where to go, dial 7080 for the staff anesthesiologist at KGH and they will happily direct you on where to go!
    - 3. HDH Eyes: You will be primarily assessing patients who are in for cataract/eye day surgery. For this day, you will show up to the HGH patient holding area where the nursing staff are, and introduce yourself. Find the staff anesthesiologist and introduce yourself as well. Your main tasks will be to complete a focused anesthetic record with a history + physical exam, and then place a peripheral IV. It is advised to Youtube "how to place an IV" and know what steps need to be done. If you need help, the nursing staff or anesthesiologist will happily assist you and give you tips on how to place a saline locked IV. You will likely spend the majority of the time in the holding area, and get great practice putting in IVs.
    - 4. Acute Pain: The day will start at 0730 at the PACU in KGH. Arrive there, and either find Sue (NP for APMS) or wait for the anesthesiologist for the pain service to arrive. There is usually a list of patients that will be seen, and you will follow the attending around. The day before your shift, go to this link: https://anesthesiology.queensu.ca/academics/undergraduate and click on " Acute pain

management" to learn more about common medications used. You may also see nerve blocks being put in, or epidural's re-sited. Some days may be very slow with a small patient list, and you will be done quite early (for the AM portion at least).

- OBS/CON/Call: Go to the PACU at KGH for just before 0730, and you can call the resident number at 7080. For this shift, you will work directly with the resident/fellow/attending and provide anesthetic care to patients on Connell 5 labour and delivery. This may include assisting with epidural/spinals, setting up the 2 OR rooms on C5 and being present for C-sections, and completing the OBSTETRIC anesthetic record. It is the same idea, but a different form that needs to be completed. These can usually be found in the patient charts on Labour and Delivery, or if you need extra copies just ask the Unit Clerk at the front desk and they can assist you. In the back room behind the main desk there is a large computer/TV screen with patient information displayed on it. You can use that to determine what patients are scheduled for C-sections, and where they are on Connell 5. Go visit these patients and complete the Obstetric anesthetic record. Review with your staff, and then assist them in setting up the OR room or any other tasks for the day. You will be done at 1530.
- Evening Shift: This shift will go from 1530 to 2330 pm, and you will work in the General Emergency OR. Please check the KGH OR schedule to see the name of the staff anesthesiologist you will work with, as well as the OR you will be in. To locate the staff, use a KGH phone and dial 7010 and tell them you are the clerk working with them this evening. Tasks are similar to HDH and KGH OR days, and are staff dependent. Some will like you to be hands on, others will allow you to observe or do small procedures. You only have 1 evening call shift during your 2 week rotation in anesthesia, and no weekend shifts.

Expectations for Clerks

- **Dress Code**: Scrubs. Bring OR appropriate footwear and your stethoscope AND A PEN.
- Be on time. If you aren't sure when to arrive, CHECK THE OR SCHEDULE on the KGH Intranet as most procedures begin around 0730 or 0745. If you are keen, come early to assess the patient and complete the anesthetic record or help set up the OR room. Otherwise, aim to arrive in the specific OR about 15 minutes early to introduce yourself, and set some objectives with your staff or resident for the day. **Write your name + level of training on the whiteboard**, and head out to Surgery Day Unit (SDAC) to introduce yourself to your patient and conduct your preanesthetic assessment.
- You can find the OR lists on the KGH Intranet tool for both the Hotel Dieu and Kingston General Hospitals (PCS), starting at 2PM the day before the surgery.
- Know your patients by reviewing their chart and the procedures the day before. Be sure to pay attention to the **anesthetic considerations** - which cases require intubation, have the highest risk of postoperative nausea, etc.

Assessment Strategies

- Clerkship Anesthesiology Clinical Daily Encounter Forms - triggered on Elentra
  - 12 total (11 clinical days, 1 evening call)
- Anesthesiology Case Assignments - paper forms to be submitted to the anesthesia office

    - 3 required for course completion
- Mini-CEX assignment - triggered on Elentra
    - 1 required for course completion
- Online Modules
    - 4 including Post-Partum Hemorrhage, Preoperative Assessment, Intraoperative Management, and Cardiac Physiology.
- Logging
    - Complete all mandatory encounters on Elentra
- Final Examination

How to prepare for the rotation

- High Yield Topics to Review
    - Preanesthetic Assessment - you will use this to assess every patient, perform consults, etc.
    - Where to put ECG leads (3 and 5 lead ECGs) on the body, as well as how to put on a blood pressure cuff. Seems simple, but don't be thrown off guard!
    - Procedural Skills (Bag-Valve Mask, Intubation, IVs)
    - Anesthetic Considerations (patient populations, comorbidities, clinical situations)
- Resources
    - Clerkship Anesthesia Module **- Recommend completing this prior to the rotation.** There is a picture of the preanesthetic assessment here, which is important to review and be familiar with. It can be found on the Preoperative Assessment Table.
    - Understanding Anesthesia - A Learner's Handbook (Raymer. K)
    - Other resources available on the course page

Last Important Tips

- Introduce yourself to your team and the people you encounter! It sounds obvious, but can be overlooked.
- There is a computer screen on the wall which will let you know where your patient will be in SDAC. Their charts will be in the red folders on the adjacent wall. Usually, all you will need from the chart is the pre-op record (also known as the Pre-Surgical Screening (PSS) Patient Assessment form), their vitals/height/weight/investigations, and to see if they've received any pre-medication that day. If you have any trouble locating a patient, the nursing staff in the SDAC are very friendly. If the patient is not there, they are likely in the Connell 2 "holding area" that is directly across from the main office when you first enter the C2 doorway. Extra anesthetic record charts can be found at the base of the computer stands on either side of the holding area
- These are important numbers to keep in mind when on your anesthesia block:
    - 7071 - Anesthesia OR manager
    - 7080 - Anesthesia Resident number (If you don't want to bother the staff, it is advised to dial this number. The residents are all EXTREMELY helpful and nice)
    - 7010 - OBS/CON/Call number, specifically for the staff on this service. Call this number only if you are on this shift
- **Also important, check if/when any blood thinners, anti-diabetic agents and ACEi have been stopped. Different medications need to be stopped at different time intervals before surgery.**

- Anesthesia is one of the few specialties where you have uninterrupted 1:1 time with your preceptor. Be interested and curious, ask well thought out questions, and take advantage of the time you have!

Previous Clerks to Contact

Daniel Shi - dshi@qmed.ca

Ken Choi - kchoi@qmed.ca

Tyeren Deacon - tdeacon@qmed.ca

3b. Periop/Acute Care 1 (Surgical Subspecialty: Plastics)

Rotation Format

- Typically a 2-week rotation in Kingston. Shifts will be at either KGH OR, or the HDH OR.
- Plastics is one of the 4 surgical subspecialities that you will pick from before you start clerkship (the others being thoracics, neurosurgery, vascular).
- A typical day in plastics will involve **morning rounds**, and then choosing one of 3 places to follow (depending on what is available that day): KRCC clinic, OR, HDH plastics emergency clinic.
    - Morning rounds: These typically start anywhere from 7AM-7:30AM (depending on how many patients you have). The plastics patients are on Kidd 3 (it is a good idea to confirm the location with the plastics residents). Rounding will usually take **an hour**.
    - KRCC: This clinic is on burr 1 (ask your resident for exact details of how to get there). This is a procedures clinic, where skin cancers (usually BCCs and SCCs) are excised. You will work with an attending and assist in suturing the surgical excisions.
    - OR: Plastics ORs typically take place at the HDH site, on the 2nd floor (refer to the getting around KGH/HDH for an idea of where the scrub machines are, the signs to the ORs are not too far there!). ORs usually start at **7:45AM and end at approximately 3:30PM** (depending on the patient load), and you will work with an attending to assist in surgery. This may include retracting, suturing, irrigating, and cauterizing bleeds. Rarely, there will be an urgent surgery, which would take place at the KGH ORs.
    - HDH Emergency Plastics Clinic: Plastics clinic takes place at HDH Johnson 7 and **starts at 9AM**. Typically, patients are assessed here for possible surgery, followed for postoperative care, or receive minor procedures (e.g. carpal tunnel release, which is actually done in the office!). You will see a broad range of presentations, including phalanx injuries, assessments for breast reduction surgery, melanoma referrals, craniofacial injuries, and suture removals.
- You will be scheduled for 3 call shifts (2 weekday and 1 weekend) and sent a schedule via email by Mara Kottis that outlines the attending physician and residents “on call” that day. The **weekday call shifts** occur between 5 - 10 pm. Go to Switchboard (Floor 1 in KGH by the Security Office) and knock on the door to obtain the quad call pager. Reach out to the resident on call (on either Neurosurgery, Cardiothoracic, or Plastic Surgery) via text or page and notify them that you will be on call. You may be asked to do consults or come to the OR for the quad call services.

    - **Weekend call** occurs from 8 am to 10 pm. Check the call schedule and contact the resident/s on call that weekend 1 day in advance to inquire about where to meet in the morning. You will be required to help them round in the AM, and take consults/ORs during the rest of the shift. Ensure you pick up the quad call pager from Switchboard! If you get paged and you are at home/away from the hospital, you can dial 613-549-6666 and enter the extension of the individual who paged you.
- There is NO EXAM. However, you may write your anesthesia exam at the end of your Periop 1 block.

Expectations for Clerks

- You will work **mostly with off-service residents** , but you may work with preceptors depending on the shift.
    - Each day typically lasts **9 hours**, and the end time will vary depending on which clinic/OR you are in and the patient load.
    - **Dress Code**: Scrubs.
    - You will be expected to round on the post-operative patients with the residents and write a progress note for each one in their chart. You may be expected to round by yourself, once you start to get to know the patients.
    - **Procedures to know:** simple interrupted sutures, horizontal mattress sutures, running subcuticular suture, abscess incision & drainage.
    - In the plastics clinic at HDH, you will see patients on your own and write notes. Perform an appropriate history and physical before you review with your attending. You will also be expected to dictate a note after you assess them. To dictate a note, follow this format:
        1. Call the dictation number and sign on using the voice prompts.
        2. Start by stating your full name, level of training (e.g. CC3), who you are dictating for, the type of note, the date, the patient CR#, and the referring physician to CC.
        3. State “start dictation”.
        4. Start with “Dear (insert referring physician), it was a pleasure to see (insert patient name) in clinic today for (insert reason for referral)”.
        5. Dictate an appropriate history, physical, pertinent lab findings, and any procedures performed on new paragraphs. Do not forget to dictate periods and other appropriate punctuation/spacing. Spell out terms/names that may be difficult for the transcriber.
        6. Be sure to end with the final assessment for this patient and recommendations moving forward (include who to follow-up with and when, if needed).
        7. End with “Thank you for involving us in the care of (insert patient here). Should you have any questions, please feel free to contact the plastics clinic. This is (insert your full name, level of training, and who you are dictating for)”.
        8. State “end dictation”.
- General Tips <u>BEFORE</u> starting your rotation
    - Text your residents the Friday before starting your rotation to figure out where to meet them for morning rounding (you will receive their numbers via email prior to starting).
    - Have your dictation login set up - you can test this through any phone.

    - KGH: ext. 2700 (inside hospital), 6135482356 (outside hospital)
    - HDH: ext. 5100 (inside hospital), 6135482356 (outside hospital)
    - ID & Password: PCS number
    - Worktype numbers that you will likely use:
        - 1 - Operative Reports
        - 5 - Clinic Notes
        - 2 - Discharge Summaries
    - There should be a beeping noise when you have entered all of the prompted questions. **To start your dictation, press 2, and the beeping noise should stop.**
    - Press 8 to end the report and dictate another note.
    - Press 5 to end the report and disconnect.

Surgical Progress Note Format & Suggestions

- **ID: 70M/F POD 5 for Lt thigh FTSG 2/2 to burn**
    - This is your one-liner to summarize your patient, and should always include the post-op day (POD #), the type of surgery that they had/will have (FTSG), and the reason for the surgery.
- **Subjective:**
    - Pain control, #prn opioids used - check the medical administration record (MAR) in their chart
    - Chest pain, shortness of breath, calf pain/swelling - the main ROS necessary in plastics
- **Objective:**
    - Check vitals - AVSS if stable (look at flow sheet in patient chart)
    - Surgical site - clean, dry, intact (CDI)?
    - Record Input/Output from drains (also on flow sheet in patient chart)
    - Labs if pertinent/abnormal
- **Assessment/Plan:**
    - Make a list of active issues that need to be addressed. Think about what this patient needs to go home. Note if new concerns.
    - Continue current management
    - Physio, OT, other IP services needed or following?
    - **Include Dispo** - is the plan for home, rehab, LTC, transfer? E.g. D/C home when skin flap has healed/graft has taken
    - Sign w/ your name and level of training
- **Your note should be succinct & quick**

Assessment Strategies

- ONE (1) Subspecialty Surgery Rubric per week (total TWO (2) per block). This is triggered on elentra and you can send them to the resident that you work with.
- ONE (1) Subspecialty Surgery Daily Encounter Form per week (total TWO (2) per block). This is triggered on elentra and you can send them to the resident that you work with.
- There is no Plastics exam, but the General Surgery exam will have 2-3 basic plastics questions on it.

How to prepare for the rotation

- High Yield Topics to Review
    - Approach to reading wrist/hand x-rays, phalanx injuries (e.g. tuft fractures), avulsion fractures of hand, skin lesions (melanomas most commonly), cranial fractures, carpal tunnel syndrome
    - The most common surgeries you will see are bilateral breast reduction, breast reconstruction, excisional melanoma with sentinel node biopsy, phalanx ORIF, carpal tunnel release (mostly done in office but complicated cases can be done in the OR)
    - **Suturing is important** - knowing the steps will make your life easier during this rotation
- Resources
    - HDH clinic student plastics handbook - can be borrowed during your rotation
    - **https://www.youtube.com/watch?v=NnKdmjX5pWU&t=497s - Intro to suturing + simple interrupted, good video to watch first**
    - **https://www.youtube.com/watch?v=-rvJZ3jR7AU&t=90s - Running subcuticular suture**
    - **https://www.youtube.com/watch?v=p-g89FF5l7w - Horizontal mattress**
- You can buy a suture kit package off Amazon for about $50 here. Decent practice kit to get started on suturing, but the model is not representative of human skin. If you have a laceration kit from the school, an orange or banana would work great.

Last Important Tips

- Review how to scrub in on a surgery - although there was a training session in pre-clerkship, it is always good to review it and know how to navigate the sterile fields in the OR. This will make the nurse's jobs in the OR a lot easier.
- Be aware of OR etiquette. Some important things include:
    1. writing your name + level of training + glove size (find this out before the rotation starts!) on the white board when you walk in
    2. Respecting the sterile field (do not touch any of the blue sheets!)
    3. Checking in with the attending + the scrub nurse before scrubbing in
    4. Helping with setting up the patient/taking them to the recovery room (you can ask the nurses how to be helpful!).

Previous Clerks to Contact

Daniel Shi - dshi@qmed.ca.

Ken Choi - kchoi@qmed.ca

3c. Periop/Acute Care 1 (Surgical Subspecialty: Neurosurgery)

Rotation Format

- Typically a 2-week rotation in Kingston.

Expectations for Clerks

- Clerks on this rotation do not receive a schedule. To start, you can either text/page one of the residents or the PAs (all this info is on the call schedule accessed via PCS) to let them know

you're coming, or just show up on Kidd 7 in the PAs' office at 8 am on the day you start your rotation.
- To find the office, go to the Kidd 7 nursing station and ask for someone to help you find it (it is very close to there).
- You can check the OR schedule the day before after 2 pm on the KHSC website, or look at the printed schedule in the PAs' office (just shows which surgeon is operating).

Assessment Strategies

- ONE (1) Subspecialty Surgery Rubric per week (total TWO (2) per block). This is triggered on elentra and you can send them to the resident that you work with.
- ONE (1) Subspecialty Surgery Daily Encounter Form per week (total TWO (2) per block). This is triggered on elentra and you can send them to the resident that you work with.
- There is no Neurosurgery exam, but the General Surgery exam may have 2-3 basic neurosurgery questions on it.

How to prepare for the rotation

- High Yield Topics to Review
    - Imaging (which types for which issues)
    - Types of bleeds on imaging
    - Lumbar drain procedure
    - Post-craniotomy complications
- Resources
    - Toronto Notes
    - Course notes

Last Important Tips

- Depending on your interests, you can either do only/mostly ORs, only ward work, or somewhere in between.
- Advocate for your interests and do whatever you feel would be most helpful for your learning. There are sometimes clinics but these may be cancelled due to covid.
- Ward days are mostly managed by the PAs and generally go 8am-4pm, and you will have time for lunch. You can help with seeing patients and discharge summaries.
- The exams for patients are brief and focused on the surgery/issue that they have.

Previous Clerks to Contact

Julia Robson - jrobson@qmed.ca

3d. Periop/Acute Care 1 (Surgical Subspecialty: Thoracics)

Rotation Format

- 2-week rotation in Kingston. Shifts will be at either KGH OR or HDH clinic
- Thoracics is one of the 4 surgical subspecialities that you will be placed in before you start clerkship (the others being plastics, neurosurgery, vascular)

- A typical day on thoracics will involve **morning rounds**, and then spending the day either in the KGH OR or the HDH clinic.
    - **Morning rounds:** These typically start anywhere from 5-6:30am (depending on how many patients are on the thoracics list) and you will always meet **on Kidd 6** first. The thoracics patients are located on Kidd 6, Kidd 3, and the Kidd 2 ICU. On Wednesday mornings you will round early (usually 5am) because the residents have academic half-day teaching, which you will attend and listen to. Rounding will **usually take an hour**.
    - **Clinic/ORs:** The master surgery schedule can be accessed here: https://docs.google.com/spreadsheets/d/1LZpmtl0kVyfAfBBMYdhieXUA9cl67FO_bu0R5_ZWIzA/edit#gid=978447761
        - OR: all ORs will take place at KGH and they start at 7:45am. You can check the OR schedule after 2pm the day before so you can prepare for the cases in advance.
        - HDH Clinic: all clinics will take place on **Johnson 5**. You can check the clinic lists on PCS to read up on your patients the day before the clinic.

Expectations for Clerks

- You will work **mostly with surgical residents** , but you may work with preceptors depending on the shift.
    - Each day typically lasts **9 hours**, and the end time will vary depending on which clinic/OR you are in and the patient load.
    - **Dress Code**: Scrubs, but business casual for clinic.
    - You will round as a team on the post-operative and admitted patients and write a progress note for each one in their chart (see Plastics on how to write a surgical progress note).
    - Your responsibility as a clerk will be to scribe and write down the plan for the patient as discussed by the residents.
    - You may be asked to dictate at the clinic (see Plastics on how to dictate a clinic note).
- General Tips BEFORE starting your rotation
    - You should contact your resident on WhatsApp or via text the Friday before the rotation to see what time you will be meeting on the Monday morning (you will be sent the residents' contact information before the rotation starts).
    - Try to show up 15 minutes before you meet your team to print patient lists for everyone and start to write the date/patient ID/vitals on the charts so rounds will be less stressful as they move very quickly.

Assessment Strategies

- ONE (1) Subspecialty Surgery Rubric per week (total TWO (2) per block). This is triggered on Elentra and you can send them to the resident that you work with.
- ONE (1) Subspecialty Surgery Daily Encounter Form per week (total TWO (2) per block). This is triggered on Elentra and you can send them to the resident that you work with.
- There is no Thoracics exam, but the General Surgery exam will have 2-3 basic thoracics questions on it.

How to prepare for the rotation

- High yield topics to review
    - Approach to reading CXRs, lung cancer screening, mediastinum anatomy, mediastinal tumours (terrible Ts), Barrett's esophagus/esophageal cancer, pneumothorax, pleural effusion/empyema, pain management of rib fractures
    - The most common surgeries you will see are lobectomies, esophagectomies, and bullectomies/talc pleurodesis.
- Resources
    - Preclerkship course notes - Dr. Reid's lectures are particularly helpful
    - First Aid Surgery Clerkship book
    - Surgical Recall Book

Last Important Tips

- Carry several X-Ray requisitions with you on rounds because almost all patients will need one and it helps save time on rounds
- Carry a few yellow sheets, physiotherapy is a common consult for rib fracture patients

Previous Clerks to Contact

Marika Moskalyk - mmoskalyk@qmed.ca

Alessia Di Carlo - adicarlo@qmed.ca

3e. Periop/Acute Care 1 (Surgical Subspecialty: Ophthalmology)

Rotation Format

- Typically a 2-week rotation at HDH as part of the periop rotation that you may be assigned. Can be challenging to get it by lottery, as it has historically been a very popular choice for all medical students.
- Clinics are in J6, emergency eye clinic in MA1, and ORs are in HDH.
- Rotation will consist of **OR time (approximately 2 days/week) and clinic (approximately 3 days/week)**. Given that this rotation is relatively new, the Undergraduate Education team is still trying to find a balance between clinic and surgical time, so this is subject to change.
- Hours are usually light with clinics starting around **9:00 am and ending prior to 5:00 pm** (perhaps with the exception of the retina clinic which is usually a little bit busier).
- You will typically spend each half-day with a different preceptor and residents, however, it is possible by chance that some days you may be with the same preceptor.
- At the end of rotation there is a possibility to have a one-on-one meeting with Dr. Law to discuss your experience. She is the Undergraduate Education Director.

Expectations for Clerks

- Really there are no expectations since this is very different than all we are taught! Due to the pandemic many classes did not have an opportunity to participate in an in-person clinical skills fair. The residents and faculty are very eager to teach. If you are interested in pursuing ophtho,

let the preceptor and resident know and they will do everything to teach you some additional clinical skills or impress you with interesting cases to solidify your choice to pursue the field!
- **Dress code**: No formal word on this, but business casual attire to be safe. Staff and residents dress casually usually.

Assessment Strategies

- ONE (1) Subspecialty Surgery Rubric per week (total TWO (2) per block). This is triggered on elentra and you can send them to the resident that you work with.
- ONE (1) Subspecialty Surgery Daily Encounter Form per week (total TWO (2) per block). This is triggered on elentra and you can send them to the resident that you work with.
- There is no Ophthalmology exam, but the General Surgery exam may have 2-3 basic neurosurgery questions on it.

How to prepare for the rotation

- Review the Queen's website: https://ophthalmology.queensu.ca/academics/undergraduate/education/clinical-skills
- Resources: "Basic Ophthalmology '' and "Practical Ophthalmology" are two fantastic books published by American Academy of Ophthalmology.
- Wills Eye Manual is a great resource for looking up clinical entities in the clinic.
- New since the pandemic, Canadian Ophthalmology Student Interest Group website:https://www.cosig-gecio.com/about-us created by fellow students is packed with all things eye related you would ever need to know as a clerk.

Last Important Tips

- Ophthalmology is a clinical skills heavy field and at times you may feel lost playing with the slit lamp and other instruments. **Try your best and the faculty will teach regardless of where your skills are.**
- Perhaps the only real expectation is that **you have completed the clinical skills fair**, which was part of the curriculum, which can be found on the Queen's website.

Previous Clerks to Contact

Parsa Mehraban Far - pmehrabanfar@qmed.ca

3f. Periop/Acute Care 1 (Surgical Subspecialty: Otolaryngology/ENT)

Rotation Format

- Typically a 2-week rotation in Kingston.
- ENT can accommodate 2 clerks at the same time, so if you are on with another clerk, one clerk will be on the Head & Neck service for 1 week, one will be on General ENT for 1 week, then you will switch. If you are the only clerk on ENT it may be a mixture depending on OR times etc.
- You will be contacted by Dr. Hollins prior to your rotation with a general schedule, as well as your ENT schedule; Dr. Phillips will be in contact with you to provide your H&N schedule

Expectations for Clerks

- You are expected to round during your Head & Neck week with Vicki the PA. You will also assist her with Discharge summaries, orders etc. for the H&N patients
- **Dress code**: Clinical wear for clinics, Scrubs for OR
- General ENT clinics are held at HDH
- H&N has usually 1 oncology clinic per week on Thursdays at the KRCC at KGH
- General ENT ORs are usually at HDH, H&N ORs are usually at KGH

Assessment Strategies

- ONE (1) Subspecialty Surgery Rubric per week (total TWO (2) per block). This is triggered on elentra and you can send them to the resident that you work with.
- ONE (1) Subspecialty Surgery Daily Encounter Form per week (total TWO (2) per block). This is triggered on elentra and you can send them to the resident that you work with.
- There is no ENT exam, but the General Surgery exam may have 2-3 basic ENT questions on it.
- **There is an ENT assignment**, to be emailed to Dr. Hollins by the end of the block. It is a brief case report/literature search on a topic you have encountered during your rotation.

How to prepare for the rotation

- High Yield Topics to Review
  - ENT Take-Home Points
  - ENT Consolidated Notes
- Resources
  - Rotation Guidelines
  - General Resources from 2022 Drive

Last Important Tips

- ENT ORs, especially H&N, have lots of anatomy! To be prepared, I recommend reviewing basic muscles, blood supply, and cranial nerves that are pertinent to the case you will be involved in.
- Be on time, be helpful, have fun!

Previous Clerks to Contact

Jennifer Payandeh - jpayandeh@qmed.ca

4. Periop/Acute Care 2 (Emergency Medicine)

Rotation Format

- Typically a 4-week rotation in Kingston. Shifts will be at either KGH Emergency Department, or the HDH Urgent Care Centre.
- There are a minimum of 8 shifts for you to complete. At the start of the rotation, you will receive the schedules of **2 preceptors**, and the mandatory **8 shifts** will be highlighted in red. The remaining shifts are optional, as you can attend up to **12 shifts** in total.

- The types of patients that you see will depend on where you are assigned. KGH has 5 different sections, while HDH only has one.
    - Section A: Acutely ill patients: chest pain, traumas, delirium, toxicology presentations
    - Section B: Straightforward/procedural cases: fractures, lacerations, localized swelling, other MSK presentations.
    - Section C: High-risk COVID presentations. You will NOT be expected to see patients here.
    - Section D: More complex patients that require further workup: abdo pain, dizziness, nausea, etc.
    - Section E: Emerg Psychiatry.
    - HDH Urgent Care: Generally straightforward cases that require less workup. Many minor procedures are performed here. **To find the urgent care**, take the elevators at the main lobby to floor zero and turn right once you get off. Follow the hallway all the way down and it will be on your left. There are change rooms in the urgent care you may use. One tip is to introduce yourself to one of the nurses and ask where things are.
- There are **7 interprofessional shifts** that are separate from the emerg shifts. These are mandatory, and a doodle poll will be sent out at the start of the rotation for you to schedule on your free days.
    - ECG Technologist. Head to the ER at 7AM and call ext. 1335 (this will connect you to vocera) on one of the phones, ask for ECG East when prompted. You will read 10 ECGs and place leads on the patients where the technologist is called.
    - Phlebotomist. Head to the ER at 7AM and call ext. 1335 (this will connect you to vocera) on one of the phones, ask for Phlebotomy when prompted. They will let you practice on a fake arm and then perform 10 blood draws on patients.
    - ER Triage/Personal Care Assistant. Head to the ER at 7AM and look for the PCA (they will usually have black scrubs). If you can't find them, ask the charge nurse in Section A. You will help them with a variety of tasks, including stocking inventory, folding blankets/PPE gowns, and distributing patient meals. At 12PM, head to the triage in section A and spend the rest of the day (until 3PM) working with the nurse there, where you will help triage incoming patients, take vitals, and perform COVID screens.
    - ER Nursing. Head to the ER at 7AM and talk to the charge nurse in Section A. They will assign you to one of the nurses to work with for the day (until 3PM). You will help with monitoring patients and administering medications.
    - ER Nurse Practitioner. Head to the ER at the specified time and ask the unit clerk in Section D for Danny Quan. This is a 2 hour shift. You will follow a few cases with Danny and learn about his role in disposition planning for patients who are not sick enough to be admitted to the hospital, but also not well enough to return home.
    - Social Work. Head to the ER in Section D and ask the unit clerk to page Sociology. You will follow them for the night and see consults in the ER.
    - Procedure Shift. Head to HDH urgent care and meet the ER resident. You will perform any procedures in the ER, including laceration repair and abscess draining.
- You will not need access to a car if you live close to campus.
- There is a short emergency medicine exam at the END of your rotation. This will be ~20 questions and involve both MCQs and SAQs.

Expectations for Clerks

- You will work **directly with a preceptor**, but there may be a resident depending on the shift.
    - Each shift is **8 hours**, and the start/end time will vary depending on when your preceptor is scheduled for (can be anytime from 6:30AM to 7PM start time). Meet your preceptor at the assigned section/hospital on your schedule.
    - **Dress Code**: Scrubs.
    - When patients are ready to be assessed, they will show up on the computers, with a program called EDIS. There will be a green bar next to their name, with the words "MD EVAL". You can click the med student column, add your name, and it will prompt you to add your preceptor's name.
    - You will have the opportunity **to assess patients on your own** and conduct your own focused history/physical.
    - You will be expected to chart your encounter using the EDIS system, using a **SOAP** note. Afterwards, you will present your patient to your preceptor or senior resident with **an oral report**.
    - Procedures to know: **laceration repair, casting, conjunctival foreign body removal (you may review the basics of a slit lamp), abscess incision & drainage.**
    - Make sure **you review each patient** with your preceptor before moving onto another patient - do NOT sign up for more than one patient at a time unless your preceptor allows you.
- General Tips <u>BEFORE</u> starting your rotation
    - Ensure that your EDIS password has been set up. You only need a password to login to the system (provided to you with your PCS password). Any computer in the ER will have EDIS, and you can access it through the icon called "Wellsoft", with a heart symbol. There is a module on how to use EDIS on Elentra.
    - Use this guide to figure out where the scrub machine is/how to use it!
    - Email your preceptor **a few days** before starting your first shift with them to introduce yourself and clarify where to meet them, **as Emerg doctors tend to switch shifts with their colleagues**.

<u>ER SOAP Note Format & Suggestions</u>

- **ID: 70M w/ 1 day hx of retrosternal chest pain in the context of previous MI**
    - This is your one-liner to summarize your patient, and should be suggestive of what is most concerning in this patient.
    - Include the age, sex, presentation complaint with important subjective details, and relevant PMHx (usually only 1-2 conditions)
- **Subjective:**
    - Always include the **course** of the presenting complaint, including when it started, if it's worse or better, and what brought them into the ER
    - **Sometimes the presenting complaint is not what is listed on EDIS - keep an open mind as you take your history! Patients may mention more concerning things as you talk to them and establish rapport.**
    - Include your basic history component (SOCRATES)
    - List PMHx/Family Hx as relevant
    - Social Hx as relevant

- **Objective:**
  - Include vital signs on EDIS - stable vs unstable, note any abnormalities.
  - Document physical examination findings as relevant. A basic format:
    - CVS: NS1 S2? regular vs irregular? extra heart sounds? JVP (flat vs raised)?
    - Resp: GAEB? Crackles, wheezes?
    - Abdo: SNT? Masses?
    - Extremities: Swelling? Skin changes? Temp? Varicose veins? Distal pulses?
    - Neuro: Cranial nerves? Power arms/legs bilaterally? Sensation arms/legs bilaterally? Coordination, gait?
    - MSK: Deformities? Swelling? Localized tenderness? ROM?
- **Assessment/Plan:**
  - Make a list of active issues that need to be addressed. Think about what brought the patient to the ER and why they are not well enough to be at home.
  - Suggest investigations/management plans for each issue. Example:
    - 1. SOB NYD
      - CHF vs COPD vs Anemia
      - Not likely PE (PERC -ve), Pneumonia (no clinical signs of infection), Ischemia (no chest pain, SOB is ongoing issue for months)
      - CBC, Lytes, CXR, ECG, troponin. If all negative, then send home w/ tiotropium bromide inhaler and follow-up for PFTs + Echocardiogram

Assessment Strategies

- At least EIGHT (8) Clerkship Emergency Medicine Shift Report Assessment Forms must be completed by your preceptors at each Emerg shift. This is triggered on Elentra. **Most preceptors will fill this out at the end of your shift, as it is hard to keep track of later.**
- SEVEN (7) Interprofessional Assessment Forms. Print out these forms here and bring them to your appropriate IP shift, where your preceptor will fill out and sign it. You will then take a picture of the form and email it to Tiffany Roy (tiffany.roy@kingstonhsc.ca).
- ONE (1) Mini CEX form. You will be assigned a two hour session with a random emergency medicine faculty member, where they will watch you perform a history and physical. This is triggered on Elentra after the session.
- ONE (1) mid-rotation assessment form after 4 emerg shifts. This is triggered on Elentra for your preceptor.
- ONE (1) Exit meeting assessment. You will be emailed to attend an end-of-rotation meeting with Dr. Rahmani. You do not need to trigger any forms.
- 60% on the Emergency Medicine MCQ and SAQ exam.

How to prepare for the rotation

- High Yield Topics to Review

    - Have a general approach to common Emergency Medicine presentations: Abdo pain, Nausea/Vomiting, Chest Pain, Palpitations, Syncope/Presyncope, Localized Swelling, Vertigo, Tick Bites
    - Know your common fractures well - history, physical, how to read an x-ray, and the management.
        - The modules on Elentra are great. Running through them will give you a great approach to fractures in the ER.
    - Have an approach to reading ECGs (rate, rhythm, narrow vs wide complex, sinus vs non-sinus)
        - Identify the most common presentations: A-fib, A-flutter, signs of obvious ischemia (ST elevations), pericarditis, heart blocks, signs of PE (RV strain + S1Q3T3)
        - Also know V-fib, V-tach, and when to be worried about torsade de pointes.
    - Know how to manage electrolyte abnormalities and when to be suspicious of them causing the patient's symptoms
        - Hyper/hypokalemia, hyponatremia, acidosis
- Resources
    - https://flippedemclassroom.wordpress.com/ - Great videos that cover 10 of the most common presentations for Emerg and their general approaches. It is a good starting point.
    - https://litfl.com/ - Great for ECGs - has case examples in addition to the explanations.
    - https://emcrit.org/ - Great general resource for the more detailed management of specific presentations. Their sections on electrolyte abnormalities are particularly helpful.
    - **https://www.youtube.com/watch?v=isM2MJdRjyE - Must watch 5 minute video for oral presentations in the Emergency Department.**
    - **https://www.youtube.com/watch?v=ztqn5Br44UQ&t=2s - 10 minute video for oral presentations.**
    - https://www.uptodate.com/login - Uptodate. Good for any rotation. On Emerg, uptodate will mostly be useful for deciding investigations to order.
    - https://www.amazon.ca/Anti-infective-Guidelines-Community-acquired-Infections-2019/dp/1894332199 - Good antibiotic resource. You can either get the book **or the app** on your phone.
    - https://spectrum.app/ - Good antibiotic resource. It is available as an app on your phone.

Last Important Tips

- The emerg rotation is a great opportunity to improve your oral presentation skills. You will present many patients directly to your preceptor and receive feedback at the end of each shift. This will be a valuable skill for other rotations, so it's a good idea to keep this in mind and get a sense of what information is important to present.
- Include an assessment/management plan in your presentation, even if you are not sure about it. This lets your preceptor know that you are thinking about the differential diagnosis of a patient, and represents a good opportunity for them to teach you about specific presentations. If your

preceptor doesn't agree with your assessment, that's totally okay, and they'll be happy that you attempted.
- Think about why you are ordering specific investigations. Oftentimes, preceptors will challenge you on the reason for these things, and you should have some justification prepared based on the patient's story or past medical history. Remember that not everyone gets a CBC!
- Don't rush your assessment of patients. While it's good to get a sense of how the flow in the emergency department works, no one will rush you, and preceptors are okay with you taking the time needed to perform a thorough assessment. Your job is to get the most out of your learning experience, and they will manage things if the department gets busy.
- If you need to go back to ask more questions or do a physical exam, that is completely okay! A lot of the times the differential you come up with can prompt you to investigate more things that you forgot initially. This is actually preferred by preceptors, and patients generally do not mind.

Previous Clerks to Contact

Daniel Shi - dshi@qmed.ca.

Ken Choi - kchoi@qmed.ca

5a. Medicine – Core (CTU), Kingston

Rotation Format

- Typically a 4-week rotation in KGH. Shifts will be at Connell 9 or Connell 10. You will be a part of a CTU Team (A, B, C, D, or G), which includes another clerk, 2-3 residents and an attending physician. Attendings change every 2 weeks.
- You will be assigned a pager for this rotation, and the pick up location will be discussed at Orientation on the first day. You will likely only be paged when on call. Communication while on the wards is typically done via a WhatsApp chat with your team members. **Remember: do not include patient identifiers in chats** (initials are okay).
- Approximately 2 weeks before the rotation you will receive an email identifying your assigned CTU team and your on-call schedule. You will be assigned 4 - 5 overnight call shifts, including at least one weekend.

Expectations for Clerks

- On the wards:
    - Arrive **by 8AM** to receive your assigned patients for the day.
    - Clerks are typically assigned 2 patients at the start. By the end of the rotation, you may be assigned up to 5 patients per day. **These numbers may vary** depending on patient complexity, your resident team, etc. but generally expect to round on more patients as the rotation progresses.
    - Using PCS, check your patient's blood work or new imaging reports and make note of any abnormalities or trend changes. Then, go see your patients and complete a focused history and physical exam. Your history should be tailored to how they are feeling today, and any changes in their symptoms. Remember to always ask about pain management

and physiotherapy progress. **Rounding requires different clinical thinking than consults – less about diagnostics and more about advancing patient care and getting patients back to their baseline.**
    - **If your patient becomes unstable, or if there are emergent issues that you are uncertain of how to handle, get a resident immediately**. If the nurses are worried about a patient's stability, this is usually a good indication that you should tell a resident about the situation.
    - After you see your patient, write a progress note (see example below) and come up with a plan to advance their care. **Write your own orders and bring them to rounds to have them co-signed.** Don't worry if the team doesn't agree with your orders! It is better to try to propose a plan even if you are wrong.
- "Running the list" – you will run the patient list with your team between 10-11AM. You will present a **short** oral report on your patients, hitting on the pertinent points:
    - Patient name, age, reason for admission
    - Examples of pertinent points: day X of antibiotics, current symptoms or changes, response to medications, abnormal blood work/ imaging, PT/OT updates, and **plan for discharge** (what is keeping them in hospital, where are they going after – long term care, retirement home, home, etc.)
    - **Overall, use your patient's itemized problem list as a guide and focus on your management changes.**
- During the day you may be asked to complete a consult in the ER
    - Similar format to when on-call - see info below. You will review the consult case with your preceptor that day.
- Afternoons are spent dealing with issues that come up on the wards, completing orders/ plans discussed at rounds, and doing any new consults in the ER
- On Call
    - Weekday call is from 5PM until up to 10AM the next day. You work a typical day on the wards until 5PM on your call day. At 5PM, go to Section A of the ER – the "CTU Consult" section is on the right-hand side with all the computers. **Write your name and pager number under your CTU team on the white board and introduce yourself to the senior resident.** You can then proceed to your call room and wait to be paged for consults! Note: if you are on call on Friday, your post-call day is Saturday and you work the following Monday.
    - Weekend call is from 8AM until up to 10AM the next day. You typically round with your CTU team during your weekend call. Meet in your team room at 8AM to get your list of patients to round on. Weekend rounding is faster than weekday rounding and you will be assigned 5-7 patients. **Only pressing issues are addressed on weekends.** Also remember that there is no allied health on weekends. Your team will decide when to run the list, typically between 10-11AM. After running the list and writing any orders, you will go to Section A of the ER at 12PM to write **your name and pager number** on the whiteboard. You can then proceed to your call room and wait to be paged for consults! Note: If your weekend call is on Saturday, your post-call day is Sunday and **you work on Monday**. If your weekend call is on Sunday, then your post-call day is Monday.

- Your responsibilities during call are to complete consults in the ER when paged. You are not responsible for ward issues.
- Once you are paged, the senior resident on call will always see the patient first. **If the patient becomes unstable while you are with them, get a resident immediately.** You will never be faulted for getting a resident if you feel the patient is unstable! See below for what to include in a CTU Consult. Note: You can remain in your call room (please see section 2 for how to find the call rooms) or elsewhere within the hospital until you are paged.
- Once you have examined the patient and completed your written CTU Consult note, **complete the admission order set on PCS** (can be either ICU or Ward Admission). Review with your senior resident when you are done both of these things.
- **In the morning, go to Section A of the ER at 7AM (don't forget to set your alarm!)**. You will typically meet your CTU preceptor (or multiple attendings if you admitted patients to different CTU teams) between 7-8AM to review the consults you completed overnight. Before reviewing with your preceptor, it is good to **check PCS to see (1) where the patient is within the hospital and (2) the results of any labs/ imaging you ordered overnight that came back** when you were sleeping or doing another consult. Some preceptors will see the patient with you again the next morning, others will tell you to go home after your oral report. You will complete anywhere from 1 – 5 consults while on call, depending on how busy the night is.

CTU Consult Note Format & Suggestions

1. **Patient ID**: Age, sex, chief complaint, where from (home, long-term care, retirement home, etc)
2. **RFR**: Reason for referral
3. **Code Status:** Ask the patient or next of kin – if it is your first time asking about code status let a resident know. Don't forget to fill out the blue sheet, which can be found beside the order sheets.
4. **Allergies**: Include type of reaction (GI, rash, anaphylaxis)
5. **Medications**: Include dose, route, and timing - *Where to find? Past discharge summaries, patient lists, Connecting Ontario*
    a. **Don't forget to also talk to the patient!** They may bring their medications/blister packs. Additionally, they can give you an idea of recent medication changes, their actual adherence/compliance, collateral to contact, and the contact information of the pharmacy they use (you can also find this on PCS/Connecting Ontario).
    b. Investing the time to have an accurate medication record is **essential** to a good consult, as it can make **a huge difference** to the patient's investigations/management.
    c. If you have time, grouping medications by their associated diagnosis can be very helpful for people who read your consult note. Although not every diagnosis needs medication, **it will help create a picture of the severity of each illness**.
6. **PMHx**: Past Medical History - *Where to find? Past discharge summaries*
    a. Include conditions and last known status
    b. Include surgical history – dates and indications for surgeries
    c. *Common Examples & What to Include:*
        i. Diabetes – Type I or II? HbA1C? Recent glucose readings? Well controlled? Insulin dependent?

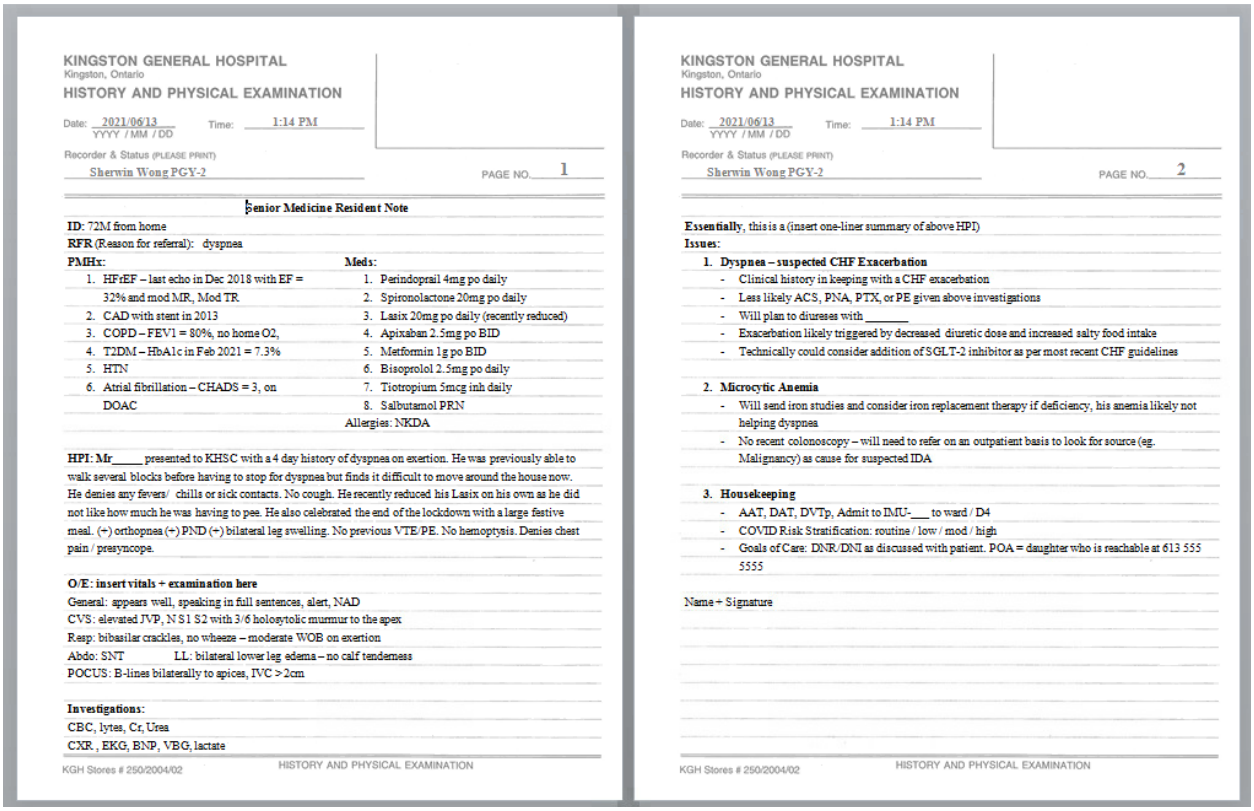
ii. Congestive Heart Failure – most recent echocardiogram date and results (EF, severe valvular abnormalities, changes from previous echo)? HFpEF vs HFrEF
iii. Atrial fibrillation – CHADS score? Anticoagulation status?
iv. ACS – STEMI/NSTEMI? PCI? CABG?
v. COPD – GOLD score? #exacerbations? Home oxygen? Latest PFT results? Recent antibiotics? Nocturnal BiPAP?
vi. Liver Disease - MELD score? Compensated vs. decompensated cirrhosis? Previous ascites, SBP, hepatic encephalopathy?
vii. Cancer - Staging? Primary cancer? Active/previous treatment (chemo, rads, surgery)? Year of diagnosis? Recent CT scan? Followed regularly? Goals of care (palliative vs. curative)?

d. **A detailed past medical history depicts the severity of a patient's illness and identifies the possible contributing factors behind their presenting symptoms**. Aside from the medications needed to manage these diagnoses, complications such as kidney disease, retinopathy, leg amputations, etc. can provide important insight into their health. In such a case, these complications demonstrate a very different picture compared to a patient with tightly controlled T2DM on oral antihyperglycemics.

7. **SHx**: Social History
    a. Smoking history – past and present, quantify pack years
    b. Alcohol use – past and present, quantify drinks/week and number of years
    c. Recreational drug use – past and present, type of substance and quantify
    d. Other social circumstances such as occupation, living conditions
    e. Travel hx, sick contacts, COVID exposures
8. **FHx:** Family History
    a. First degree relatives only
9. **HPI**: History of presenting illness
10. **ER Evaluation** – what has been done for the patient already in the ER
11. **O/E**
    a. Relevant physical exam findings
        i. VS – on presentation and most recent (BP, HR, RR, oxygen saturation, temperature), orthostatic BP if relevant
        ii. *Note: if the patient received Tylenol on presentation their temperature may be falsely decreased.*
    b. Neuro – Cranial nerves, sensation, power, oriented to person/place/time
    c. Resp – normal/decreased breath sounds, crackles, wheezes, work of breathing
    d. Cardiovascular – normal/extra heart sounds, murmurs, carotid bruits, pulse regular/irregular, JVP elevated/flat/normal, lower extremity edema (pitting/non pitting), volume status
    e. Abdominal – signs of peritonitis (rebound tenderness), tenderness on palpation (location), masses, ascites, distention
    f. Derm - new rashes, swelling, indwelling lines
12. **Investigations**
    a. Bloodwork, imaging, ECG, etc.
        i. *Include results from what has been done in hospital/ED*
        ii. *Compare to recent investigations from previous discharge summaries, PACS reports, clinic reports etc in the patient chart*
13. **Issues**
    a. Chief complaint/RFR – why the patient is presenting

i. Example – Community acquired pneumonia
ii. DDx
iii. Plan

b. Why the patient cares they are here – can be the same as (1) or different depending on presentation
   i. Example – Pain
   ii. DDx
   iii. Plan
c. Other findings from investigations that need workup/treatment
   i. Example – Anemia ,hyponatremia,
   ii. DDx
   iii. Plan
d. Optimize PMHx conditions
   i. Example - Afib – are they anti-coagulated?
   ii. Referral to necessary outpatient clinics/family doctor
e. Housekeeping
   i. Pharmacy reconciliation – every patient
   ii. PT consult – almost every patient
   iii. OT consult – almost every patient
   iv. Dietician consult – as needed
   v. SLP consult – as needed



KINGSTON GENERAL HOSPITAL
Kingston, Ontario
HISTORY AND PHYSICAL EXAMINATION

Date: 2021/06/13 (YYYY / MM / DD) Time: 1:14 PM

Recorder & Status (PLEASE PRINT)
Sherwin Wong PGY-2

PAGE NO. 1

Senior Medicine Resident Note

ID: 72M from home
RFR (Reason for referral): dyspnea

PMHx:
1. HFrEF – last echo in Dec 2018 with EF = 32% and mod MR, Mod TR
2. CAD with stent in 2013
3. COPD – FEV1 = 80%, no home O2,
4. T2DM – HbA1c in Feb 2021 = 7.3%
5. HTN
6. Atrial fibrillation – CHADS = 3, on DOAC

Meds:
1. Perindoprail 4mg po daily
2. Spironolactone 20mg po daily
3. Lasix 20mg po daily (recently reduced)
4. Apixaban 2.5mg po BID
5. Metformin 1g po BID
6. Bisoprolol 2.5mg po daily
7. Tiotropium 5mcg inh daily
8. Salbutamol PRN

Allergies: NKDA

HPI: Mr_____ presented to KHSC with a 4 day history of dyspnea on exertion. He was previously able to walk several blocks before having to stop for dyspnea but finds it difficult to move around the house now. He denies any fevers/ chills or sick contacts. No cough. He recently reduced his Lasix on his own as he did not like how much he was having to pee. He also celebrated the end of the lockdown with a large festive meal. (+) orthopnea (+) PND (+) bilateral leg swelling. No previous VTE/PE. No hemoptysis. Denies chest pain / presyncope.

O/E: insert vitals + examination here
General: appears well, speaking in full sentences, alert, NAD
CVS: elevated JVP, N S1 S2 with 3/6 holosytolic murmur to the apex
Resp: bibasilar crackles, no wheeze – moderate WOB on exertion
Abdo: SNT LL: bilateral lower leg edema – no calf tenderness
POCUS: B-lines bilaterally to apices, IVC > 2cm

Investigations:
CBC, lytes, Cr, Urea
CXR , EKG, BNP, VBG, lactate

KGH Stores # 250/2004/02 HISTORY AND PHYSICAL EXAMINATION

KINGSTON GENERAL HOSPITAL
Kingston, Ontario
HISTORY AND PHYSICAL EXAMINATION

Date: 2021/06/13 (YYYY / MM / DD) Time: 1:14 PM

Recorder & Status (PLEASE PRINT)
Sherwin Wong PGY-2

PAGE NO. 2

Essentially, this is a (insert one-liner summary of above HPI)
Issues:

1. **Dyspnea – suspected CHF Exacerbation**
   - Clinical history in keeping with a CHF exacerbation
   - Less likely ACS, PNA, PTX, or PE given above investigations
   - Will plan to diureses with _____
   - Exacerbation likely triggered by decreased diuretic dose and increased salty food intake
   - Technically could consider addition of SGLT-2 inhibitor as per most recent CHF guidelines

2. **Microcytic Anemia**
   - Will send iron studies and consider iron replacement therapy if deficiency, his anemia likely not helping dyspnea
   - No recent colonoscopy – will need to refer on an outpatient basis to look for source (eg. Malignancy) as cause for suspected IDA

3. **Housekeeping**
   - AAT, DAT, DVTp, Admit to IMU-___ to ward / D4
   - COVID Risk Stratification: routine / low / mod / high
   - Goals of Care: DNR/DNI as discussed with patient. POA = daughter who is reachable at 613 555 5555

Name + Signature

KGH Stores # 250/2004/02 HISTORY AND PHYSICAL EXAMINATION

CTU Progress Note Format & Suggestions

Date/Time

CTU A/B/C/D

1. **ID (Identification)**: Patient age, gender, reason for admission, where from (home, long term care, retirement home etc)
2. **S (Subjective):** Patient feeling well/unwell, pain/no pain, relevant ROS
3. **O (Objective):** VS, relevant physical exam findings (*ie* RESP/CVS/ABDO)
4. **A/P (Assessment/Plan):**
    a. Issue 1
        i. Management – e.g. on day 1 of 14 of antibiotics
        ii. Plan to advance patient care
    b. Issue 2
        i. Management
        ii. Plan to advance patient care
    c. Issue 3
        i. Etc.
5. Dispo (Disposition):
    a. What is keeping them in hospital, where/when for discharge, PT/OT evaluation
    b. Sign off (e.g. Sarah Gomes, CC3, signature)

Assessment Strategies

- Logging of mandatory encounters. This is done on Elentra.
- ONE (1) Mini CEX form. It is your responsibility to ask a PGY3 or above to observe you perform part of a history or physical exam and ask them to complete the form for you. This is triggered on Elentra.
- TWO (2) Longitudinal Clinical Assessments (LCA) to be completed by your preceptors. ONE (1) is due mid rotation (end of week 2) and ONE (1) is due at the end of the rotation (end of week 4). This is triggered on Elentra.
- 60% on CTU Exit Exam (~100 MCQ)

How to prepare for the rotation

- High Yield Topics to Review
    - Delirium (“DIMS”)
    - GI bleeds – upper and lower
    - Antibiotic choices for cellulitis, pneumonia, and UTIs. Remember that choices change for inpatient vs outpatient settings
    - CHF
    - Anemia
    - Approach to shortness of breath
    - Approach to syncope
    - Approach to weakness/ falls
    - AKI
- Resources

- UWorld questions are great for learning. Don't be discouraged if only getting 30-50% correct – they are tough and targeted to the US
- Toronto Notes are a great quick resource
- Notes from pre-clerkship! Free and targeted to what we should know
- Ordering a pocket book is very useful for when on call and on the wards. Here are some good ones:
  - https://www.amazon.ca/gp/product/1975142373/ref=ppx_yo_dt_b_search_asin_title?ie=UTF8&psc=1
  - https://campusstore.mcmaster.ca/cgi-mcm/ws/trdetail.pl?pwsPRODIDG1=9780111391976&sType=tr&pwsCLASSG1=1706&author=MCMASTER&proddesc=HOUSESTAFF%20SURVIVAL%20GUIDE%208TH
- UptoDate is worth spending the money for. Residents and attendings will want to know what UptoDate says and it's easy/fast to use.

Last Important Tips

- If you feel that a patient's condition is unstable, get a resident for help immediately
- Photocopy your note AND the senior resident's note AND grab a few patient stickers when on call for the next morning. It is much easier to read off/ refer to your notes the next morning when reviewing with the attending. Give the attending the patient stickers.
- If while on call, your patients were kept in the ED overnight instead of being moved to the floor, check on them in the morning before reviewing with the attending. The attending will want to know if the patient needs to be admitted and if their status has changed overnight.
- There are a lot of mandatory encounters to log for CTU. Don't wait until the last minute to do them all!
- Don't be afraid to be wrong! It's better to come up with an impression and plan, even if the resident or attending don't agree with you.

Previous Clerks to Contact

Sarah Gomes - sgomes@qmed.ca

Daniel Shi - dshi@qmed.ca

5b. Medicine - Core (CTU), Collingwood

Rotation Format

- There are 2 main rotation formats for clerks going to Collingwood. 1) If you are part of the integrated stream, you do half of your rotation in Collingwood with the internal medicine team, and then the remainder of IM with a Kingston CTU team. 2) You do your entire rotation in Collingwood if you have an IM block scheduled there.
- There is only 1 IM staff on duty in Collingwood at a time. The staff are on for 2 weeks at a time (occasionally for 4 weeks), and then rotate off. The head of the IM department is Dr. Mark Bonta, who also is on for 2-4 week rotations. There is no overnight call for clerks in Collingwood, while staff are supposed to be available 24/7 for the duration of their rotation, clerks are expected to

work for the day, and then the staff will field any patient consults and concerns for the evening and night.

- Occasionally an off service rural family medicine will be part of the team, and at times a PGY4 or PGY5 IM fellow will also join to gain rural medicine experience.
- IM in Collingwood is a consult service, IM is not MRP for any patients, hospitalist staff in Collingwood are MRP. MRP physicians will consult IM if they have any patient that 1) is complex and need further medical management experience, 2) have a specific query that they would like IM's opinion on, 3) a transfer of a medical patient to the ICU.
- There is no specialized IM service (eg. cardio, resp, GI etc) in Collingwood, thus the IM team handles all generalized and subspecialized IM problems.
- Presentations that are seen on rotation that IM clerks handle include: post-stroke patients, CHF exacerbation, patient in sepsis, liver cirrhosis, endocarditis, PEs, cardiac arrythmias that necessitate admission, AKIs, COPD, severe allergic reactions, basically any inpatient problem that does not require specialized tertiary care.

Expectations for Clerks

- There are no set clerk timings, for instance, there is no set time to round on patients and a set time to review.
- The typical day flows as follows: 1) clerks come in between 8:00-9:00am, and round on patients, and write a summary of their rounds in the EMR, 2) a resident on service or staff texts/messages the clerk of an incoming consult, 3) the clerk prioritizes the consult, checks in on the patient (does HPI, hx, px, etc.), looks through previous admissions, looks through patient's EMR 4) texts the resident/attending when they are ready to review, 5) reviews with resident/attending and comes up with patient impression/plan, 6) writes orders according to plan, 7) dictates the consult note on the patient, 8) finishes remainder of follow ups, 9) if there are no more consults/follow ups pending, either resident/attending will do a bit of teaching, or clerk will be told to go home. 9) Clerks go home when the work is done, sometimes this can be 3:00pm, other times 7:00pm.
- Multiple consults happen throughout the day, and clerks usually do ~2-3 consults per day, in addition to their follow ups, this of course depends on how large a person's IM team is (eg. number of residents and clerks on service).
- There is no formal teaching in Collingwood, but staff and residents are EXCELLENT and are more than willing to teach on different topics.
- There is no overnight call, but clerks often work the weekends and if you ask for time off, staff are usually willing to give it to you.

Last Important Tips

- All communication in Collingwood is either by text or Whatsapp. Please contact your staff beforehand and exchange numbers, and find a time to meet the morning of the day you start.
- All staff are excellent, but Dr. Bonta is especially great at teaching as he also works at UHN, and manages CTU teams there.
- You will get very comfortable with dictating in Collingwood, all consults are dictated and ROMP will reach out to you to set up a dictation ID before you start

- The great thing about Collingwood is that most patients are rostered with their family doctors and all use the same EMR which is interconnected and has information on all the patients. You have access to the EMR, and can look through it to gather more information about the patient.
- You also have the opportunity to get experience reading ECGs and PFTs.
- A lot of tests (eg. BNP, iron studies) are send out tests and take several days to return, just be conscious of that when recommending these tests for your patients.
- You can use the following template for your dictated consult note.
    - ID (why IM consulted, why pt admitted):
    - PMHx (list):
    - Medications (list home meds):
    - Medications started in hospital (usually in ER, or if admitted patient then all other meds):
    - Soc Hx (alcohol, rec drug, smoking hx):
    - Fam Hx:
    - Allergies (any anaphylactic rxn?):
    - HPI:
    - Physical examination (include vitals, date of examination, and who examined pt):
    - Investigations (blood work, imaging):
    - Impression and Plan:

Previous Clerks to Contact

Salman Surangiwala - ssurangiwala@qmed.ca

6a. Medicine Subspecialty – Respirology

Rotation Format

- Typically a 2-week rotation in Kingston. You will only be involved in the care of in-patients and new admissions under respirology. Clerks normally do not go to the respirology clinics, but you can ask if you have a specific interest in respirology.
- The team meets in the conference room on Kidd 4 around 8/9 am and divides patients among the residents/fellows/clerks.
- You will go round on your assigned patients and meet back with the team in the conference room around 11 am (Rounding = history and physical PLUS review of patient chart). The attending will usually be present as well. You will run the list with the team at this point.
- For the rest of the day, you will hang around, and wait for consults to be assigned to you. You may also be asked to join in for bronchoscopies.
- You will have a different preceptor for each of the two weeks you are on respirology (Moffat, Crinion, Liak, DeTorres).

Expectations for Clerks

- Print the patient lists and bring them to the conference room in the morning.
- Round on patients assigned to you and leave a SOAP-format note in their chart.
    - Respirology-relevant history and physical exam.

- Present a succinct summary of your patient's status (One liner ID followed by breathing status → history + exam findings, then state each active resp issue/new issues along with the proposed management plan).
- Write on the back of yellow consult sheets when doing a new consult. You will then find the senior resident and review the patient with them before seeing the patient together. Remember to slap on a sticker as well. In your note, make sure you include the following:
    - ID
    - Reason for consult
    - PMHx - ask specifically about asthma, copd, ILD, etc. Also ask about home oxygen. Exacerbation history. Need for intubation during previous admissions.
    - Meds - specifically inhalers
    - HPI
    - ROS
    - SHx - SMOKING, alcohol, EXPOSURES (asbestos, farmwork, etc.)
    - FamHx - lung cancer, atopy, CF, etc.
    - Labs/Imaging/Scopes - Ask/Look up previous scopes, CTs, PFTs (There is a tab for PFTs on the chart review page)
    - Assessment and Plan
- Update the resident handover tool for respirology during downtime.

Assessment Strategies

- A total of ONE (1) Mini CEX
- Longitudinal Clinical Assessment (LCA) (1 for rotation A)
- Longitudinal Clinical Assessment (LCA) (1 for rotation B)
- Logging - Log a minimum of Five (5) clinical cases per specialty, for a total of TEN(10)
- Mid-rotation Meeting Assessment

How to prepare for the rotation

- High Yield Topics to Review
    - Asthma and COPD (diagnosis, management, exacerbation management)
    - ILD (hypersensitivity pneumonitis, IPF, asbestosis, sarcoidosis, etc.)
    - Acid base balance - CO2 retainers
    - Pulmonary embolism
    - Pulmonary hypertension
    - Pneumothorax
- Resources
    - Toronto Notes
    - Dynamed/UpToDate
    - Class notes

Last Important Tips

- A sticker is needed for the chart, any prescriptions, and any imaging/scope requisitions. Take those with you to the preceptor when reviewing.

- If you're not sure what is going on with a patient, ask their nurse! This will give you a better idea of why respirology was consulted and save you the embarrassment of blanking out when asked why respirology was consulted while presenting to your attending.
- Check ConnectingOntario for labs or imaging that might not be in PCS.

Previous Clerks to Contact

Hamza Asif - masif@qmed.ca/647-784-7361

6b. Medicine Subspecialty – Gastroenterology (GI)

Rotation Format

- Typically a 2-week rotation in Kingston. This rotation is entirely clinic-based. The GI clinic is located on Jeanne Mance 4 at HDH. Directions → To reach the Clinic, enter the main (Brock Street) entrance of the HDH site and take an elevator to Level 4. Turn right off the elevator and follow the hall until you reach the Registration and waiting area.
- The morning clinics run from 8 am to 12 pm and the afternoon clinics run from 1 pm to 5 pm. You will either be assigned to the same preceptor for both clinics or two different ones for the morning and afternoon clinics. Note: You can have different clinics in the morning and afternoon (e.g. Urgent GI in the morning and IBD in the afternoon).
- There are a few different preceptors you will work with during the following clinics:
    - General GI → Dr. Louw, Dr. Reed, Dr. Vanner, Dr. Beyak, Dr. Hookey, Dr. and Dr. Ropeleski.
    - Urgent GI → Dr. Louw, Dr. Reed, Dr. Vanner, Dr. Beyak, Dr. Hookey, and Dr. Ropeleski.
    - IBD → Dr. Beyak and Dr. Ropeleski.
    - Liver → Dr. Lowe and Dr. Flemming.
- Tuesday afternoons are reserved for endoscopy procedures, so we have Tuesday afternoons off. Depending on COVID-19 restrictions, you may or may not be able to join these as an observer. You can email Brenda DeLonghi at Brenda.DeLonghi@kingstonhsc.ca for more information.

Expectations for Clerks

- You will mainly work with your assigned preceptors directly. There might be a GI fellow around for some of the clinics and you may be told to review with them instead.
- When you arrive at the clinic, you will notice a sheet of paper with patient names, appointment times, appointment types (follow-up/new referral), and the gastroenterologist's name at the top. This can be found on the registration desk. Ask the secretary if you are not able to locate it. We are encouraged to prioritize new referrals over follow-ups for a better learning experience.
- There are 4 types of appointments:
    1. Follow up phone calls
    2. New referral phone calls
    3. Follow up in person
    4. New referral in person
- For in person appointments, if a patient's name has a check mark beside it, that means the patient has arrived and has been registered. If there is a star and room number (1-6) in addition, that means the patient has been placed in a room and is ready to be seen.

- You can sign up for patients by putting your initials beside their name in the blank box on the aforementioned sheet.
- For in person appointments, use the white, blank paper charts available in the dictation room where you will work and organize your notes as following:
    - New Referrals:
        - ID
        - Reason for referral
        - PMHx and Meds
        - HPI
        - ROS
        - SHx
        - SurgHx
        - FamHx
        - Labs/Imaging/Scopes
        - Assessment and Plan
    - Follow ups
        - ID
        - HPI
        - Current GI meds
        - Labs/Imaging/Scopes
        - Assessment and plan
- ***Note: For new referrals, wait for the patient's chart to be placed in the bins after the nurse has assessed them and write on that same chart (Might have to wait for the nurse to complete her assessment - jot down notes on a separate sheet from PCS in the meantime and then copy them over). New referrals are accompanied by a paper referral package which you may review in the meantime. If it is a phone call, you can write on the blank charts available in the dictation room and don't need to wait for anyone.
- After seeing or calling a patient, you will find your preceptor and review with them. Present your assessment and plan at the end. The preceptor will discuss your plan with you and either agree or disagree with components of it before finalizing it. You will then see/call the patient together.
- Once the patient has been seen by both of you, you will go back to the dictation room and dictate a clinic note - follow up ones are much shorter than new referrals. Instructions for dictation are written on the whiteboard in the dictation room.

Assessment Strategies

- A total of ONE (1) Mini CEX
- Longitudinal Clinical Assessment (LCA) (1 for rotation A)
- Longitudinal Clinical Assessment (LCA) (1 for rotation B)
- Logging - Log a minimum of Five (5) clinical cases per specialty, for a total of TEN(10)
- Mid-rotation Meeting Assessment

How to prepare for the rotation

- High Yield Topics to Review
    - Crohn's disease and ulcerative colitis

        - IBS vs. IBD
        - Drugs used for IBD
    - NAFLD, alcohol-related fatty liver disease, viral hepatitis, and Cirrhosis
        - FibroScan's role in assessing liver cirrhosis
        - HCC screening in liver disease
        - Compensated vs. decompensated liver cirrhosis
    - Celiac Disease
    - Approach to constipation and diarrhea
    - Indications for upper/lower endoscopy
    - Colon cancer and screening guidelines
- Resources
    - Toronto Notes
    - Dynamed/UpToDate
    - Class notes
    - MDCalc (Rome IV criteria and others)

Last Important Tips

- A sticker is needed for the chart, any prescriptions, and any imaging/scope requisitions. Take those with you to the preceptor when reviewing.
- Try dictating after seeing each patient so that the information is fresh in your mind.
- Check ConnectingOntario for labs or imaging that might not be in PCS.

Previous Clerks to Contact

Hamza Asif - masif@qmed.ca/647-784-7361

6c. Medicine Subspecialty – Infectious Disease (ID)

Rotation Format

- Typically a 2-week rotation in Kingston. You will be assigned to the consult service team, which includes a senior GIM fellow, a junior GIM fellow, a resident, and an attending physician. Attendings change every 2 weeks.
- Your day can be spent either in on the inpatient service or at the ID clinic.
    - Inpatient Service: The team will typically meet around 8:30 AM at the Connell 3 library to run the list and assign patients for morning rounds. Once you exit the main elevators, take a right turn and the library will be on your left, across the hall from the ECG department.
    - ID Clinic: The ID Clinic is located on JM3 at HDH. Once you exit the elevators, there will be signs directing you toward the clinic. It will usually run from 9:00 AM to 4:00 PM.
- You will be emailed about a week before the rotation starts with a schedule for your assigned clinic days and the senior fellow on service. Make sure to reach out to the senior before you start and confirm where and when to meet for your first day.

Expectations for Clerks

- On the wards:
    - You will work as part of the team of residents and participate in morning rounds, completing consults, and writing orders.
    - Arrive by **8:30AM** to receive your assigned patients for the day. The team will run the list and provide a brief summary of the ID patients and their active issues.
    - **Dress code:** Business casual or scrubs.
    - You will typically have until **1PM** to round on your patients. This will include your lunch time, so make sure you head to the cafeteria during this time. If there are new consults, the fellow will usually message your group chat and you may be assigned to complete them. As ID is a consult service, any orders will be suggest orders on the green sheet and must be co-signed by the admitting service.
    - You will be expected to check on a patient's blood work and write a progress note (see CTU on how to write a progress note and round on in-patients).
    - At 1PM, you will meet the team back at the Connell 3 library and the attending physician will join you. At this point, the senior will run the list and you will present **a short oral report** on your assigned patients, including **your plan, any suggest orders you've written, and if you think that ID should continue to follow** (see CTU on how to present a patient at rounds and tips for creating a plan).
    - In the afternoon, the team will head to the micro lab and check on any cultures/PCR tests that have been ordered. The attending will also want to check in on any patients that require further management. The team will also complete any new consults. You will follow the team and help out as needed. Depending on the workload, you will typically be able to leave the hospital around 5:00PM.
- At the clinic:
    - You will **work directly with an attending** and see any patients scheduled for that day.
    - Arrive by **9:00 AM** and meet the attending at the clinic. They will review their expectations and assign patients for you to see.
    - You will perform **a focused history and physical** for the patients for that day. You will also use PCS to review any blood work or investigations that they may have had (bronchoscopy, imaging, etc.). A key tip is to **read the previous clinic report on PCS** and find out the patient's history and why they are followed by the ID clinic.
    - You will usually see patients on **long-term antibiotics** or patients on **long term antiviral therapy**.
    - You will write a quick note while you see the patient (the clinic uses **paper charts**) and you will review your case with the attending. You will then see the patient together and decide on a management plan.
    - Afterward, you will **dictate a clinic note** (see Plastics for a guide to dictation at the KGH/HDH hospital sites).
    - Patients will usually be scheduled until **3:00PM**.

Assessment Strategies

- Logging a minimum of Five (5) clinical cases, with no specific mandatory encounters. This is done on Elentra.

- ONE (1) Mini CEX form. It is your responsibility to ask a PGY3 or above to observe you perform part of a history or physical exam and ask them to complete the form for you. This is triggered on Elentra.
- ONE (1) Longitudinal Clinical Assessments (LCA) to be completed by your preceptors. ONE (1) is due at the end of the rotation (end of week 2). This is triggered on Elentra.
- 60% on CTU Exit Exam (~100 MCQ). No specific exam for ID, but there may be related questions on the CTU exam.

How to prepare for the rotation

- High Yield Topics to Review
    - Fever of undetermined origin (most consults will involve locating the source of the infection and determining the appropriate antibiotic regimen)
    - Tick-borne diseases (lyme, rocky mountain spotted fever, anaplasmosis, etc.)
    - Approach to meningitis (CSF analysis, cultures and PCRs to order, empiric therapy)
    - General classes of antibiotics (empiric vs targeted therapy, gram positive vs gram negative coverage)
- Resources
    - Harrison's book of internal medicine has a good chapter on infectious disease. There is a lot of content, but reading the first few pages on the general approach to the infected patient will be helpful. You should have free access to the textbook through Queen's here: https://library.queensu.ca/search/database/accessmedicine
    - IDSA has an app and a website for the types and duration of antibiotics to use: https://www.idsociety.org/practice-guideline/practice-guidelines/

Last Important Tips

- If you feel that a patient's condition is unstable, get a resident for help immediately.
- When you are completing a new consult, bring the yellow sheet and grab a few patient stickers when you review with the attending during afternoon rounds. They will typically want a few patient stickers for their reference.
- Follow a lot of the tips outlined in the CTU rotation. Most importantly, don't be afraid to be wrong! It's better to come up with an impression and plan, even if the resident or attending don't agree with you.

Previous Clerks to Contact

Daniel Shi - dshi@qmed.ca

6d. Medicine Subspecialty – Cardiology

Rotation Format

- Typically a 2-week rotation in Kingston. The 2022s' cardiology rotation was restricted to the wards; clinics were closed to students due to COVID-19.

- There is NO exam for medicine subspeciality, but the concepts seen in your medicine subspeciality rotations (especially cardiology) are testable on the IM exam. You are required to submit 2 LCAs and 1 mini-CEX.
- You will work in a team consisting of an attending physician, at least 1 fellow, and 1-2 residents.
- Bullet rounds start every morning at 7:30 in Davies 4 conference room.
- Clerks are not responsible for patients in the CSU, only for patients on the ward.

Expectations for Clerks

- After bullet rounds, the team will split up the patients among themselves
- **Dress Code**: Business Casual
- You will be responsible for 3-4 patients; after the patients are split up, you will have the morning to see your patients.
- Check for old Echos, cath reports, CXRs etc. Know the results of these reports and not just if they were done.
- See your patients - take a focused cardiac and resp history, and tailor questions to other symptoms they may be having (i.e. endocarditis, ask about general ROS etc). Physical exam was usually a focused cardio resp exam. Get good at seeing the JVP because everyone asks about it.
- After you've seen your patients, write a progress note in their chart - base your assessment/plan both on what was written before, and on new issues.
- Write your own orders and discuss them with the resident. They will want to know why you are doing things, so be prepared to defend why you want certain things to be done.

Assessment Strategies

- A total of ONE (1) Mini CEX
- Longitudinal Clinical Assessment (LCA) (1 for rotation A)
- Longitudinal Clinical Assessment (LCA) (1 for rotation B)
- Logging - Log a minimum of Five (5) clinical cases per specialty, for a total of TEN(10)
- Mid-rotation Meeting Assessment

How to prepare for the rotation

- High Yield Topics to Review
    - The most common presentations are ACS, Afib, syncope, endocarditis, and CHF exacerbation. Review Canadian guidelines on the management of these presentations.
- Resources
    - I found AMBOSS to be very helpful in solidifying my knowledge.
    - Cardiology is a well-research field and patient management is strongly guideline-based. Review the CCS guidelines on the common presentations discussed above. Note: you are not required to memorize said guidelines, but should have a basic understanding of them. - https://ccs.ca/guidelines-and-position-statement-library/

Last Important Tips

- Write your discharge summaries on a day-to-day basis. Leaving discharges to the end of a patient's stay makes it much longer, and it also makes it harder if a resident has to discharge on a weekend.

- Write down your own little summary of the patient. You will routinely be asked “When was their last echo? What is their LVEF? What did their cath show...etc...” and you will be expected to know this about your patient without having to run to the chart.

Previous Clerks to Contact

Mehras Motamed - mmotamed@qmed.ca

6e. Medicine Subspecialty – Nephrology

Rotation Format

- Typically a 2-week rotation in Kingston.
- No weekends and no call unless you are scheduled for a CTU overnight call shift
- Type of Service: This is a **consult service**, so the patient list is based on how many nephrology consults there are. The amount of patients you will see depends on how heavy the service is. For example, when I was on, we had a double sided patient list and throughout my 2 weeks we had between 40-50 patients. I rounded on anywhere between 8-12 patients a day. You will also be given new consults (yellow sheet).
- Team: you (clerk), 1 attending, 1 fellow, and a few residents. When I was on the service we had 2 IM residents. The dialysis nurse (Renee) will also be there in the morning as well to notify you of any dialysis prescriptions, dialysis schedules, and she also knows pretty much everything.
- The patient list is divided among you, the fellow, and the residents (and usually the staff too)
- **Typical Schedule:**
    - **830-1000**: Typically **meet in the boardroom** at 8:30am on M, T, F, 9:00am on W and 8:45am on Th (Wed and Thurs are later because of M&M and grand rounds). Depending on your staff, these times may change. When you meet in the morning, the fellow will run the list and refresh the team about the patients, their dialysis schedule, etc. Then the list will be divided among the team. Running the list in the morning takes ~30 min to 1 hour.
    - **1000-1300**: **Round** on your patients until 1pm (this includes lunch so manage your time wisely!). This also includes completing any orders. Usually to-dos will be discussed while running the list prior to rounding. When you write orders they are suggest orders (e.g., Nephro Suggests) so you don’t have to get them co-signed by your nephro residents, because they will be co-signed by the main service (usually GIM).
    - **1300-1430**: Meet back in the boardroom by 1pm and **run the list** again/report on your patients.
    - **1430-end of day**: finish any tasks that need to be done for patients, see consults if leftover, follow the fellow/staff around. Usually go home by 5pm.
- First day:
    - You can page the nephro fellow (check who is on-call through PCS) OR
    - Ask the nephro nurses in dialysis unit A (Burr 3) to page for you (when you enter the dialysis unit, there will be a clear desk with nurses) OR
    - Go to the meeting/boardroom in the nephrology department which is also on Burr 3 if this is in the morning, before 9:30am. The team will probably be in there running

through the list. If you are entering Burr 3 from the elevators on Burr 1, turn left after you exit the elevators, go past the dialysis units, past the clinic rooms and there will be a door on your left (across the patient elevators) to the nephro department. There is also another desk/nursing station on the way so you can ask if you are unsure. You will need to scan your hospital ID for access. Once you enter the dept, go straight to the end where you will see a desk with computers and to the right of the computers is the boardroom.
    - I know that's a lot of info! But I paged the fellow on the first day and didn't get my call returned, so ended up running into another nephro fellow who showed me the boardroom…

Expectations for Clerks

- **Nephrology sees all dialysis patients that are inpatients as well as consults.**
- *See typical schedule above*. This is what you will be doing everyday pretty much.
- You will be given patients (depends on how heavy the service is) and be expected to see them by 1pm to run the list (usually you will get approx. 3 hours)
- Patients may be currently in the dialysis unit (on dialysis), or on the ward. Renee will tell you if they are currently in the dialysis unit. You will see them while on dialysis and can ask the nurse at the desk in Unit A where the patient is located.
- **Rounding**: See your patients - take a focused history/physical exam.
    - History: how dialysis is going/last HD session (if on dialysis), eating/drinking, voiding/bowel movements. Essentially focused on nephro/volume status!
    - Physical exam: **volume status!!!** (e.g., JVP, mucous membranes, edema, cap refill, etc.). Are they hypovolemic, euvolemic or hypervolemic?
    - Medications: are they on iron supplement, calcium supplement, phosphate binder, EPO, are their medications renally adjusted?
    - Dialysis: If on dialysis, check the dialysis run sheet (in a plastic folder by the dialysis machine if they're in the dialysis unit, or in the "therapy" section of their chart if on the ward). This tells you their dialysis prescription, amount of fluid removed, pre and post weight, etc. Does their dialysis include anticoagulation? (Dalte or heparin)
- **Write your note** - vitals, labs (check renal panel on PCS - e.g., electrolytes (K+ usually most important), Cr, Ca, Mg, Phos, albumin), volume status exam, IVF (if on any), I/O, stool charting
    - If on dialysis: include dialysis schedule (e.g., MWF, TThS), last session, amount of fluid removed, pre/post weight
    - Plan: if on dialysis and not much going on for them, I usually just write their dialysis schedule (e.g., continue HD MWF)
- Dress code: business casual or scrubs

Assessment Strategies

- A total of ONE (1) Mini CEX (over entire med subspec rotation)
- ONE (1) Longitudinal Clinical Assessment (LCA) (another LCA will be done for the 2nd subspecialty rotation)
- Logging - Log a minimum of Five (5) clinical cases per specialty, for a total of TEN(10)
- Mid-rotation Meeting Assessment

- I would recommend writing the CTU exam during subspecialty block as the nephro rotation was very helpful (lots of nephro content on exam)

How to prepare for the rotation

- High Yield Topics to Review (based on what I encountered)
    - AKI. Usually pre-renal, but most of the consults will be AKI - review harmful medications/renal adjustments (NSAIDs, antibiotics, etc.)
    - Indications for dialysis (AEIOU)
    - Hyponatremia
    - Acid/base problems
    - Fluids
    - Dialysis
- Resources
    - OnlineMedEd (in Google Drive)
    - Watching videos like Osmosis, Khan Academy, MEDSKL

Last Important Tips

- Don't be afraid to ask for help especially before writing an order if you are unsure. A lot of the stuff on nephro may be pretty high level (e.g., dialysis prescriptions, iron supplements, EPO).
- When reporting during rounds, report the salient stuff like 1) how they are doing (well/unwell), 2) volume status, ins/outs, electrolytes (e.g., if AKI, is their Cr improving?), diet if relevant, if on HD the volume taken off last session and target today, any updates on meds/missing meds (e.g., pt should be on EPO but isn't, needs a phosphate binder, etc.), 3) what you did/plan, dispo if any
- When reporting labs, always report the trend!
- Keep in mind of other investigations the patients are undergoing like echo, cath, if relevant
- It is a fast paced service. Lots of learning, be curious, be engaged, it will be great! :)

Random stuff I learned/found useful to know:

- Diet: how are they eating, drinking, are they fluid restricted? Did they have high K+ and are drinking orange juice (high K+) and consuming other high K+ foods?
- Ins and outs - how are they peeing? (Over 24h period)
- Dialysis prescriptions: setting a K bath = amount of K+ in dialysate. Rule = patient's K+ + dialysate K+ = 7 (e.g., if a patient's K+ is 3, then they should be on a K4 bath). They will be impressed if you know this/suggest it.
- Post-obstructive diuresis fluid replacement rate typically = half the amount of UO over the last 1-2 hours. E.g., if their urine output was 500cc over the last 1h, then replace at a rate of 250cc/h. You want to replace as close to the urine output from the previous 1-2 hours, if not then you can do 4h, if not then look at UO over 24h. Fluids usually NS but depends on the patient. Ask the fellow if unsure.
- KFRE for CKD/ESRD (they will be impressed): https://kidneyfailurerisk.com/
- Hypoalbuminemia affects Ca and anion gap. Adjusting for Ca using albumin → for every 10 points below 40 (albumin), add 0.2 to Ca. Adjusting AG → for every 10 points below 40 (albumin) add 3-4 points to AG (different sources may say different things).

Previous Clerks to Contact

Kimberley Yuen - kyuen@qmed.ca

6f. Medicine Subspecialty – Rheumatology

Rotation Format

- Typically a 2-week rotation in Kingston. The service is **clinic and consults**. You will be scheduled for clinics. **Clinics may be in-person or telephone**. Generally a lighter rotation, all the staff are super nice, and lots of learning and interesting cases.
- Team includes staff, fellows (two PGY-4s and two PGY-5s), and rotating residents
    - Consults will be received by the resident who is on-call and they will divvy up the consults/let you know if appropriate for you to do
- No weekends and no call unless you are scheduled for a CTU overnight call shift

Expectations for Clerks

- Holly Shea (sheah@queensu.ca) is your admin contact and should send you your schedule before you start the rotation as well as an iBook and various other resources
- You will be scheduled with any of the rheumatologists in their clinic. Clinics are currently a mix of in-person and telephone
    - **In-person - JM5 at HDH**
    - **Telephone** - check PCS night before to confirm, or email your attending. You will probably be in **Etherington Hall, beside KGH (2nd floor, your attending's office)** or you may be able to do phone clinic from home if you have remote PCS access (so far I've only heard of Dr. Kung allowing this)
    - **AM clinic typically starts at 830AM, PM clinic starts at 1PM** (can check PCS for times and patient list)
    - As any clinic, see patient - focused history and physical, then report to attending, see patient again with staff. You will also be expected to dictate.
- On days you are not scheduled for clinic, you will be expected to be available for consults. However consults are quite rare (I only did 1 consult over the 2 weeks)
- You will be scheduled to do a presentation at **Rheumatology Rounds** on a Thursday at 1PM (Holly will notify you). **Thursdays are half days** (PM off, it is their academic half day).
- **Dress code: business casual**

Assessment Strategies

- A total of ONE (1) Mini CEX (over entire med subspec rotation)
- ONE (1) Longitudinal Clinical Assessment (LCA) (another LCA will be done for the 2nd subspecialty rotation)
- Logging - Log a minimum of Five (5) clinical cases per specialty, for a total of TEN(10)
- Mid-rotation Meeting Assessment

How to prepare for the rotation

- High Yield Topics to Review
    - Arthritis (OA vs. RA)
    - Medications like DMARDs, biologics, prednisone and regimens
    - Osteoporosis (only with Dr. Towheed)
    - Connective tissue diseases
    - Different antibodies
- Resources
    - www.rheumtutor.com ← VERY GOOD RESOURCE
    - https://osteoporosis.ca/health-care-professionals/clinical-practice-guidelines/
    - OnlineMedEd in the Google Drive

Last Important Tips

- **Read the last clinic note from that staff** to see what their primary dx is and what they're being treated with/what happened last time (i.e. did they increase/decrease a med, symptoms etc) - this will guide your interview and assessment
- Review **MSK exam** - rheumtutor is very good!
- Review pertinent questions/ROS to ask for specific rheumatologic conditions (e.g., SLE - malar rash, photosensitivity; RA - hot, swollen joints; general - headache, vision changes/uveitis, skin changes/rash, nail changes etc.)
- Medications → DMARDs, biologics, first/second line agents
- For osteoporosis (OP), review guidelines although Dr. Towheed will go over everything with you. He has his own template for OP patients, it is very straightforward and you do not have to do an MSK exam for OP.
- Figure out **patient needs → blood work req** (if on certain meds like MTX, need routine blood work), **medication refills (and their pharmacy)**
    - Check ConnectingOntario for blood work as this is usually done at LifeLabs/elsewhere and won't be on PCS
- **Dictating:** find an empty room, pull up last clinic note (very helpful and good to have a reference) and use following format:
    - Header: e.g., "Rheumatology/Osteoporosis Clinic"
    - Dear Dr. XX,
    - Intro/brief paragraph about seeing patient today, reason for visit, condition we are following for. *If spoken via telephone can include consent.*
    - Current Medications (name, dose, frequency)
    - Interval History (very briefly what happened at last visit, and how things have been going since then)
    - Physical Examination
    - Recent Investigations (see ConnectingOntario)
        - Recent blood work usually CBC, ESR/CRP, liver enzymes (AST, ALT, ALP), albumin, bili, Cr, eGFR, any antibodies
    - Impression and Plan (summarize patient/encounter, condition getting better or worse? any changes to medications, other recommendations, continuation of bloodwork, any imaging, and follow up)

Previous Clerks to Contact

Kimberley Yuen - kyuen@qmed.ca

More comprehensive info from Sasha (2021):
https://docs.google.com/document/d/1q67tpmbaBarx234bJkZN0Db8exquO8Xt/edit

6g. Medicine Subspecialty – Oncology

Rotation Format

- Typically a 2-week rotation in Kingston. You will be scheduled for clinics and emailed a copy of the schedule typically 3-5 days before your rotation begins. **Clinics may be in-person or telephone**. Generally a lighter rotation, all the staff are super nice, and lots of learning and interesting cases.
- Your time will be split between the Medical Oncology and Radiation Oncology teams
- No weekends and no call unless you are scheduled for a CTU overnight call shift

Expectations for Clerks

- Elaine Carroll (medclerk@queensu.ca) is your admin contact and should send you your schedule before you start the rotation
- You will be scheduled with any of the oncologists in their clinic. Clinics are currently a mix of in-person and telephone
    - **Med Onc Clinics:** This includes lung, GI, breast, head and neck, brain. These will typically take place on Burr 1 in the Cancer Centre. Clinics begin at 08:30 AM and sometimes at 09:00 AM in the morning, and 1300 in the afternoon. It is worth heading to the Cancer Centre on Burr 1 for 08:30 AM, asking the nursing staff which room your attending/team will be working out of, and starting the process of looking at the patient list and reading old clinic notes on PCS. You will be expected to do a relevant history and physical examination for patients undergoing chemo treatments, but you are NOT expected to come up with a management plan. You will be required to dictate afterwards
    - **Rad Onc Clinics:** Typically occur in Clinic H on Burr 0. There is usually a nurse practitioner, RN, and resident working with you. Ask the nursing staff for a copy of the patient list, as they use a separate system in Oncology and you will not have access to it. Again, you will be expected to do a brief history and physical exam on patients undergoing radiation therapy. Make sure you know how far along they are in treatment (how many fractions), and the common side effects of radiation treatment (N+V, fatigue, skin changes, changes to bowel and bladder movements, rectal pain, bleeding, dry mouth, mucositis, dysphagia etc). You will be expected to dictate a note afterwards. Clinics usually begin around 08:30 AM or 09:00 AM in the morning and 13:00 PM in the afternoon.
    - **SSAC:** This clinic is somewhat strange. It is located at Clinic F on Burr 0. Follow signs for Clinic F or ask any of the reception staff in the area to show you where it is. Essentially, it is an assessment clinic that is only accessible to oncology patients. If they are coming in for treatment and feeling ill, they can present to the SSAC instead of heading to the ER. Essentially, you wait in the assessment clinic until a patient comes in. Sometimes you

have 1 all day, sometimes there will be many. You will be working with a nurse and there is usually a resident or attending that must cover the SSAC as well. They will be contacted if any patients come in, after you do your general H+P and assessment. The SSAC begins at 08:30 AM and closes at 16:30 PM. You can bring your laptop or work on the computers in the clinic when it is not busy. As any clinic, see patient - focused history and physical, then report to attending, see patient again with staff. You will also be expected to dictate.

- On days you are not scheduled for the clinic, you have the day off! You have the Med Onc schedule, so it is up to you if you want to show up for additional clinic
- **Dress code: business casual**

Assessment Strategies

- A total of ONE (1) Mini CEX (over entire med subspec rotation)
- ONE (1) Longitudinal Clinical Assessment (LCA) (another LCA will be done for the 2nd subspecialty rotation)
- Logging - Log a minimum of Five (5) clinical cases per specialty, for a total of TEN(10)
- Mid-rotation Meeting Assessment

How to prepare for the rotation

- High Yield Topics to Review
    - Lung, breast, GI, colorectal cancers, how they generally present in patients, work up of a cancer diagnosis including bloodwork and imaging, and basic knowledge of chemotherapy and radiation (i.e. when to use them, neoadjuvant vs. adjuvant)
    - Have a general idea of common side effects to chemotherapy and radiation, especially pertinent to which areas of the body are receiving chemo/rads.
    - Have a basic understanding of staging for cancers
    - The attendings and residents do NOT expect you to be an expert in management and treatment, or to know various cancers off by heart.
- Resources
    - www.uptodate.com

Last Important Tips

- **Read the last clinic note from that staff** to see what their primary dx is and what they're being treated with/what happened last time (i.e. did they increase/decrease a med, symptoms etc) - this will guide your interview and assessment
- Honestly, oncology had some of the nicest and most patient attendings, so you will have a great learning experience
- Don't forget to review bloodwork and imaging for follow-up patients if you see them in the clinic. Also helpful to review the last clinic note to get an idea of how to structure a dictation in Oncology.
- You will have many patients with Stage 4 cancers. Always remember to be cognizant of your mood or how you begin the interaction. Some patients are extremely sad/depressed or in shock of their diagnosis, some are able to cope better. It all depends, so gauge how you interact with patients based on their body language and tone.

Previous Clerks to Contact

Ken Choi - kchoi@qmed.ca

7. Family Medicine

Rotation Format

- Typically a 4-week rotation at a regional site within ROMP, ERMEP or the Weeneebayko Health Authority (unless you are in a Longitudinal Integrated Clerkship stream)
- You may need access to a car to commute to these areas if accommodations are unavailable. If accommodations are available, they may be far from the clinic/hospital. ROMP and ERMEP offer travel reimbursements that you can submit at the end of your rotation. The required forms are given to you in the introduction/orientation email.
- There is NO EXAM. Instead, you are required to submit 1 formative case reflection, 4 summative case reflections, and 1 community reflection. Full assignment details and the rubrics can be found at this link: https://elentra.healthsci.queensu.ca/community/familymedicine:assessment_for_meds_2022

Expectations for Clerks

- You will work **directly with a preceptor**, and he/she may have a resident with them as well. Note that your preceptor may be involved in coroner work, emergency medicine shifts, hospitalist work, geriatrics, or have other interesting additional training, such as primary care dermatology.
    - Family Medicine clinic days typically run from **9AM-4PM** (although this will vary by preceptor).
    - **Dress Code**: Business Casual for Clinics, Scrubs for hospitalist/emerg.
    - You will likely have the opportunity **to see patients on your own** and conduct your own focused history/physical for follow-up appointments before reviewing with your preceptor. You will also write a SOAP note for each patient (see Periop 2 Emerg on how to write a SOAP note).
    - Procedures to know: **IM injections, punch/shave biopsy, simple suturing, pap smears, conjunctival foreign body removal**, and **cryotherapy**.
    - Take this opportunity to involve yourself in some of the many things family physicians are able to provide to their communities!
- General Tips BEFORE starting your rotation
    - Selecting ROMP or ERMEP is a **personal preference**! If you have ties to a certain community located in these regions, or if you have a good experience during community week and want to return to that area, **you are able to rank your locations** when submitting the ROMP or ERMEP application. You may also specify if you wish to be placed with a preceptor that does obs/gyn, hospitalist medicine, emergency medicine, psychiatry, etc.
    - Once you know the location and name of your preceptor, ROMP or ERMEP will usually provide you with their email or contact information. It is good to **EMAIL** your family medicine preceptor **2-4 weeks** before the start of your rotation. Introduce yourself, tell

them what dates you will be with them for, and be sure to ask what time they want you to arrive at the clinic/office on the first day.
    - The Northern communities in the **Weeneebayko Health Authority and NOSM regions** are a fantastic opportunity to learn more about Indigenous health and get a better understanding of the health disparities that are present.

Assessment Strategies

- 60% (6/10) on all 4 summative case reflections, and the 1 community reflection (does not include the formative case reflection)
- ONE (1) longitudinal clinical assessment form (LCA) is due for completion by your supervisor/primary preceptor prior to meeting with them at the midpoint of the rotation (3 weeks into the rotation). This is triggered on Elentra.
- ONE (1) LCA is due for completion by your supervisor/primary preceptor prior to meeting with them at the end of the rotation. This is triggered on Elentra.
- Logging all 19 mandatory clinical encounters on Elentra
- 1 Mini CEX directly observed by your preceptor. The evaluation form is triggered on Elentra.

How to prepare for the rotation

- High Yield Topics to Review
    - The diagnostic criteria for HTN, DM, and dyslipidemia, along with commonly used medications and the doses. Also know the target blood pressure and glucose that you try to achieve.
    - Anxiety + depression - diagnostic criteria, red flag questions on history (suicidal ideation etc), and commonly used meds and their doses
    - Acne, psoriasis, and eczema. Know a bit about how they may present on skin, location, and treatment methods for each
    - Headache and fatigue. Although super broad complaints, have a clear approach in terms of questions on history, red flags, and some investigation methods (i.e. blood work for anemia, TSH. Or triptans for migraines)
    - Well-baby visits. You will be expected to perform these visits, so it is a good idea to get familiar with the Rourke baby record, which explains exactly what to do at each visit for the history & physical. It is also a good idea to talk to the nurse who first assesses the baby, as most of the time, they will have taken care of most of the exam already!
- Resources
    - https://www.aafp.org/home.html - AAFP, the go-to resource for diagnostic/treatment algorithms for almost anything in family medicine (if you liked Dr. Gilic's flow diagrams, then this website will be perfect)
    - https://www.rourkebabyrecord.ca/downloads.asp - Rourke baby record. The 3 visit per page format is a perfect quick guide to any well baby exam!
    - https://www.uptodate.com/login - Uptodate. Great resource with good pictures for dermatological presentations as well.
    - Your family medicine rep also should hand out a family medicine clerk guide. This will summarize high-yield topics and be useful to keep in your back pocket during rotations.

Last Important Tips

- Ask your preceptor about how their charts or EMR works. They may have short cuts/templates available depending on the system they use. Also, spend some time getting acquainted with their system for inputting notes, prescriptions, logins, etc.
- Approach your preceptor with specific goals of the rotation in mind. Do you want to do emerg shifts? Do you want to do more pap smears or procedures? Are there any specific patient presentations that you want to see? What do you want to gain or learn from this rotation? Bring these up with your preceptor at the start of your rotation to solidify an action plan. It also shows you're invested in your learning.
- At the end of a work day you may be really tired, but if something stood out to you (a patient encounter, a weird presentation, or something cool you saw/experienced), keep a Word document or notebook handy and write it down! It'll help you bring up some memorable experiences come interview time (a time you advocated for a patient, a favourite patient encounter, a time you had a difficult conversation etc)
- If there's a topic you're really interested in, approach your preceptor about doing the mini-scholar assignment with them on your block! They may already have research ideas you can use and build on

Previous Clerks to Contact

Daniel Shi - dshi@qmed.ca. Perth Family Medicine Integrated Rotation.

Ken Choi - kchoi@qmed.ca. Napanee Family Medicine Away Rotation.

8. Pediatrics

Rotation Format

- Typically a 4-week rotation in Kingston. Shifts will be at either KGH Kidd 10 (Pediatric inpatient floor), KGH NICU located on Kidd 5, HDH Children's Outpatient Clinic on Jeanne Mance 1 (COPC) and pediatric ambulatory clinics (typically located in the same area as the COPC)
- You will rotate between 4 core units during the 4-week rotation. You will receive an email from Elizabeth King with a schedule of where you need to be for each respective week
    - Inpatient Week (Kidd 10 at KGH, morning handover typically begins at 7:30am): During this week, you will be assessing and caring for pediatric patients who have been admitted to hospital for a variety of reasons (i.e. seizures, generalized weakness, vertigo, post-op appendectomy etc.). Wear clin skills attire.
    - Well Newborn Week (go to Nurses desk on Kidd 5 at 8am and ask them to Page Lynn Newton or Dr. Dow for you): Performing well newborn exams and documenting this in the patient chart. You may wear scrubs or clin skills attire.
    - Ambulatory Clinic Week (Jeanne Mance 1 at HDH, usually begin at 9 am and 1 pm for AM and PM clinics, respectively): You will be exposed to a variety of pediatric outpatient clinics, such as cardiac, general pediatrics, asthma, infectious disease, neuro, development, respiratory, endocrine/diabetes, genetics (in Armstrong 4 KGH), oncology and heme (in Burr 1 KGH). Note that the pediatric genetics and oncology + heme clinics are located in KGH and not HDH. Wear clin skills attire.

    - COPC Week (Jeanne Mance 1 at HDH, opens at 9:00am): This is essentially a children's ER. You will assess and work-up a variety of acutely ill children with lumps and bumps, viral illnesses, abdo pain, etc. You can show up in scrubs if you want.
- There are 4 call shifts that are required to be completed during the peds block. You will either sign up for these slots or they will be assigned to you. You must do 1 NICU Weekend, 1 Ward Weekend, and 2 NICU/WARD/ER Weekday call shifts as well as 1 Bilirubin Clinic shift (2-5pm on a weekend).
    - NICU/WARD/ER Weekday: These shifts go from 4:30pm to 10pm. You must go to Kidd 10 and walk down the pediatric hallway. There will be a locked room for residents/physicians (called the FISHBOWL - if you need help finding it just ask the unit clerk). The door code is 5321. You will be expected to do similar tasks to that of your inpatient week, ER consults, checking in on NICU etc. You will work directly with lovely residents and they will guide you!
    - NICU Weekend: These shifts are 8am to 6pm. Show up to the NICU on Kidd 5 in scrubs. You will be assigned a number of NICU babies to write progress notes on. Usually, the resident will assign you stable babies that require minimal follow up. During this shift, you may also be called to births on the Labour and Delivery floor (Connell 5), and assess newborn babies
    - Ward Weekend: These shifts are 8am to 6pm. Tasks are much the same as what you will do in the inpatient week. Show up to the fishbowl on Kidd 10 at 8 am for resident handover. You will receive patients to update and reassess, write daily progress notes, and see ER consults
    - Bilirubin Clinic: This shift is mandatory and goes from 2pm-5pm on weekends. Show up to the NICU on Kidd 5 at the start of the shift and introduce yourself to the resident. You will be required to perform well-baby exams and assess the serum bilirubin levels for babies on the unit or coming back as an outpatient. There is a helpful nomogram in order to assess the need for phototherapy or exchange transfusion.
- You must complete 12 online cases on AQUIFER and log them on Elentra as mandatory encounters using Dr. MacLean as the “preceptor”. The cases can be found here: https://queens-md.meduapp.com/document_sets/2464
    - The following videos needed to be reviewed are: 2,3,10,11,18,20,21,25,26,29,30,31
- There is a pediatrics exam at the END of your rotation. It will be a 3 hour exam with ~100 MCQs on common pediatric presentations, investigations, and management.

Expectations for Clerks

- Inpatient Week Info:
    - You will work directly with an attending pediatrician, as well as 2-3 residents on the Kidd 10 wards. Days will usually begin at 7:30 am for morning handover and the senior resident will assign you patients to assess. It can be helpful to bring along a clipboard to write pertinent findings on history and physical exam, as well as vital signs, fluid ins/outs, and medication changes. After assessing the patient on your own, you will round as a team with your attending on all the patients on Kidd 10. Be sure to update the Resident Handover Tool on PCS with any new findings or lab results. Keep checking

on your patients periodically for updates, and you may also be required to see new consults in the ED

- Well Newborn Week Info:
    - You will see babies on Kidd 5 with a resident/NP/MD, and perform well newborn examinations and document findings into the patient chart
    - It is helpful to review the Well Newborn Physical Exam on Youtube, and have an idea of how congenital abnormalities could appear (Cafe au lait spots, epicanthal folds, low-set ears etc)
    - The days are usually short (end at around 11 am depending on the number of babies to assess). Some days you may even be completely off. It is helpful to book weekday and weekend call shifts during the Well Newborn Week since you have lots of spare time
    - You may also be in the NICU during this week. This is much the same as the call shift. You will go to Kidd 5 and enter the NICU by scanning your card. Introduce yourself to the resident, and you will be assigned babies. Do your assessment and write a progress note in the babies' charts. If you have any questions, talk to the nurses. It is 1:1 care in the NICU, and the nurse will have all the up-to-date info on their respective baby
- Ambulatory Clinic Week Info:
    - Exposure to a variety of pediatric outpatient clinics. You will be asked to dictate, so ensure that you have the specific physician ID and you know how to dictate from KGH or HDH.
    - Clinics usually begin at 9am and 1pm. Show up and introduce yourself to the attending or residents working in the specific clinic. There will be a list of patients to be seen. Sign up for patients and go assess them with a standard history and physical. In some specialized/phone clinics, you may be seeing patients directly with a resident/preceptor and just observing. It is helpful to have a foldable clipboard to bring along with you to write notes.
    - If you are keen, you can search up the clinic list the night before using PCS (find Patient List by physician name) and read up on the patients that will be seen.
- COPC Week Info:
    - Fast paced, acute care for a variety of pediatric presentations. You will work directly with a preceptor and sometimes 1-2 residents. The very helpful nursing staff will bring patients in from the waiting room as space opens up. Their charts will be placed on each numbered door. A list of patients currently in rooms will be at the front nursing desk inside the COPC. As a clerk, sign up for patients on the list by writing your initials, then go to the respective room and look at the chart. The nursing staff will write down the chief complaint on the chart.
    - It is useful to have a foldable clipboard to bring the chart in with you to write findings of the history and physical exam
    - Be wary of contact precautions. You'll get great practice with the otoscope and fundoscopy, learning how to deal with difficult or non-verbal children, and common pediatric management options for pain, constipation, or mild traumatic brain injury
- Bilirubin Clinic

    - Familiarize yourself with the nomogram, this article by CPS is fantastic to review for the clinic and final exam: https://www.cps.ca/en/documents/position/hyperbilirubinemia-newborn
    - Know the difference between breastmilk jaundice and breastfeeding jaundice, and know causes of hyperbilirubinemia in newborns
- General Tips BEFORE starting your rotation
    - Ensure your dictation ID and password is working, and that you know how to dictate from KGH or HDH (what number to call, physician ID, report type etc)
    - Use this guide to find out where your clinic will be (They are NOT all in HDH) if you are on ambulatory week
    - Think about any EPAs that you have outstanding. COPC week is a great opportunity to complete a Preventative Health/Advocacy/Child Otoscopy (Procedural skills) EPA, and Inpatient week is easy to complete the Handover EPA. Just keep this in mind since the pediatric attendings and physicians are all very nice and more than willing to help fill these out for you!

Assessment Strategies

- Logging of all mandatory encounters on Elentra
- Logging of all 12 CLIPP/Aquifer Online Modules on Elentra
- At least FOUR (4) Outpatient Clinic (COPC or Ambulatory) assessments. Make sure to ask your preceptor/resident if it is ok to send them an assessment form.
- TWO (2) Mini CEX forms. Expected to do a focused history and physical. From experience, it is EASIEST to ask your preceptor/resident to complete this with you ON THE FIRST FEW PATIENTS when you're on COPC week. Usually it is not busy by then, and they will have time to observe you
- ONE (1) Newborn Week Assessment form
- ONE (1) Inpatient Week Assessment form. Can usually be completed by the senior resident or attending. Make sure you ask them directly if it's ok to send them a form at the end of the week.
- ONE (1) mid-rotation meeting/phone call
- ONE (1) Exit meeting/phone call
- 60% on the Pediatric Clerkship MCQ exit exam.

How to prepare for the rotation

- High Yield Topics to Review
    - Have a general approach to the common Pediatric presentations: Abdo pain, Nausea/Vomiting, constipation + diarrhea, common pediatric skin rashes, fever + sore throat, headache
    - Know doses of Advil, Tylenol and other pain medications for children
    - Read up on diagnosis and management of pediatric asthma, diabetes, common tumours and blood disorders, viral URTIs, and vaccination schedules
- Resources
    - www.pupdoc.ca - great to learn about general pediatric clinical presentations and final exam

- http://www.cps.ca/en/documents - awesome to review guidelines when on Inpatient or COPC week
- www.pedscases.com - good study resource for pediatric presentations and management, and final exam
- https://cards.ucalgary.ca/institute/6 - amazing case-based online study tool for the exam
- https://www.uptodate.com/login - easy to search any pediatric condition on the fly, and to look up dosing

Last Important Tips

- Ambulatory Week may be a bit overwhelming because some aspects of the outpatient clinics are very specialized, but rest assured that the residents and attendings are more than happy to give you ample time to take a history and physical and clarify any complex information
- Fine tune your oral presentation and handover skills. Look up ways to present patients or effective handover communication techniques on YouTube. You will be doing that a lot during COPC week and Inpatient Week, and it's great practice for other rotations
- Always try to include your differential diagnosis into your questions on history, and formulate an assessment/management plan in your presentation

Previous Clerks to Contact

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9. Psychiatry - Consult Psychiatry

Rotation Format

- Typically a 4-week rotation in Kingston. All your shifts will be at KGH, and you meet the team in Burr 4. You see patients who are in the hospital under other services (i.e. internal medicine, neurology, surgery, etc.). You do not see the in-patient unit in Burr 4, except on your weekend call day when you will round with the residents/preceptor on these patients.
- You will be working with the Consult Liaison team, which will be composed of 1 - 2 psychiatry residents, 1 - 2 off-service residents, 1 - 2 fellows, and the preceptor for the week. You will have a new preceptor every week - they are all wonderful to work with!

Expectations for Clerks

- You will be expected to answer the pager and take all the consults likely by Day 2 or 3. They will give you a document with all of the expectations of the rotation on the first day (i.e. what information to take down for consults, how to add the attending to the patient's service, etc.). This document will be extremely useful, so make sure that you read it!
- You are expected to print out the daily patient list and the handover. Additionally, you are expected to update the handover to all of the patients. Usually, residents/fellows will do their patients, but sometimes they forget and it's nice if you update them as well.
- You round every day around 9AM. Have the patient list and handover (which should always be printed 2 pages on 1 and double sided) ready for everyone. You will round again in the afternoon

around 1/2PM. At this point, people give an update on their patients, and if you are keen, you can update the handover for them.

- You will get some patients to check up on yourself. Make sure you look at the overnight events, and also make sure that they are medically stable. I know sometimes we think that psychiatry and the rest of medicine are so far apart, but they are very related! Additionally, if they are on antidepressants or antipsychotics, make sure their QT length is normal, as these drugs can cause long QT syndrome which can turn into Torsades. Ask your patient how they are doing, if the medications have been helpful, anything that has changed, etc. You will not see every patient every day, and the urgency of seeing them will be graded at morning rounds.
- You do 2 evenings of home call and 1 weekend call. You are supposed to be there until 10PM on weekdays, but you will likely get out around 8.30PM. On weekends, you are only expected to be there until 8PM, but if there are no new consults by 6.30PM, you are free to go.
- Once you get a consult, look at the patient's entire medical history and medications, in addition to their psychiatric history. Read the EDIS record, ConnectingOntario information, and other external documents. Do not just assume the information given to you is accurate. I found more often than not the "diagnosis" was wrong, and very important information on a patient's psychiatric history was often missing. Often, a patient will express that they are anxious, and their physician will label them as someone with "anxiety", which isn't entirely accurate. Thus, I would highly recommend doing some of this detective work yourself.
- You get as much out of this rotation as you put into it. If you are uncomfortable seeing patients alone, the residents/fellows are more than happy to supervise or take the lead. If you want to improve your psychiatric interviewing skills or psychiatric management, then accept the opportunities to do so, or even ask (i.e. "I have never done a suicide risk assessment, may I take the lead on this one?"). Most importantly, read the room and trust your instincts. Patients are very vulnerable when speaking with you. If a resident says they are going to interview someone, let them - they usually have a reason. Additionally, you will realize quite quickly in a psychiatric interview whether or not the patient is agreeing with your interview style - I strongly caution against interviewing with bullet points in mind (i.e. going down a checklist), but instead fluidly asking all of the relevant questions based on the patient's answers. This, of course, takes a lot of practice and observation. Additionally, patients are usually very ill, and asking them questions such as, "Are you depressed?" or even "Do you have a low mood?" will seem rhetorical. Instead, ask them about whether or not they enjoy simple things in their life or what they're looking forward to, in order to gauge their mood.

Assessment Strategies

- Assessments required: Psychiatry exam, 1 Mini-CEX, 1 formative Mini-Clinical Encounter, 1 LCA.

How to prepare for the rotation

- High Yield Topics to Review: Depression, Anxiety, Substance Abuse Disorder (especially alcohol misuse and opioid addiction), Borderline Personality Disorder, Bipolar Disorder, Psychosis, Schizophrenia, Adjustment Disorder, Pharmacology
- Resources: QMed Handbook, Alex Morra's consolidated notes, Online MedEd

Last Important Tips

- Suicidal ideation is a sensitive topic - I found a good way of asking patients about this was to say: “Some people in your situation will feel that life isn’t worth living, and they would rather not wake up the next day. Have you ever felt this way?”

Previous Clerks to Contact

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10. Obstetrics/Gynecology

Rotation Format

- Typically a 4 week rotation in Kingston or two weeks at one of the regional sites and two weeks in Kingston. Regional sites include Brockville and Peterborough. While in Kingston the time is split between obstetrics and gynecology. You will spend time on labour & delivery, clinics, colposcopy, and OR days. Most clinics are located at KGH on Armstrong 5 with the exception of colposcopy (Dietary 1) and cancer clinic (Burr 1) . This rotation also includes one weekend call shift and 2 overnight week shifts.
    - Labour and Delivery: rounding typically starts around 6:30 on Davies 5, but your resident will let you know exact times the day before. Hand over occurs at 7:00am on Connel 5. From there you spend the day involved in and C-sections, deliveries, or emergency consults that occur.
    - Clinics: clinics include general gynecology, prenatal, high risk maternity, urogynecology, and contraception clinics. These are located on Armstrong 5, starting at 8:30am. You will typically see new patients. Colposcopy clinic is located on Dietary 1 and the cancer clinics are located on Burr 1 in section C.
    - The ORs for gynecology are located at KGH on Connel 2 and at HDH in the second floor ORs. The start time is 7:45am.
    - Call shifts are also done on the labour and delivery ward. The week night shifts run from 5:00pm to 7:00am and the weekend shift is from 8:00 am to 8:00am.
- The structure varies depending on the regional site. In Peterborough, there is a 3 day rotation schedule consisting of one clinic/OR day, one 24hr call shift, and one post call day.
- You will receive your schedule from Julie Wimmer, the course administrator a week in advance. If there is a specific aspect of OBGYN that you are interested in you can let her know ahead of time.

Expectations for Clerks

- Labour and Delivery:
    - When rounding in the morning clerks are expected to write progress notes. You will assess the patients who come in to triage, complete face sheets for labouring patients, scrub in and assist with c-sections, and assist on deliveries where possible. If you are interested, there is also the opportunity to practice cervical checks. It is extremely important that you introduce yourself to the patients before they are actively pushing. Following the delivery clerks measure, inspect, and weigh the placenta. Patients who

have an uncomplicated vaginal delivery do not require discharge summaries. However, if a patient does need a discharge summary, clerks often work on these as well.

- Clinics
    - The expectations are similar for the different clinics. It is a good idea to review patients ahead the day prior to clinic, this information can be found on PCS. Clerks should arrive a few minutes early to the clinic. You will review new patients, present them to your attending, and complete notes/dictations. Not all attendings will have you complete dictations, so it is important to clarify this expectation. During colposcopy clinic, clerks complete the speculum exam under direct supervision.
- OR Days
    - When you are scheduled to be in the OR, the expectation is to look up your patients and their procedures ahead of time. It is expected that you arrive early to write an admission note if your patient will be admitted overnight and start a discharge summary. It is important that you introduce yourself to the patients prior to surgery. Then head to the OR and put your full name and glove size on the board and introduce yourself to any OR staff that is there. Clerks usually have the opportunity to scrub in during procedures and there may be the opportunity to suture. When your patient is admitted overnight, it is expected that you will round with the team the following morning.

Assessment Strategies

- Logging all mandatory encounters on Elentra
- Assessment forms completed by every preceptor you work with
- 1 mini CEX
- One (1) mid assessment meeting
- One (1) exit assessment meeting
- Final exam

How to prepare for the rotation

- It is helpful to review the material covered in 2nd year.
- Specific clinics require additional preparation. There are specific modules for urogynecology, high risk obstetrics, and teen obstetrics clinic available on Elentra.
- There are templates of L&D notes and admission notes available in the class drives
- High yield topics include gestational diabetes, pre-eclampsia, endometriosis, abnormal uterine bleeding, and incontinence.

Last Important Tips

- If you are interested in practicing a certain skill or getting more involved let your residents or Julie know. This will increase your chances of getting experience.

Previous Clerks to Contact

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11a. General Surgery

Rotation Format

- Typically, a 2-week rotation at KGH. You will be assigned to one of the following teams; GS-1 Colorectal/Critical Care, GS-2 Hepatobiliary, GS3 Surgical Oncology/Breast/Pediatric Surgery, GS4 Acute Care, GS5 Thoracic Surgery, GS6 Bariatric surgery
- GS4 Acute Care is different from the other teams such that it is purely a consult service. You do not have clinic days, but are with the assigned call staff for that week and will do any consults for patients, mostly in the ED.
- The other team are traditional surgical services. You will have a combination of clinic days and OR days and +- endoscopy depending on the team you are on.
- Oftentimes you may spend a day or two on another team you are not originally assigned to. For example, all clerks will spend at least one day in the breast clinic which is under GS3. However on these days you are still expected to round with your originally assigned team.
- Your schedule will be available on a master google sheet that is sent out at the beginning of the rotation. Your resident will assign you clinical activities for the week.
- Residents will typically add you to a WhatsApp group for communication

Expectations for Clerks

- Rounding
    - All teams round in the morning, they can be as early as 530 am depending on the number of patients on your list and/or if it is an OR day. Rounds are fast and efficient. You are expected to print the list for every member of the team so arrive 10 minutes early before rounding time. There is no need to pre-round unless otherwise clarified with your resident. As a clerk you will take turns with the other clerk or junior resident on your team writing down the progress notes. It is very handy to carry around X-ray and CT reqs as well as consult forms to save time in the morning.
- OR
    - In the OR you are expected to help where you can, whether it be getting the bed, warm blankets, inserting the foley etc. Always introduce yourself to the team when you arrive and write your name down on the board with your glove size. Because there are a lot of residents you may not get to scrub in at times so go in with that expectation. When you do get to scrub you can expect to help with retraction, operating the camera and closing the incisions. You are not expected to write post-op orders, but residents are always appreciative when you try. There are many order sets for different surgeries so try searching for those, but if not you can use the regular adult post-operative order set. If it is a day surgery (HDH and sometimes at KGH) post-op orders only need to be written on the green sheet. Always nice to review the patient and the procedure/anatomy before to help you better follow what's going on.
- Clinic
    - There is a large variety of clinics. Some clinics are at HDH and others are at KGH so always clarify the location and start time the night before. At the start of the clinic, always clarify the expectations of the patients the physician would like you to see as well as whether they want you to dictate (some like to dictate themselves). For clinics that may involve sensitive exams such as breast or DRE, always clarify with the physician if they want you to have a chaperone for these exams or not. It is helpful to briefly review

the types of conditions that you will be seeing in the clinic the night before so you can prepare how to best spend your patient interactions. Before you see a patient, always check the referral letter, past medical records and Connecting Ontario to get important information. It is a good learning practice to also review the imaging yourself.

- Call
    - You will have one night of baby call until 10 and one 24 hour call
    - On call you will typically do consults in the ED and may assist with OR cases.
    - Things can get busy very quickly if you have baby call you are expected to round the next day, so it is important to ensure your resident knows that you finish call at 10pm. If they call you for a consult 9 pm or later, gently remind them that you have to leave the hospital by 10 pm. If you don't you can get stuck for several extra hours at the hospital and then will still be expected to be rounding in the morning, so make sure you advocate for yourself.

Assessment Strategies

- Logging all mandatory encounters on Elentra
- 2 Surgery Daily Encounter Forms
- 2 Surgery Rubric Forms
- 1 mini CEX (or can be completed on your other surgery core rotation)
- One (1) mid assessment meeting
- One (1) exit assessment meeting
- Final exam

How to prepare for the rotation

- Review pre-clerkship notes
- Youtube/Google surgeries the night before to review the pertinent anatomy, the main steps of a procedure, and complications
- First Aid for the Surgical Clerkship is a great study guide that covers more in depth topics for specific general surgical subspecialty conditions that are not necessarily taught in clerkship
- Surgical Recall is a helpful quick on hand review for high yield pimp questions. It is great to review before a surgery or before you go see a consult.

Last Important Tips

- If there is a certain attending, clinic, or OR you want to attend let your resident know in advance so they can help tailor your schedule so you can meet your specific learning goals
- Sometimes the rotation can feel a bit like an observership because the teams are often large, so just always stay motivated and keen. Try to find other ways to be helpful like updating discharge summaries and checking in on patients when you have time.

Previous Clerks to Contact

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11b. Urology

Rotation Format

- Typically, a 2-week rotation at KGH
- Rounding can begin anywhere from 6-730 depending on the day
- You will participate in clinics, cystoscopy, ORs, as well as perform consults
- Cystoscopy is JM4 at HDH
- ORs are in KGH at Connell 2 or HDH. Typical start time is 7:45
- You also attend teaching with the residents on Wednesday mornings and academic half days on Fridays
- Two week days of baby call until 10 and one full weekend of call. All calls are usually from home if there is nothing currently needing to be done on the floor. You will round in the morning on your weekend call then go home.
- Communication with the team is typically with WhatsApp

Expectations for Clerks

- Knowledge expectations are quite low, but you should have a good approach for history taking of a urological presentation (ie. FUNWISE and a differential for hematuria)
- Rounding
    - You are not expected to pre-round, but it is very helpful to print the list, collect blood work on stickers and ensure any morning discharge summaries are ready to go. Turnover for inpatients is very high so it is very important to always keep the discharge summaries up to date and start them as soon as possible. In order to stay on top of them you need to spend some time every day working on them
- Clinic
    - In a clinic you can function very independently, you do not need chaperones to perform genital exams as long as you are comfortable. You can also use the bladder US to do a PVR independently. You will also participate in phone clinics. All the attendings have clerks dictate. Keep in mind clinics are very busy in urology with long patient lists, most encounters are very short and streamlined so keep that in mind when seeing patients. Due to this, it is also not practical to review all individual patients the night before. Pick a few patients, especially the new patients to see what some of the conditions there will be and review that topic. Always review the referral letter and accompanying imaging and bloodwork before you see the patient. Know where the prescription pads, imaging and lab requisitions are as it is helpful to have those ready.
- OR
    - You are expected to help where you can, whether it be getting the bed, warm blankets, inserting the foley etc. Always introduce yourself to the team when you arrive and write your name down on the board with your glove size. The residents will often let you close most cases and scrub in when there is room. You are not expected to write post-op orders, but residents are always appreciative when you try. Rarely will you be pimped, but it is always nice to review the patient and the procedure/anatomy before to help you better follow what's going on. A lot of the ORs are day surgery (TURB/TURP) so post-op orders are not online but written on a green sheet, and patients are sent home with a day surgery sheet. The orders are almost always the same, so ask the resident to show you and then you can write the next ones.
- Cystoscopy

    - Cystoscopy is more like an observership. You will also see prostate biopsies. If you are keen they will let you use the cystoscope which is a lot of fun. To be helpful you can help prepare any imaging or blood work requisitions as well as prescriptions. Most patients are there for bladder cancer investigations or surveillance, so this is a good topic to read about the night before.

Assessment Strategies

- Logging all mandatory encounters on Elentra
- 2 Surgery Daily Encounter Forms
- 2 Surgery Rubric Forms
- 1 mini CEX (or can be completed on your other surgery core rotation)
- One (1) mid assessment meeting
- One (1) exit assessment meeting
- Final exam

How to prepare for the rotation

- Dr. Leveridge's lectures are very helpful and should be sufficient to guide you through the rotation, the CUA also has lecture slides available that are easy to follow
- Review the proper technique of inserting a foley as well as performing a DRE (granted I did not do a single DRE on my rotation)
- High yield topics include BPH, prostate cancer, kidney stones, kidney cancer, bladder cancer, OAB, recurrent UTIs. You may see some pediatric urology, but not a ton.

Last Important Tips

- Reiterating the importance of discharge summaries! Get them started ASAP and keep them updated daily.
- Residents are very open to accommodating request; if there is something you want to see or do, or someone you want to work with do not hesitate to ask

Previous Clerks to Contact

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11b. Orthopedic Surgery

Rotation Format

- Typically a 2 week rotation at KGH as a part of the "Core Surgery" block. Some students may have Urology rather than Ortho
- **Dress Code:** Scrubs
- Rounding usually begins anywhere from 6:30-7:30 am depending on the team you are on, and how many patients are on the list. A typical morning involves the Ortho team meeting and distributing the patients to be seen, then the clerk going off on their own to see their assigned patients and writing a quick progress note

- **There will be an Ortho clinic in Johnson 7 at HDH, ORs (typically at KGH Connell 2), and consults from the ER when you are on call. Pediatric clinic is on the HDH main floor in the COPC area**
- ORs usually start at 7:45 am! You can also check the OR schedule on PCS (through the KGH Intranet link) to see which OR you will be in and what time it starts
- Two week days of baby call until 10 and one full weekend of call. All calls are usually from home if there is nothing currently needing to be done on the floor. You will round in the morning on your weekend call then go home
- Communication with the team is typically with WhatsApp
- You will be emailed a link to the Master Ortho Schedule by Mara Kottis, as well as a call schedule. Check and see which residents are on your team (Team A, B, C or D). Team A is sports/upper extremity, B is arthroplasty (knee, hip, ankle), C is pediatrics and spine, and D is trauma.
- Contact your resident via KGH email! Introduce yourself and tell them you will be the clerk on the Ortho "x" team from X to Y date. Ask them where they would like you to meet in the morning for rounding, and what time. Also provide them with your phone number! They will likely contact you via text or WhatsApp. You can contact both the Junior resident and Senior resident on your team! Ideally, introduce yourself via email a couple of days before your rotation begins

Expectations for Clerks

- Remind the Junior or Senior resident of exam/personal days ahead of time so they can plan the next weeks schedule accordingly
- Rounding in the morning - your main expectations will be to show up on time, print the list from PCS for your specific team, have some imaging requisitions and consult sheets ready in case they are needed, and see the patients you are assigned to and write a short progress note on each
- You don't need to come in and pre-round! Always check in with your Junior or Senior resident via text message the night before to know what time they want you to come in the morning
- Keep discharge summaries on Entrypoint up to date as much as you can. This is very helpful for the team!
- Ortho/Spine Clinic: Ortho clinics for teams A and B occur on Johnson 7 at HDH. They typically start at 8 am in the morning, and 1 pm in the afternoon. As soon as you walk out of the elevators at Johnson 7, turn into the main hallway where the assessment rooms are and walk towards the main desk in the middle. In that area, there will be a whiteboard listing the Doctor's name and which room number they are working out of for that day. Go to that room, put your bags/coat down, and introduce yourself to the Doctor/resident/fellow working there as well. There are usually computers in the room where you can pull up the previous clinic note or imaging on PCS
    - You will be expected to see patients as they come in (sign up for them on the white paper sheet in the room), do a focused history and physical exam, come up with a brief plan (i.e. continue with physiotherapy vs. surgical management vs. trial cortisone injections of hyaluronic acid) and present this to your attending. Depending on what team you are on, it is useful to know basic anatomy, how to read X-Rays of the shoulder/hip/ankle/spine

    - You will also be expected to dictate during or after the clinic. Dr. Mann does all of his own dictations, so if you have him for a clinic you are good to go!
    - If you are keen, you can totally look up the patients for the next day's clinic beforehand on PCS, and write your own little notes to bring in. You do this by searching for a patient list by physician name, selecting your attending, and clicking "Go to" and changing the date to tomorrow's date. This is not necessary, but good for your own learning and so you don't come to clinic with zero idea what is going on
- Peds Clinic: These clinics take place on the main floor of HDH. Walk over to the COPC area, and head into the back hallway where there are assessment rooms. If you get lost, just ask one of the nurses at the COPC and they will happily show you where to go. These clinics are much the same as the typical Ortho clinics. You will be expected to assess patients and dictate a note. Make sure you know about common pediatric orthopedic issues and how to manage them, as well as pertinent physical exam maneuvers.
- OR: These usually start at 07:45 AM or 08:15 AM (on Wednesdays) at KGH Connell 2. Try to get there early so that you can introduce yourself to the patient in the SDAC or surgical holding area inside Connell 2. Introduce yourself to the nursing team, and write your name, CC3 or CC4, and glove size on the white board. Before the surgery starts, it is helpful to go into Entrypoint on PCS and begin the post-operative orders. There is a specific surgery post-operative order set that you can use. If you have not done it before, tell your resident and they will be happy to go through it with you! You will be expected to fill these orders out on subsequent surgeries. Also, make sure to ask the resident or attendings if they want you to scrub in. Sometimes surgeries will have multiple attendings or residents, and there will be no room. It is helpful to read up on the OR cases ahead of time, so you know why the patient is having the procedure and what the procedure will consist of. Assist with the OR set up as much as possible, and make sure to help with patient transport to the PACU afterwards!
- Trauma: If you are on the trauma team, you will be responsible for covering all traumas and consults from the Emergency Department. Most often, there are afternoon fracture clinics at HDH on Tuesdays and Thursdays beginning at 1300h; you will be notified in advance if there is a change of schedule. The senior resident will assign who attends each clinic. There is an Ortho Emergency OR every day, usually OR K. If you get called about a consult, please kindly refer the individual to page the senior on Ortho Trauma. This ensures that the appropriate investigations are done before seeing the consults. Patients admitted directly to our service: need a full history and physical as well as admission orders on every chart. If they are preop, make sure you prep them for the OR with NPO IV orders, appropriate blood work, investigations and consults. Review them with your resident as if they were regular consults.
- Call Shifts: Call is from 5pm (or right after teaching) to 10pm on weekdays. Text your resident as soon as you start call or as soon as teaching is done to know if there are any pending consults or ORs. You will be emailed a call schedule by Mara Kottis. See which Junior and Senior residents are on call with you. Look at the Ortho schedule and find out which of your classmates are currently working with those residents. Contact your classmates for the resident's cell phone number, so you can text them on the day of your call shift and notify them that you will be on call from 5-10pm. Ideally, text them as close to 5pm as possible.
    - You will be assigned to one overnight call shift. During the weekends, we start rounding on Kidd 4 at 0630h. We regroup at 0730h in the Kidd4 Conference Room to review which

patients still need to be seen, and whether there are any active Orthopaedic ORs starting. Once all patients are seen, we meet again to run the list and check blood work/imaging. Otherwise, weekends function much like the weekday trauma service. There are no separate teams on weekends – everyone works as one big team covering all inpatients, consults and ORs. You will be assigned to patients to round on individually in the morning. After this, your day will be divided between ward management, consults, and ORs. Again, touch base with your resident regularly to see if there are consults, ORs or anything else you can help with.

- How to book a case for the OR: After a patient is admitted and consented for surgery, the resident will go book the case. You may accompany them. This involves going up to the OR front desk and filling out an emergency booking form, as well as talking to the charge nurse and the anesthesiologist. You will need to bring up a patient's sticker.
- A case = immediate, B case = within 2-8 hours, C case = 8-24 hrs.

Assessment Strategies

- Logging all mandatory encounters on Elentra
- 2 Surgery Daily Encounter Forms
- 2 Surgery Rubric Forms
- 1 mini CEX (or can be completed on your other surgery core rotation). Easiest to complete this during call shifts (if doing a consult), or ask the resident to come with you on the first patient of the day in Ortho clinic so that it isn't too busy
- One (1) mid assessment meeting
- One (1) exit assessment meeting
- Final exam

How to prepare for the rotation

- Depending on the focus of your team (A, B, C or D), it is useful to have a general idea of anatomy (i.e anatomy of the shoulder, hips, knee, ankle), the muscles and vascular structures as well.
- Ensure you have read up on pertinent physical exam maneuvers and what they test! Very useful for clinics at HDH where you will be seeing and assessing patients on your own before reviewing with a staff. For instance, on your physical exam it may be helpful to document the degrees of ROM, how far the patient is able to externally/internally rotate and what level of the spine this corresponds to (Bottom tip of the scapula is T6)
- Know various pathophysiologies of arthritis, fractures, rotator cuff injuries, dislocations. Have a general idea of how these are treated (conservative management vs. when to do surgery). Very useful to read or study with Toronto Notes, as they go over many of the orthopedic pathologies you will see and their management plans
- OrthoBullets is also an AMAZING resource to use while you are on rotation. Check out the website: https://www.orthobullets.com/. Highly recommended!

Ortho Progress Note Format & Suggestions

ORTHO TEAM D

- **ID:** 65F POD#2 Left Hip Hemiarthroplasty for Femoral Neck Fracture

- **Subjective:**
    - Pain well controlled with oral medication
    - Passing flatus, no BM yet, tolerating a regular diet
    - Ambulating with physio
    - Denies chest pain or SOB, new numbness or weakness
    - No issues overnight
- **Objective:** 145/82 HR75 RR16 Sat 97% RA Tmax (24hr) 36.8C, A & O x3
    - Dressing: clean, dry, intact
    - Pulses: 2/2 dorsalis pedis, posterior tibialis
    - Sensation: 2/2 femoral, tibial, deep peroneal, superficial peroneal, saphenous and sural nerves
    - Power: 5/5 EHL, ankle dorsi/plantarflexion, knee flexion/extension; 3/5 hip flexion
- **Assessment:**
    - POD#2 Left total hip hemiarthroplasty. Pain under control. Ambulating well.
- **Plan:**
    - Awaiting transfer to retirement home. Continue PT for mobilization.
- **Signature, CC3**

Ortho Consult Note Format & Suggestions

- **ID:** 65 yo F from retirement home
- **RFR:** Left hip fracture
- **HPI:** Witnessed fall in bathroom January 1 @ 7am in Marda Loop Retirement Home. Not able to ambulate after fall. Cane for ambulation at baseline. No head injury, no loss of consciousness, no other associated injuries. No hx of arthritis/pain in affected hip. No blood thinners
- **PMHx:** Hypercholesterolemia, HTN
- **Meds:** Crestor 10 mg PO Daily, Coversyl 4 mg PO daily
- **Allergies:** Penicillin (unknown reaction), no food, no latex allergies.
- **PSx:** Carpal tunnel release (bilateral), appendectomy. No complications with anesthetics
- **FHx:** n/a
- **Social history:** Retired nurse from retirement home. Uses cane at baseline for ambulating long distances. 2 daughters (POA) in Kingston. 20 pack-year smoking hx (quit 1999). No EtOH. Last meal: 8 pm last night – supper. 1 cup H20 at 6am this morning.
- **O/E:** 120/80, HR 85, 98% on RA, T37.0. Overweight female.
    - Normal S1S2. No extra heart sounds.
    - GAEB. No adventitious lung sounds.
    - Abdo soft, non tender, non distended. No organomegaly. Prior appendectomy scar.
    - Left leg shortened, externally rotated. Pain with leg roll, localized to left groin. Dorsalis pedis + post tib pulses palpable. Normal sensation saphenous, deep +sup peroneal, med + lat plantar, sural, tibial nerves.
- **Ix:** WBC: 11.0 no left shift. Hgb 100, Platelets 300. Na 134. K 3.8. Cl 100. Bicarb 28. Cr 70. Urea 5.6. INR 1.0. PTT 30.
    - X-ray: left intertroch fracture
- **IMPRESSION:** 81F from nursing home with left intertroch fracture.
- **PLAN:**

    - 1) Admit to Orthopedic Surgery – Dr. Capote.
    - 2) NPO at midnight, IV fluids
    - 3) X-ray whole length femur
    - 4) Anesthesia consult
    - 5) left hip hemiarthroplasty - will discuss with senior resident and attending

Last Important Tips

- The residents on Ortho are fantastic, do not ever hesitate to reach out to them if you are having issues or if you want more information on various topics. They will usually be more than happy to take time and provide valuable teaching sessions on the fly!
- Anatomy is key, I would certainly recommend using OrthoBullets to help you gain a better understanding of Orthopedic issues (specific to your team), risk factors for various pathologies, and how to manage them. That resource also goes over XRays and imaging
- Know your MSK physical exams well, and what each maneuver is testing and what this means (i.e Hawkin's impingement, Neers, Trendelenburg sign). If on Team B, know what you want to look for on XRay for arthritis, conservative treatment options for mild-moderate arthritis, and indications for surgical intervention

Previous Clerks to Contact

Ken Choi - kchoi@qmed.ca

12. Integrated East (Picton, Perth, Brockville)

Rotation Format

- Integrated East rotations span 3 blocks in a community centre and consist of FM, peds and psych. Each week you will have one day of peds, one day of psych, and be following your assigned family physician(s) for the remainder.
- Family medicine is provided in communities with FM preceptors. The FM preceptors have diverse practices including FM clinics, emergency shifts, hospitalist, etc, which you will be joining them on. As such each week may look a little (or a lot!) different.
- Pediatrics and psychiatry may or may not be in community depending on the community.
    - Picton clerks will have 1 day a week of pediatrics in Belleville and psychiatry is split between Picton and Belleville.
- Clerks are provided accommodations in their community
- Access to a vehicle is required as some learning opportunities require a commute (i.e. Clerks in Picton must drive ~30 mins to Belleville 1-2 days/week). Some travel expenses are reimbursed providing you submit the expense forms at the end of the rotation.

Expectations for Clerks

- Most FM clinic days run from 9am-4pm although this may vary. Appointments vary in length between 10mins – 30 mins typically.
- **Dress code:** business casual for clinics, scrubs for emergency department, business casual OR scrubs for hospitalist shifts.
- Clerks are expected to be professional and reliable in the clinic. You will be sent to see most patients by yourself to gather information and then usually asked about management of the patient.
- In psychiatry, they will often give you more responsibilities as time progresses. In the beginning you may be watching the psychiatrist but soon they will have you interviewing patients and discussing their management while they watch
- You will be expected to document patient encounters (SOAP note for clinic and ED, progress note for inpatient)

Assessment Strategies

- Family medicine
    - NO EXAM
    - 1 community reflection, 4 summative case reflections (+1 formative case reflection)
    - 1 mini-cex
    - Logging the 19 mandatory clinical encounters on Elentra
    - 1 midterm LCA at 6 weeks, 1 end of rotation LCA at 12 weeks
- Pediatrics/Psychiatry
    - Pediatric exam
    - Psych exam
    - Combined 3 daily encounter assessments between both psych AND peds (i.e. 2 peds, 1 psych or 2 psych, 1 peds)
    - 1 peds mini-cex
    - 2 psych mini-cex

How to prepare for the rotation

- In the beginning it can be overwhelming trying to learn about 3 different specialties at once. It can be useful to prepare for presentations which are across all 3 disciplines (like depression and anxiety) first to perform better across the various specialties.
- Class notes and schemas from the family medicine, pediatrics and psych courses are great resources to review
- Hot topics
    - HTN and DM; know BP and glucose cut offs, how to diagnose both, and what medication classes individuals can be started on. This can be a great rotation to see your management in action as you can see the same patients over several months
    - Headache and fatigue; know red flags and bloodwork that is done for these common and general complaints

    - ADHD/autism: lots of clinic visits in pediatrics pertain to these topics, know the general diagnosis criteria for autism and medication classes for ADHD (you will quickly become comfortable manipulating these medications!!)
    - Constipation in children, Cow's milk protein allergy
- Procedures to know: **IM injections, punch/shave biopsy, simple suturing, pap smears, conjunctival foreign body removal**, and **cryotherapy**.

Last Important Tips

- It is okay to say you do not know about a presentation, especially in the beginning when you are trying to learn so much new content. This allows the preceptor to give you some teaching (if there is time) and highlights presentations/illnesses which you can read around later. This is also a good way to show a preceptor that you are improving, if you don't know much about it this week but crush the presentation next week!
- It can be good practice to write down what presentations you see throughout the day and reflect on them/read around them later that day. It is difficult to look back at the end of a busy day and remember what you saw.
- When you are having a patient back for follow up in the family medicine clinic, try and have them on days when you are around as well! This will give you continuity with patients which can be great for learning and for job satisfaction as you may make good relationships with patients and look forward to seeing them in the clinic.
- If you feel as though you are going to miss clinical presentations in any of the 3 disciplines, you should reach out to the course coordinators around the halfway mark to look for more opportunities. The course coordinators are very responsive and helpful in fulfilling your learning requirements.
- Because you are spread across several health clinics, there are a lot of passwords and logins. Keep a list of them on your phone so you are able to access what you need to perform your duties.
- Lastly, being on regional rotation can be isolating. I would highly recommend checking in with friends/family and making the trip back to Kingston every few weeks to reconnect with the class!

Previous Clerks to Contact

Paul Bullock pbullock@qmed.ca – Picton Integrated East Rotation.