

# **SURVIVING AND LOVING THIRD YEAR at ICAHN SCHOOL OF MEDICINE at MOUNT SINAI**

## **INTRODUCTION**

Welcome to your third year of medical school! This year will be very exciting, demanding, and rewarding, and we hope to help get you started right with the following student-compiled guide. All advice imparted within is student-generated and, like most advice, should be taken with a grain of salt. And a tequila shot. This is a ton of information and is not meant to be consumed all at once. **Consider referring back to this guide before you start each clerkship.** We hope you find it helpful. Good luck!

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## **GENERAL SUGGESTIONS**

### **Your Role as a Third-Year Student**

**Be a sponge.** This may be the only time in your career you will have a broad and hands-on opportunity to explore and learn about a wide range of fields within medicine. Depending on where your career takes you, there will be diagnoses you will make and procedures you will see that you may never see again! While third year can be stressful and overwhelming at times, many physicians identify third year as one of the favorite times of their career because of the diversity of experiences they had.

**Observe.** While each rotation comes with a new collection of knowledge, you will be trying hard to learn. Your residents might have neat physical exam tricks, clever ways of eliciting difficult information, or useful ways of organizing their tasks that you would like to pick up.

**Ask questions.** Many people will tell you that the key to third year is to be enthusiastic in everything you do. In practice this can be hard (how do you enthusiastically do a rectal exam?). Asking a well thought-out question demonstrates that you are curious and eager to learn, and residents are usually excited to go over a topic with you when you express interest: win-win! Consultants are also usually quite receptive to discussing their impressions with a student, which can give you an extra insight to share with your team. However, try not to ask your team something you could easily look up, and do not ask about basic topics that you'd be expected to know already.

**Use your AIs (Sub-Is).** During your first rotations, there will often be a fourth-year student on your team doing an Acting Internship. They are a great resource! They were in your shoes a year ago, and can give you insider advice on the clerkship, the floor, and your team. They do not evaluate you, so they make a great sounding board and can give you informal feedback on things you could improve.

**Take responsibility for your patients.** Your residents are responsible for the care of the patients you are following, so at the start of most rotations, especially early in the year, they will often see and examine the patient with you. The more responsibility you take and initiative you show, the more comfortable they will be with giving you more autonomy. Sometimes on busy services you'll be amazed how much you are relied upon. Your residents are generally very busy, and the more you help them out, the

more willing they will be to take some time to teach you a topic or procedure. Know as much as you can about your patients - make them your own. Read their chart thoroughly, familiarize yourself with their entire hospital course in detail, and offer to do all the tasks (calling consults (early in the day!!), ordering labs, writing notes, updating families) their care requires.

**Develop rapport.** With your patients, with your team, and with the nurses. Many patients will actually call you “doctor” and consider you as their doctor, since you will spend by far the most time with them. Spend extra time getting to know them when you have a chance. You are being evaluated on how effective you are at caring for your patient, which starts with forming a good relationship - your team will notice when your patients like you. Also, get to know the nurses by name. They are a great resource for finding your way around the floor, and can definitely make your life easier - most are happy to update you on overnight events or any other questions you have about your patients.

**Acknowledge your limitations.** Admit what you don’t know. You will learn to say, “I don’t know” a lot this year, especially at the beginning of any rotation. It’s much better to admit that you don’t know something than to make up an answer, especially when the question is relevant to a patient’s care. Saying “I don’t know” can create a learning opportunity; when possible, you can also be proactive, anticipate what you’ll be asked, and look it up first. When you are unfamiliar with a topic, your resident will often ask you to look it up and report back, so look good by volunteering to do so before they ask.

**Be respectful.** Many students struggle to find the balance between being enthusiastic and being respectful of the hierarchy of medicine. Rules of thumb: don’t interrupt residents or attendings. Be very careful about questioning the decision of a physician unless you think a patient’s safety will be harmed. Try to ask questions in a way that suggests you are curious to learn about their thought process rather than suggest they were wrong.

**Be aware of your surroundings.** While your clerkship year is a time to learn, remember that you are doing so in a real clinical environment with real patients. You should absolutely feel free to ask any questions you have, but make sure it is at the appropriate time and in the appropriate environment. For example, if a patient is hemorrhaging in the OR, that may not be the best time to ask about surgical technique. Similarly,

asking about a patient's poor prognosis in front of them during bedside rounds is likely inappropriate.

**Share what you learn.** If you were up all night becoming an expert on a topic (side note - please don't do this; go to sleep), don't keep that knowledge to yourself - volunteer to briefly share some of the interesting points you learned with your team. Bring in a relevant article or useful chart you found - they'll really appreciate it. This is most helpful when your team is scratching their collective head about a patient care-related question and you can find some data that helps answer the question. Also, talking with your classmates about the cases you're seeing is a great way to reinforce what you're learning and expose each other to more conditions than each person sees individually.

**Seek out mentors.** One of the great features of third year is that you get exposed to a hospital full of people who want to help you figure out and plan your career. Clerkship directors are excellent go-to people who can help introduce you to members of their department. Some attendings love working with med students, and some just seem too busy; seek out those who love to teach by talking with clerkship directors and other students and focusing your efforts on the attendings who are friendly and respond to your emails. Many students have developed relationships with favorite attendings they worked with on the floors, and this is a great way to get letters of recommendation. There is also a **Mentor Database** on Blackboard that is helpful if you are considering a field that isn't part of the core clerkships. Finally, residents were just in your shoes and know how stressful this part of your training is; they are usually happy to talk to you about their experiences from being a medical student through picking a specialty and applying to residency (many will do this spontaneously).

**Think about letters early.** Rotations go by quickly, and you may not always get to spend as much time with an attending as you would like to. Your specialty choice will guide exactly how many letters you will need and who can write your letters, but thinking about letters early and scoping out potential letter writers never hurts. On the other hand, don't stress if you don't start collecting letters early in the year; it's common for rising MS4s to be looking for letters over the summer.

**Think toward the future.** Use each opportunity on the wards to explore what life is like both as a resident and as an attending in various specialties. The year flies by! Try to spend time with and meet with attendings as much as possible to see what life is like beyond residency. Time for electives is

somewhat limited in third year, so use your clerkships to explore as much as you can.

**Remember your patients.** It can be helpful to keep a journal of unique or impactful experiences or patient encounters you have during your clerkships. This can help you reflect on your experiences and also may come in handy when residency applications come around and interviewers ask about patients and situations you've seen. The year flies by, things blur together, and you will forget!

## **Learning Opportunities**

**Be proactive.** Sometimes you have to create opportunities for learning. For example, it can be helpful to try to be present when consultants come to evaluate your patient. If you personally call the consult, ask them what time they think they might stop by. Watch their exam and ask them to explain their recommendations to you. You'll learn more (and be able to relay more to your team) than if you just read their note. (Logistically, it is rarely possible to catch them in the act, but it's something to hope for.) Other ways to be proactive include requesting to accompany a patient on your service to an imaging study or procedure. Nothing beats that sort of first-hand learning experience, and you can create those opportunities for yourself.

**Learn all you can from your patients.** Sometimes you will be following patients for weeks, and as their conditions stabilize it can be difficult to continue to learn from them. A patient with pneumonia, for example, may be on a 10-day course of antibiotics. By day 5, their symptoms and exam may have normalized, and you may notice your team's attention span waning during your morning presentations. Liven things up (and maximize your own learning) by trying to identify new aspects of the case and presenting new info on morning rounds. Describe average lengths of stay and hospital costs for patients with community-associated pneumonia. Look up the most common complications of their antibiotic therapy, most common reasons for readmission after discharge, etc. You shouldn't present something new every day (and when you do, it should take no more than 1 minute max), but occasionally doing independent reading (without being asked to) will impress your residents and increase your learning. And don't worry—it's OK and often suggested by residents that you drop truly stagnant/stable patients.

**Ask to do stuff.** Do not hesitate to ask to help with things like blood draws,

IVs, and blood gasses. Just as residents should make their expectations clear, you can also communicate your interests and goals to them, and remind them along the way if they forget. Remember that nurses and AIs are excellent teachers.

**Be safe. Always.** When learning procedures, become familiar with the equipment and protocol first, choose your patient carefully and then proceed. NEVER be pressured to do something that makes you uncomfortable—safety is most important. NEVER do any procedures for the first time without direct supervision. You can ask to observe and do it the next time.

## **Behavior**

**Be pleasant.** As a third-year, effort and enthusiasm count as much as what you know. When it comes time to evaluate you, your residents will think about whether you were pleasant to be around and whether you'd be a resident they'd want to work with in the future; although this is very different from the way you were graded in the preclinical years, it makes some sense as working with others is a very important part of being a doctor. They will also observe your interactions with patients, nurses, business associates (BAs), and other people on the floor. There's no need to turn yourself into an extrovert if that's not the way you are naturally, but make sure to be polite and professional with everyone.

**Be adaptable.** Third year is a time to observe and fit yourself into the complex hierarchies of medical systems. To do well this year, you need to understand what your residents and attendings want from you, which may vary from team to team. Sometimes (and only sometimes) this may involve the less glamorous aspects of delivering medical care (obtaining records, making calls, doing guaiacs, etc.). You may hear this sort of thing referred to as "being a good team player" - this means doing whatever needs to be done, scut or otherwise, and doing it all with a good attitude. Don't worry too much about this - it generally feels good to do something that helps out with patient care, even if it's not a glamorous task. Most residents are also very aware of the "scutwork" dynamic and try hard to protect you from doing too much work that's not relevant to your learning.

**Make yourself visible.** Even if there is nothing left for you to do, hang around near where your residents are working and offer to help. Always bring some sort of shelf study materials to make the most of your downtime; UWorld questions on your phone are a totally reasonable option.

**Attend didactics. Clerkship didactics are mandatory, and they take precedence over everything else.** Even if you have to scrub out of a case, skip a delivery, or leave the clinic early, you are expected to attend every lecture (unless the clerkship director specifies otherwise, like if you are transitioning from day shift to night shift). Residents know this and will never give you a hard time for going to didactics. **Be cautious about asking to leave.** It's certainly your resident's or attending's right to keep you at the hospital as long as they see fit, and there are some instances where it's clearly inappropriate to ask to leave (e.g. it's only 10:30 in the morning, your shift goes until a certain time and it's not that time yet, you still have cases to attend in the OR, etc). However, if you've finished your work and clearly have nothing to do, and/or if your resident seems to have forgotten about your existence, you can consider asking in a very tactful way about being dismissed; one strategy is to let your senior resident know that your patients are all tucked in for the day and offer to help with any other tasks the team has remaining (although be aware that the "What can I help with?" line can sometimes be overused - some residents even, sadly, interpret that as you asking to leave rather than you trying to be helpful). Overall, we want you to feel empowered to go home when it's appropriate, but please be aware that different teams/rotations/services may have very different feelings about whether it's appropriate for you to broach that topic. Tread lightly at first when on a new rotation or with a new team.

**Don't be a "gunner."** There is a significant difference between a motivated student and one who tries to show off at the expense of the team. For example, don't answer questions posed directly to other people, and don't withhold information from other students or interns in order to look good when you present it yourself (not that we think you would ever do anything like that!).

**NEVER lie.** This seems obvious, but on rounds when you're being pressed for something, it can get very tempting. If you don't have a lab value or piece of info regarding your patient, it's much better to simply say "I don't know, but I will find out" than to jeopardize the patient's care or your team's trust in you.

## **Staying Organized**

**Organize your info.** It's super important to find a way to organize your patients' info; you may have to try out a few systems and see what works for you. Some people carry a single index card per patient and write only the pertinent changes from day to day. Others use the daily sign-out document and make a to-do list under each patient's name (be sure to shred all papers with patient info when no longer needed). Others carry a



clipboard with their most recent SOAP note for reference. If you are having trouble finding a system that works, watch/ask what your interns and residents do to organize their data. Since the information you collect varies with each specialty, it may be useful to ask students who already completed your current rotation if they had any good methods or templates.

**Organize your knowledge.** Some students carry a pocket-sized notebook for facts learned on rounds, topics for further reading, etc. For example, when you listen to sign-out, you can jot down anything you didn't understand to remind yourself to look it up later.

**Regular 'PxDx Logs' logging.** Remember that you need to keep track of the diagnoses you have seen ("Required Clinical Experiences") and the procedures you have done. Try to update these on one45 at least once or twice a week rather than waiting until the end of the clerkship when you're feeling crazed studying for the shelf. To PASS your clerkship, you MUST log all of your RCEs prior to leaving that clerkship.

**Develop a peripheral brain.** See the **Apps** section for advice on helpful apps. And write down everything! You might think you'll remember something, but don't rely on your memory when you have so much else going on in your brain.

## **Time Management**

**Be on time.** For everything.

**Preround early.** At the beginning of a rotation, give yourself plenty of time to pre round (checking in on your patients prior to rounds with the team). You'll get more efficient with some practice, but you want to avoid having to tell your team that you didn't have enough time to do something before rounds.

**Study when you can.** Make the most of your downtime. It's probably best to hang out in the team room with your residents and do UWorld / AMBOSS questions on your phone or iPad or read a book or article (AMBOSS has two separate apps that are very helpful: AMBOSS Qbank to do questions and AMBOSS Knowledge to look up frequently tested concepts, standards of care, etc.). If you haven't already, also download the Anki app; you'll be surprised by how many cards you can get down throughout the day between cases, during downtime, etc. You may be able

to sneak away to the library if you really want to, but be aware you may miss what's going on with your team; if you do leave the floor, make sure the resident has your cell phone number or some other way to contact you, but know they may be too busy to call you if something interesting arises.

## Notes

**Content.** Admitting notes (H+Ps) are the notes you're used to writing for ASM. They include: CC, HPI, PMH, PSH, Meds, Allergies, Social Hx, Family Hx, OB-GYN Hx (if relevant), Psych Hx (if relevant), ROS, PE, Labs, Imaging, and Assessment/Plan. **Note: your HPI should make sense.** If you are interviewing a patient and still don't understand the chronology of events that led them to the hospital, your residents won't either. Don't accept nonsensical answers—redirect the patient with specific questions until you get a coherent story. SOAP notes (daily progress notes) are shorter and should trace the patient's progress over time. They include subjective (what has happened since your last note, usually the last 24 hours), objective (including your physical exam, recent labs and imaging), and assessment/plan. In the physical exam, don't forget to comment on things like general appearance, supplemental oxygen settings (report this along with the SpO<sub>2</sub>), and urine output/appearance/catheters.

**Length.** You don't need to write a novel, but a rule of thumb is that the medical student H&P should be the most comprehensive note of all, longer than any resident or attending note. This is particularly true of the notes you submit for preceptor sessions or for grading at the end of the clerkship. People reviewing the chart often look at medical student notes for extra info. Do not skimp. Your SOAP notes should be succinct but complete and significantly shorter than the H&P.

**Using EPIC.** EPIC has some very useful templates; ask your residents to show you which ones to use. Do make sure to analyze the data that populates them; each part of your note should be specific and relevant to that patient on that day at that moment. Once one progress note is written, you can generally copy it forward for the next day, but make sure to read it very carefully and make all the updates that are warranted.

**Don't abbreviate if uncertain.** You might think everyone knows the abbreviations you're using, but you can't be sure. It's okay to use common abbreviations in your notes, but you should never use an abbreviation if you don't know what it means (take the opportunity to look it up!). When

in doubt, don't abbreviate.

## **Presentations**

**Morning presentations.** Your daily presentations on rounds end up being a substantial part of how residents and attendings evaluate you, so it's important to show your preparation and knowledge. This could include offering a quick teaching point or some evidence-based medicine to your assessment and plan. Even if the team says "maybe later" or "there's no time" when you bring it up, it shows initiative, and they will recognize that you came prepared.

It's important to include all the relevant information while still keeping the presentation organized, so it helps to have information written down in the order you wish to present it. Having a pre rounding template that you present with is a good strategy and referring to these notes while speaking is usually not a problem on rounds.

Something challenging about presenting on rounds is that expectations for presentation format vary wildly depending on the rotation, attending, and even your experience. On your first day of the rotation, or your first day presenting a new patient, err on the side of being more formal and thorough (e.g. listing home meds, stating all lab values). After that, you can usually start being more concise and only provide updates relevant for the upcoming day. You can also ask your residents how detailed the attending likes presentations to be, and ask attendings for their feedback as you progress as well. Don't worry – you will almost never be expected to present on your first day of a new rotation, so you will have a chance to listen to rounds first and see what the general style is before you have to present.

**General appearance.** Don't forget to comment on this! It actually matters, especially if you're noting a difference from one day to the next. Also, it has been said that all of residency is about learning the difference between "sick" and "not sick," and general appearance is important in making that distinction.

**Vitals.** The amount of detail you should give here is quite variable depending on your rotation and attending. Some will prefer to hear "vital signs stable," while others will want to hear the ranges over the past 24 hours. Ask your resident on day 1 how they want them (latest values,

range over last shift, over 24hr, etc). Residents can be very particular about vital signs: some like you to interpret them ("febrile to 100.9, tachycardic to 105") and others, namely surgeons, may want literally just the numbers, not even preceded by "BP" or "temp" (i.e. "97.8, 120/80, 65, 20"). Just ask. Also keep in mind that pain can elevate HR, RR, and BP, so mention their pain scale with vitals if you think it's pertinent!

**Lab values.** The way you report these will also vary a lot. For your first presentation on a patient, it's usually relevant to state most if not all of their admission labs. However, after that you might be more likely to say "labs are stable" or only state any abnormal values. The most helpful thing for you to do is offer trends in the values (e.g. "WBC count is downtrending since starting antibiotics, 7.7 today compared to 11.5 yesterday") or an interpretation (e.g. "BUN and Cr have increased since yesterday with a ratio of 25:1 – I'm worried about prerenal AKI"). You can show off your clinical reasoning, especially in IM, by only mentioning the labs that are relevant to the patient's care today.

**Check the chart.** Read consults and attending notes (you'll say, ah-ha! So that's what we're going to do!).

**Know the meds.** And doses. And indication (what bugs do their antibiotics cover, and what day of antibiotic treatment is it? Is the beta-blocker for HTN or Afib or something else?). You don't have to present all meds in your daily update, but sometimes people will ask and if you know, it shows you're thorough about your patient.

**Take a stab at the Assessment/Plan.** Especially on your first day presenting the patient, for the assessment, come up with a strong summary statement. Start off with "in summary" to get people's attention. Gather your pertinent data and make a short differential to **demonstrate your clinical thinking** (even if it's a classic presentation, verbalize your differential—otherwise they have no way of knowing if you've considered other possibilities). For example: "68y/o male smoker with history of hypertension presents with productive cough x 3 days, decreased breath sounds and dullness to percussion in right lower lobe on physical exam, white count of 18 with left shift, and CXR showing RLL infiltration, *all likely consistent with lobar pneumonia*, but the differential includes TB, lung CA, and pleural effusion." If this is a patient you've been following for multiple days, you don't need a full assessment statement like this – the team already understands what the patient is being treated for, so you can go straight to the plan for the day.

For the plan, go by problem (or, more rarely, by system - usually only in the ICU). Always start with the problem that brought them into the hospital. Even if you are completely wrong about the plan (it happens, you get used to it!), you'll look good for trying. Try your best to read about the patient's condition and suggest possible diagnostic tests that could be helpful if the diagnosis is not yet clear; stay updated on any changes since the previous day and try to come up with your own suggestions for how to address them. Easier said than done, but it's good practice for being an intern and is impressive to attendings!

**The first few days matter the most.** Your team will set expectations for you based on what you show in the beginning. The afternoon/evening of the first day (or whenever you first get a patient assigned to you), pre-write your presentations for your patients using notes in the chart as a reference; look up your patients' conditions, testing, and treatment; and make a treatment plan including medications with doses, diet, consults, and possible disposition. The next day, come in twice as early as you think you'll need to pre round (aim for at least an hour before rounds) on your patients. If you nail the first few days, you'll feel more confident and the team will be more likely to trust you. It's a lot easier to start by presenting your best self than feeling like you're playing catch-up the whole clerkship.

**Preceptor presentations.** In some clerkships, notably internal medicine, you will meet with a faculty preceptor once or twice a week and practice presentations with them. This is a good opportunity to give a thorough presentation and show off your clinical knowledge. Try to read up on the patient's disease before preceptor sessions and discuss some clinically relevant information (e.g. how suspicious are you for PE based on Well's criteria, how severe their pancreatitis is based on the Ranson criteria). Also, you don't have to specifically memorize any part of your presentation, but you should know your patient well enough that you can give your one-liner assessment without reading straight off the paper. The write-ups you submit for preceptor sessions should also be more detailed than your typical notes, and the assessment and plan should include a full differential with supporting evidence and a rationale for the proposed treatments. It also helps to choose a patient who lends themselves to an organized write-up (e.g. great historian, consistent story and PE findings, good differential).

**Be true to yourself.** It can feel impossible to impress your team, research

everything about your patients, write impeccable notes, do all the clerkship requirements well, and prepare for the shelf. Make sure you make some space for you and your values; take some time every now and then to remind yourself why you came to med school and to learn something for yourself. Take time for yourself as much as possible on the weekends and evenings to relax, spend time with loved ones, and recharge.

## **Write-ups**

**Who reads them?** The notes you write in Epic will be read by your primary team and anyone seeking information on the patient. You will also choose several notes to submit to your preceptor or other clerkship faculty for grading; you will probably expand on these before submitting them (e.g. more discussion of the differential diagnosis, more justification in the assessment and plan).

**Be thorough.** A polished write-up is a great way to let your knowledge shine — especially if you are someone who tends toward the quiet side on the wards. Preceptors will definitely notice the student who puts earnest effort into the write-up and includes a full discussion of the differential. A well thought out discussion of differentials (and what supports and refutes each) in your assessment and plan will always garner positive reviews.

**Look at the rubric.** Most clerkship directors put the grading rubric for write-ups on blackboard. Look at this before you do your write-up. You'll notice that clerkships stress different aspects of the write-up. Ambulatory care, for example, wants a much more extensive social history than inpatient medicine. Peds, similarly, has several categories on the write-up that don't exist in adult medicine. Be meticulous and you will do well!

**Evidence Based Medicine (EBM).** Some preceptors/clerkship directors really like to see attention to evidence based medicine in the write-ups. They usually make their expectations clear (if they don't, ask!). Some people weave EBM into a narrative "discussion" section of the write-up; others just add footnotes to the plan. This is another good way to impress whoever is grading your write-up.

## Studying for the Shelf

**Shelf format.** The Shelf exams are 110 questions, 2 hours and 45 minutes long. They are taken online and these days are taken remotely, with proctoring over Zoom. Many students really like this, as you can take your shelf anywhere you like (home, Annenberg, vacation, etc), and some even use shelf Friday as the first day of a long weekend trip. You can use your own computer or borrow one of the OCS laptops (recommended if you have a Mac since sometimes the NBME shelf software is finicky on Macs), and you can also ask OCS to set you up with a quiet spot in Annenberg to take your exam if you prefer that. You will receive detailed instructions on how to test the exam software and make sure it runs on your computer at the same time as Zoom - make sure you do this prior to the day of the shelf to avoid any nasty surprises.

On the shelf, the vignettes are long and many people feel pressed for time—be aware of your pace and keep an eye on the time. There are no official breaks, but you are allowed to go to the bathroom (though time will keep counting down on your exam). You are allowed a piece of scratch paper. The NBME publishes a breakdown of the content of the test (i.e. 20% cardiovascular disease, 10% endocrine, 10% genitourinary, etc) and a set of 20 practice questions for each shelf (which are much easier than the actual shelf). That information is here: <https://www.nbme.org/assessment-products/assess-learn/subject-exams> (go to Exam Content → Clinical Science → shelf of your choice).

**Focus on the basics.** These exams tend to cover the bread-and-butter of the specialty. You are expected to understand classic presentations of common diseases for the most part. Questions commonly ask what the most likely diagnosis is, how to diagnose (e.g. the best lab or imaging study to order), how to treat, and what are the most common complications of treatment. Questions on pure pathophysiology or mechanism of action are much less common.

**When to study.** Short rotations go by FAST, so many people start doing questions right from the beginning. Even if you just do a little studying every night, it will add up. It's also okay to spend the first week or so of each clerkship devoting most of your time to your clinical responsibilities (reading on your patients, prepping for rounds) so that you establish yourself as a conscientious student. Then, toward the end of the rotation, you can spend more time focusing on your shelf studying without feeling like you've neglected your clinical role. Some students, alternatively, prefer to focus on clinical responsibilities during the week and just try to do a lot of questions on weekends.

**Use UWorld / AMBOSS, NBMEs, and Lauren Linoowski's suggestions.** At the



beginning of each clerkship, the amazing learning coach Lauren Linkowski will send you an email with her recommended resources and strategies for studying for that particular Shelf exam. Generally, most students use UWorld / AMBOSS questions as the backbone of their studying. Many students will try to get through all (or most) of the UWorld / AMBOSS questions for a shelf one time and very carefully read and learn from the answer explanations; however, some students find it more helpful to go a bit more quickly through the questions and try to get through all the questions for a shelf 2 or even 3 times before taking the shelf (or at least do their incorrects). If you're using AMBOSS, you can also take advantage of the "Study Plans" for each clinical clerkships & shelf exam. For ACG, since they do not have an ACG-specific study plan, you're better off creating custom Qbank sessions using the "Ambulatory Care – Shelf" exam tag.

It is also generally helpful to take some of the practice NBME exams as the question style is a little different and you can get a specific predicted score (find them here: <https://www.mynbme.org/s/login/>). If you take several of them, you will start to see the common conditions and presentations that keep coming up, and some students find this helpful as a way to guide the rest of their studying.

You may or may not add on either a text or a video resource for each shelf to help you get the basics down; Lauren will make recommendations for which ones are good for each shelf. **OnlineMedEd** is a popular, free resource that has videos covering the bread-and-butter content for each shelf; some students use this as a primary resource throughout the year. **Dr. High Yield, Divine Intervention, and Emma Holiday** also offer great shelf reviews for each clerkship. Many students like to watch these videos either during the first week of each rotation to get a broad overview of all the topics that will be covered on the shelf or during the last week of the rotation as a review.

**Think about Anki (or not).** Anki is much less ubiquitous in the third year compared to the preclinical years. Many shelf questions will ask you to interpret a general clinical picture, apply a clinical algorithm, or otherwise use your instincts on how best to approach a patient. These skills are not always Anki-able! However, if Anki works well for you, some students do like to use a deck (common choices include **Cheesy Dorian** or **Anking for Step 2**) to study for their shelves. Also, the general thinking is that you do not need to keep up with cards from old clerkships after they've ended. **Pro tip:** If you're using AMBOSS to study for shelf exams, you can use the "Get Anki cards" button to help you select relevant Anki cards more efficiently.

**Don't forget you can postpone your Shelf due to inadequate academic readiness!** If you're not feeling prepared, you can postpone any Shelf and take it at a later date after consulting with Lauren. This may affect



whether your Shelf score can count towards the criteria for Honors, but there are other ways to meet the criteria, so you should feel empowered to postpone if you need to.

**You are not alone in your Shelf studying.** Lauren is, as always, extremely helpful in guiding your studying if you make an appointment with her, and if you need it, she can set you up with a peer tutor (usually an MS4 who has completed the clerkship) to help you with your studying.

## **Preparing for DOs**

**Psychiatry and Neurology clerkships have DOs in the Morchand Center.** The DOs (Direct Observations) are OSCEs where you work with an SP and are graded based on a checklist. These occur at the Morchand Center, mostly on a weekend half day. Every clerkship has one history DO and one physical exam DO, with the exception of peds, which has no physical exam DO. Sometimes both the history and the physical exam refer to the same patient/clinical case, whereas sometimes they are two entirely different cases, so be sure to double-check the information the clerkship director sends you about each clerkship's specific DO. The other unique DO is the OB/GYN physical exam DO, which you do on a SIM model rather than on a real person.

**Use the checklists provided.** The clerkship directors have compiled checklists of what you are expected to do on your DOs – these are the checklists the SPs will use to grade you, so they are extremely helpful! Use them to rehearse what you'll say or do a few times in advance. If you're rusty on certain physical exam skills, the ASM physical exam videos are a helpful resource to return to.

## **Other clerkship assignments**

**These vary by clerkship.** In addition to write-ups and DOs, which you'll need to complete in some form for every clerkship, there are various other assignments required for each clerkship. Smaller, scattered assignments may include having a resident fill out a form after watching you take a history or do a physical exam; keeping track of certain topics you have seen or small procedures you have done; taking weekly quizzes; participating in a TBL session; completing Aquifer modules; completing clinical reasoning assignments on Blackboard; and/or others. Listen carefully during orientation and look at the clerkship information sheet (CIS) at the beginning of each clerkship to make sure you know what assignments you have to do and when they are due. For the most part, these smaller assignments don't require much prep or outside studying.

## **Evaluations and Grades**

**Grades.** The stress of third year is compounded by suddenly having to worry about grades after two years of pass/fail. However, now that you are working with a criterion-based grading system, hopefully some of the pressure will be taken off. In addition, remember that Sinai students match very well, and you will have a great career even if you don't happen to get straight Honors in every single rotation.

**Honors/Pass/Fail.** For each clerkship, there is a set of criteria that tell you what you need to do to qualify for "pass" level or "honors" level in each category. If you reach "honors" level in the majority of the categories, your overall grade will be Honors; there is no longer a curve for grading. The clerkship directors will share the criteria for the specific clerkship when you start the rotation, so you will know exactly what you need to do.

**Know who evaluates you.** The criterion-based grading system should take some of the pressure off evaluations, but your evaluations are likely to still play a part in your final grade, and comments from your evaluators will still end up in your clerkship narratives, so it's worth making a good impression. If you know who will evaluate you, try to make sure that they have adequate opportunity to observe you. Some rotations let you choose who evaluates you, so keep this in mind early so you aren't scrambling for evaluators at the end of the rotation.

**Discuss expectations at the start of the rotation.** Residents will often be happy to chat with you on day 1 or 2 regarding what they expect of you. This can help you find your role, and inform what you need to do to exceed their expectations. Often students feel uncomfortable broaching this subject, especially shortly after meeting your resident, but it is a valuable conversation to have and can help with building the resident-student relationship early on.

**Get early feedback.** Touch base with your residents early (at the end of the first week) to see how you're doing. This can help you be a more effective part of the team and give you the opportunity to demonstrate to your residents that you take their feedback seriously and can put it into action. It is helpful to give someone a heads up that you'll be asking for feedback, so that they have time to gather their thoughts. You can certainly ask attendings for feedback throughout the clerkship as well – many are impressed when students take the initiative to do this. In addition, informal verbal feedback is great, but written feedback is even better – this way, if your grade at the end of the clerkship doesn't match what you were told during mid-clerkship feedback, you will have specific evidence to show.

**Talk to the clerkship directors.** If you don't understand how your final grade was determined, the clerkship directors are very willing to sit down with students and go over it. You may get some valuable advice to apply toward your future clerkships. Rarely, something might happen during a clerkship such that you may feel a specific person won't give you a fair evaluation. If that happens, it's best to be proactive and explain your concerns to the clerkship directors before evaluations are turned in. They want to hear about problems students are having on their rotation, and it is wise to voice your concerns as they arise, not when the clerkship is over. Certainly if there are any issues with racism, sexism, bias, etc, the clerkship director would like to hear about these and address them sooner rather than later.

**Grade appeals.** If you truly feel your final grade is incorrect or unfair, there is a formal grade appeals policy, which you can find in the student handbook: <https://icahn.mssm.edu/education/students/handbook/grading>. Read it carefully and be aware that you have to start the process (at least contacting the clerkship director to set up an initial meeting) fairly quickly after your grade is final (grades are released within 6 weeks of the conclusion of the clerkship rotation). Many grade appeals result in no change in the final grade, but it is a resource you should at least know about.

**Letters of recommendation.** If you have an excellent experience with an attending, consider asking them for a letter of recommendation. You will have partial access to ERAS (the residency application system) during third year, so LORs can be uploaded. If possible, it's best to ask soon after you work with the attending so that they still remember all the great things you did and can write a more personal letter. Always offer to provide letter writers with resources, such as your resume or some reminders about patients you took care of together, to help jog their memory of you and strengthen their letter.

## **General Resources**

**UWorld & other question sources.** Sinai will provide you with a yearly subscription to AMBOSS, which has more than enough questions to use as your primary source for shelf preparation. The practice NBMEs are also a good resource. Some students prefer UWorld or a shelf-specific prep book (e.g. Blueprints or Step Up to Medicine) as an additional question source, but it's generally a personal preference.

**Limit your books.** Lauren will recommend either a textbook resource or a video resource for each clerkship; don't overload yourself with too many resources. There is not a lot of time for reading during your clerkships, so don't put pressure on yourself to get through an entire textbook. Also, **do**

**not break the bank** with study resources – almost everything (other than UWorld which Sinai pays for) can be found free online or through the Levy Library.

**UpToDate.** The most useful resource for the third year student. You can download the app for easy access from your phone as well. Contact the Levy Library - we do have an institutional account.

**NEJM reviews.** NEJM periodically publishes review articles focusing on the latest understanding of the pathophysiology and current treatment strategies for various diseases. These reviews are more detailed than UpToDate and give a better understanding of the current challenges with respect to the clinical management of that disease process.

**Cochrane Reviews.** They publish systematic reviews of the literature aimed at answering a clinical question, usually regarding the efficacy of treatment. An excellent source for evidenced based medicine and for understanding or questioning the standard of care.

**Levy Librarians.** They are a majorly underused resource. If you ever need help finding good resources or researching something, consider asking for their assistance. They are true search wizards.

**Procedural skills.** Most of the time, your resident will be watching you like a hawk and talking you through exactly what to do when you are doing a procedure, especially for the first time (e.g. placing a foley catheter, IV, or NG tube). However, for your surgery and OB/GYN clerkships, it's good to try to teach yourself some basic scrubbing, knot-tying, and suturing skills ahead of time as they require some practice and you may be expected to do some of them on day 1. Here are some helpful videos:

- Traditional scrubbing (always do this for your first case of the day):  
<https://www.youtube.com/watch?v=WpZqLbWL0c0>
- Scrubbing with Avagard (usually can do this after the first case of the day, but some attendings don't like Avagard, so check with your resident): <https://www.youtube.com/watch?v=DhIIQskLhKU&t=1s>
- Two-hand knot tying (you can practice at home with a piece of dental floss): <https://www.youtube.com/watch?v=o8OqxTGaS7o&t=11s>
- One-hand knot tying (practice at home with dental floss, it takes some getting used to):  
<https://www.youtube.com/watch?v=uFJbTbjEU4Y&t=132s>
- Instrument tying: <https://www.youtube.com/watch?v=eh74OqUwMz4>
- Suturing (don't worry about the fancy ones like vertical and horizontal mattress): [https://www.youtube.com/watch?v=TFwFMav\\_cpE&t=2s](https://www.youtube.com/watch?v=TFwFMav_cpE&t=2s)
- Male urethral catheterization:  
<https://www.nejm.org/doi/full/10.1056/nejmvcm054648>

- Female urethral catheterization: <https://www.nejm.org/doi/full/10.1056/nejmvcm0706671>

## Logistics

**Where do I put my stuff (storage)?** For the most part, it's totally okay to bring a backpack or bag to the hospital. On almost every rotation, there will be a team room, resident room, or lounge where you can safely store your things. A notable exception is the IM rotation at MSH – you will have to use the lockers in the student lounge (or just carry everything you need in your white coat pockets). It may also be harder to find a place for your things in the ED if you are there on peds, psych, or elective. Check out the CIS to find these storage areas. It also provides you with areas to relax and study per clerkship site.

**What will I eat?** Most of the time, there will be a fridge where you can put food, so you should be able to bring your lunch if you want to; however, this isn't guaranteed, so on the first day of a new rotation, you may want to plan on buying lunch rather than bringing. Most students end up buying lunch in the cafeteria most days anyway. Most residents are good about sending you to lunch in the middle of the day, but on busier rotations like surgery and OB/GYN, you may want to stash an energy bar in your scrub pocket in case you don't have time to leave the floor to eat a meal.

**What will I wear?** Almost always, scrubs. For hospital scrubs, the scrub machines on GP3 are a convenient place to exchange your scrubs every day (on OB/GYN, the machines on KP4 are most convenient). Occasionally, you might wear business casual clothes instead (e.g. during outpatient portions of ACG); if you have any doubts, just ask the clerkship director during orientation on the first day of the rotation.

**What should I carry on with me?** It's helpful to keep your ID and a credit/debit card on a lanyard so you can easily access them anytime and don't have to worry about leaving them behind somewhere. Carry at least 2 pens (attendings will "borrow" them) and your phone on you all the time (this is usually easy because you will almost always be wearing scrubs which have plentiful pockets). For most rotations (IM, ACG, peds), you will want to carry your stethoscope around your neck. That's pretty much it! Sometimes you also may want to have a snack in your pocket or wear a white coat stuffed with supplies for dressing changes (see the surgery clerkship-specific tips below), but not universally.

## Epic Tips and Tricks

### General Tips

- Find out what your team likes in notes - they may want you to use a standard resident template.
- Make your own patient lists - you can put your favorite patients on and

see if they have new lab results or notes, or you can add the team you're on currently.

- Choose pertinent categories for the columns of your patient lists: age/gender, recent vitals, attending, length of stay, diet, to-do list, etc. If you have to print lists for your team, they may want specific columns in a specific order; ask the residents what they want.
- If the note you're working on is in a separate window, anchor it to the right side of your screen by clicking the little black and white icon in the upper right of the note window. Now you can work on the note and read the chart at the same time.
  - Addendums: no shame in editing your notes.
- Shortcut to copy a note from the previous day - it's one of the buttons above the text box when you write a note.
- Pended a note and getting back to it hours later? Update vitals etc by clicking the refresh button in the text box.
- There is a treasure trove of patient-friendly information (many with Spanish translations!) available by clicking the Epic menu, then tools, then clinical references. Topics include medical problems, drugs, PT exercises, and more. Lots of good illustrations too.

### **EPIC Smartphrases (aka dot-phrases)**

**.vs** - displays most recent vitals (also **.vitalsM** - displays chart of four most recent vitals and **.vitals24** - displays current vitals with 24-hour range)

**.thisvisit** - displays all labs for current outpatient visit or admission. Good for H&Ps.

**.24hrlabs** - displays all labs from last 24 hours

**.labs** - displays an "F2" menu to select the most common recent labs (CBC, BMP, coags, etc.)

**.meddetails** - displays table of current medications with dose, route, and frequency

**.radrcnt[xw]**, where x is the number of weeks - displays radiology reports for most recent x weeks (can also use h for hours)

**.urineoutput** - displays ins/outs (also try **.io**)

**.bpfa** - BP percentile base on gender, age and weight - useful in peds

You can also make your own dot-phrases. Click the Epic button in the top left, then tools, then explore the smartphrase options.

## **Apps**

**EPIC Haiku.** An Android and iPhone app, you can get this through library website – a great app to check on patients at night, pre-round from bed (you obviously still need to see your patients but this can give you a quick look at labs, recent vitals, and recent notes), and quickly access results while on rounds. Instructions for setting it up are here: <https://libguides.mssm.edu/apps/sinai> (also included are instructions for setting up Canto - the same app as Haiku but for your iPad instead of your phone).

**UpToDate.** For the Android and iPhone apps, you will need to create an individual account. As long as your account has logged in to UpToDate on the Mount Sinai network within the last 6 months, you will be able to access UpToDate through the app with the hospital's subscription.

**Doximity.** Has many functions but among the most useful are that you can create a personal fax number (faxes will come straight to your phone) and make phone calls (e.g. to patients' family members) without your personal cell phone number showing up to the recipient.

**MedInfo App.** The MedInfo App (<https://ismms-md-program.gitbook.io/medinfoapp>), which you can download to the home screen of your phone, is packed with clerkship specific items such as the psych interview, neuro exam, and disease screening guidelines. Very helpful to check out throughout the year.

**Epic Chat, GroupMe and WhatsApp:** Commonly used by teams to quickly communicate between all of the residents and students on the team.

**MDCalc.** This app has useful formulas and is often used by house staff for calculations.

**USPSTF.** Helpful for screening recommendations, especially during ACG.

**Amion (amion.com).** This is where you find pager or phone numbers of consultants you need to page. There is an app, though the desktop version of the site is easier to navigate.

**Micromedex and Epocrates.** Excellent apps for drug information.

**Sinai Specific Apps and Websites:** These mobile websites can be saved to your phone's home screen as an "app."

**Inpatient Medicine:** <http://inpatient.careteamapp.com> Under the "Contact" tab, you can search for phone numbers of various inpatient

areas (very useful! Frequently your resident may ask you to “call down to expedite a patient’s imaging” – this is where you find the number to call). Otherwise generally meant for residents but has lots of useful guides and logistical information that will be useful during any inpatient rotation at Sinai.

**Anesthesiology:** <http://gas.careteamapp.com> Great resource for the Anesthesiology rotation and also includes useful links to OR schedules for the Surgery rotation.

**OB/GYN:** <https://ismmsobgyn.glideapp.io> Created by the OB/GYN co-clerkship director and has tons of information helpful for that specific clerkship.

### **Paging**

On many rotations, you will need to page consultants for help with clinical questions about your patients. Here is the process for doing that:

1. **Make sure you know your patient and the consult question.** You should be able to give the consultant a quick one-liner about your patient’s PMH and why they are in the hospital. You should also have a very specific consult question in mind and know all of the information relevant to that question – if this information is unclear to you, ask your resident before you call!
2. **Go to amion.com.** Type “mssm” in the “Access Code” box and look for the service you need to consult.
3. **If you can click on the phone or pager number, send a text page.** You have very few characters to use, but give a tiny bit of background about your patient, what the consult question is, and most important your name and callback number (you can usually use your cellphone).
4. **If there is a phone number but you can’t click on it, call the number.** And discuss your question with the very nice and helpful person who picks up.
5. **If there is a pager number but you can’t click on it, page it.** From any hospital phone, dial “41300.” The system will prompt you to enter the pager number, then enter the number you want to be called back at. You can give your cell phone number or the number of a hospital phone if you’re going to be sitting next to that phone for a while. To know the 10-digit number of that hospital phone: the first digits are always 212-241- and then the last 4 digits are the last 4 digits displayed on the screen of the phone (e.g. if the phone screen says “47776” the full phone number will be 212-241-7776).

### **Wellness**

**The first week of every rotation is challenging.** Every few weeks you’ll be in a new environment, with new people who have different expectations of



you than the last setting you were in. This is the most disorienting part of the year and it's always hard settling into a new rotation. Try not to stress – after a few days, you'll know where you're supposed to be, what you're supposed to be doing, and will feel more comfortable.

**Take a break/vacation.** You should feel free to use as much elective time as you want for vacation. **You will have more elective time than you know what to do with fourth year**, when your schedule is light and you don't need a break as much, so give yourself a break from the stresses of third year.

**Don't get trapped in the bubble.** Despite the demands on your time, it's important to maintain the relationships and activities that are valuable to you. You can take a night or weekend off from studying to go out to dinner, visit a friend, or attend a concert. It's great to have something to look forward to at the end of a long week. Plus, with so many people evaluating you, it's important to maintain a sense of self outside of your grades. You are more than a med student!

**Reflect.** There will be many intense experiences during the third year. Most people experience patient death for the first time. Whether it was a difficult operation, a challenging patient encounter, a crazy experience in the ED, or an upsetting event that you witnessed, take time to process what happened. Talk to your classmates about what you've seen; it's cathartic, and most of them will have something to share as well. In the past, one specific source of support has been **Circles**, a program where you meet with a small group of classmates and 1-2 psychiatrists (not affiliated with Sinai) monthly to debrief (and get UberEats vouchers!). This slightly more formal venue for reflection has been helpful for many students in addressing the challenges of third year.

**Use resources, including mental health ones.** This year is hard, and many students struggle throughout it. Nothing is more important than your own health – don't hesitate to make an appointment at STMH, Student Health, or wherever you prefer if you are suffering.

**Please try not to be too nervous.** The transition to third year can be very stressful for a lot of us, but it doesn't need to be. Rest assured that the vast majority of people you interact with this year (residents, attendings, staff, patients) want to help you learn and feel welcome in the clinical setting.

**Be yourself!** We all have our particular strengths that suit us well to medicine. Some are extroverts who get along with their residents immediately; some are super compassionate and have wonderful bedside manners; some have excellent clinical knowledge and enjoy thinking about

basic sciences. Don't be nervous if you don't fit every single one of those criteria naturally. Lean into your strengths and don't feel you have to change who you are to fit in better with your team or on your service.

**Providing humanistic care.** In general, you will have more time and less responsibility than any other member on the team. You can use this to your advantage to get to know your patients better and help support their psychosocial needs. Not only will this help alleviate your patients' discomfort and suffering, but it will be rewarding to you personally. We've found that the biggest barrier to this can be shyness or anxiety around not knowing what is appropriate to do for patients. Herein we provide tips and tricks to help you know what you can always safely do for patients in order to make their hospital stays better. In general, if you proceed with respect, humility, and a desire to make your patients feel better, you will succeed.

## General Tips:

### Direct Patient Interaction

- Always introduce yourself to the patient (first!) and any visitors
- Ask the patients and their families if they have any questions or needs before you leave the room; answer what you can and defer questions you are unsure of (but make sure to ask the clinical team and *come back* with answers)
- Figure out your patients' music/tv show interests; it can help you connect
- Ask your team whether it is okay to defer pre-rounding if a patient is sleeping (this varies by specialty - surgery more likely to wake patients than psych - and attending)
- If you must wake a patient: apologize, use as little light as necessary, and turn off lights as you leave the room

### How We Talk About Patients

- Avoid using a patient's diagnosis as an adjective (i.e. do not say "schizophrenic/diabetic/hypertensive/asthmatic/alcoholic patient", but rather "patient with schizophrenia/diabetes/hypertension/asthma/alcohol use disorder")
- Don't trade patient's stories like baseball cards (i.e. use discretion, maintain respect, be thoughtful about why you are sharing - i.e. is it for educational purposes?)
- Recognize that there are legitimate reasons for patients to refuse treatment (side effects, not in line with their goals of care, etc) & that this should not affect our opinion of the patients
- Sometimes you will dislike your patients or feel a closer attachment to them; be mindful of how these feelings are affecting your plan of care
- Be mindful of patients with conditions that are life-long; their frustration towards their illness can sometimes manifest itself as annoyance or hostility toward the medical team

### Family Members/Loved Ones

- Keep family members updated on the patient's care
- Ask a patient if he/she has pictures of family (especially kids or grandkids)
- The hospital operator can make courtesy long-distance calls to family members/friends

### Supplies

- Know where the warmed blankets are located and distribute liberally
- If a patient's back/butt is exposed, get a second gown to cover them
- Find out where the pantry (for juice, snacks) and extra linens (and pillows, if you are lucky!) are located on each floor
- You are allowed to bring patients outside things (specific foods, newspaper, etc.); check with your team, but you can do this if you feel comfortable with the effort/cost

## SPECIFIC CLERKSHIPS

### INPATIENT MEDICINE

#### Clerkship Information Summary (CIS)

Review this document before you begin: [Inpatient Medicine Clerkship Summary](#)

#### Structure

The clerkship is 5 weeks of inpatient (2-3 weeks at Sinai and 2-3 weeks at another training site):

#### A Typical Day on Inpatient Medicine

1. **Signout.** This is when you meet up with the intern who was covering your patients overnight so they can update you on any overnight events. This happens at 6:30 at Sinai and at variable times at the away sites. Sometimes, your resident may not require you to come to signout (this means you can usually sleep a little later) – you can catch up on overnight events for your patients by reading their chart; talking to their nurse; and asking your day intern what they heard during signout, which they are usually happy to share.
2. **Prerounds.** Usually it's easiest to chart review first, then go see your patient. Things you should focus on:
  - a. Events from the last 24 hours, including overnight (e.g. was a rapid response called? Did important imaging come back?)
  - b. Vitals over the last 24 hours (Try to list them as a range of min-max in this order: Temp, HR, BP, RR, O2 sat). If patient is on any kind of respiratory support (nasal cannula, bipap, ventilator), remember to check the settings (i.e., X L of NC, "ventilator settings= Tidal Volume/RR/PEEP/FIO2)
  - c. Labs, both daily labs (e.g. most medicine patients will get a CBC and electrolytes every morning) and any older labs that may take a few days to come back. Make sure you are noting trends in the labs and, if there are abnormalities, thinking of possible etiologies. Remember to check back for culture growth if your team sent blood/fluid cultures earlier in the week!!
  - d. Imaging, if there's anything new since yesterday. Try your best to look at the actual images yourself, but check your work with the written impression (radiologists exist for a reason)
  - e. Consultant recommendations, if there are any recent new ones. These will be stated in the consulting services' notes and are

very helpful in forming your plan for the day

- f. Once you're done chart reviewing, go see your patient. You can do a very brief, focused history (is anything bothering them this morning? How is their abdominal pain compared to yesterday?) and exam
3. **Meet up with your residents.** The senior resident may quickly discuss the patients on the team's list in advance of rounds and/or ask you if you have any questions about your patients before you present them.
4. **Rounds.** These start at 8AM at Sinai and at variable times at other sites. You will give SOAP updates on the patients you're following and hear about all the other patients on your team along with your residents and attending. Take a look at the "Presentations" section in the first section of this guide for tips on presenting.
5. **Work time.** The late morning and early afternoon is usually when you get most of your work for the day done – calling consults, pending orders, helping out your team by getting home medication lists, etc. When you've done your time-sensitive tasks, you can work on your SOAP notes for the day for your patients.
6. **Noon conference.** On some (not all) days, you will have a required MS3 noon conference (lecture). There is usually free lunch available when you are at Sinai or Elmhurst.
7. **Preceptor sessions.** Once or twice a week (not every day), you'll meet with your preceptor in the afternoon to practice presentation and physical exam skills.
8. **Work time.** Any extra time you have in the afternoon, especially if there's no noon conference or preceptor session for you, is devoted to finishing your work and your notes for the day. You can also use this time to go back and talk further with your patients/ check in with them to see if they have any questions about the consultants who may have come by to talk to them during the day.
9. **Running the list.** This just means talking with your residents (and sometimes attending) about what's happened during the day for your patients, what needs to be done, and any updates that are new since morning rounds. You can give a quick update on each of your patients if you like. However, your presence at this point is not essential, and your resident may send you home before it's time to run the list if you've finished all your work.
10. **Long call.** Once a week, you're expected to stay late, usually until about 8PM. You can usually pick which day you do this, but it's best to pick the day your senior resident is also on long call. The main goal of call is to do an admission, meaning you will see a patient in the emergency room who needs to be admitted to the hospital. Along with



your resident, you will take a history, do an exam, and write a thorough H+P note; you should also be prepared to present this patient thoroughly on rounds the next morning.

11. NOTE: **Nighfloat is paused for academic year 2025-2026**: One of your weeks at MSH will be a **night float**. You work Sunday night to Thursday morning with hours of roughly 10PM to 9AM. You will NOT show up for the clerkship before that time. During this rotation, which you will help the night float intern do admissions for your team. Usually you will work on one admission, which gives you lots of time to dig through their chart carefully, read about their condition, and write a really good admission note – it's actually kind of a nice learning opportunity. You'll present this patient to the team on rounds the next morning (and then go straight home – you are not expected to stay for the rest of morning rounds). You can also help your night intern with "cross-coverage" events, i.e. helping as things arise for patients on the list. If the list for your team is capped, you may help other teams with admissions if they're being slammed.

## **General Advice**

**Take ownership of your patients.** This is the key to this clerkship. You should try to know every aspect of their pathology, medications, and hospitalization course, but also get to know them on a personal level, which can help guide medical management in-house and at discharge. It's impressive if you can take charge of doing all the work for your patients, including calling consults, pending orders, updating family members, writing notes, thinking through the logistics of discharge planning, and more.

**Be an advocate for your patients.** Make sure they get that X-ray, family meeting, translator, special dietary request, whatever you can do to help them navigate the bureaucracy and maze that the hospital can be. There is usually time after rounds to go back and spend more time with your patients once you have finished calling consults/writing your notes. Use these opportunities to get to know your patients and to understand how you can best support them during their hospital stay.

**Use the primary literature.** When there is a clinical question or when an attending or resident asks you to look up a topic, see if you can find an article that answers a question specific to your patient. Bring in copies for everyone else on your team or (perhaps better) type up a quick summary of the article's main points and application to your patient and print one for each member of the team. If your team never asks you to bring in an

article, you can still take the initiative to do so. Some sources students have found helpful in the past include UptoDate, the “In the Clinic” series published in the Annals of Internal Medicine, NEJM clinical review articles, and DynaMed (provided through Levy Library). Also recommend carrying a small notebook or just keeping a note in your phone of topics that come up during the day that you are unsure of or sound interesting. This can be helpful when your residents put aside time for teaching in the afternoons and ask you to provide topics that you want to learn about.

**Note: Nightfloat is suspended for AY 2025-2026. Some night float-specific tips.** Lots of students are nervous to try to flip their sleep schedules for the first time. Don’t worry – it’s not as hard or as terrible as it sounds. If you start night float Sunday night, try to stay up late the preceding Friday night and then even later on Saturday night, and sleep as late as you can in the mornings. Buy blackout curtains for your windows (seriously, this is a game-changer) and put on white noise in the background so you can more easily sleep during the day. You might not sleep as much during the day as you would at night, but you’ll be tired after your shift, and your body will get the sleep it needs. Bring snacks or a meal to the hospital at night (there is a fridge in the resident room), but don’t feel like you have to eat since you may not naturally feel hungry during the night. Keep some comfort foods around at home – things you wouldn’t mind eating at any time of day since your dinners/breakfasts will be weirdly swapped (chicken soup for breakfast? Sign me up).

**Enjoy!** This is one of the rotations where you learn the most and get to take the most ownership over your patients. By the end, you will be shocked at how much you’ve learned and how much more competent you feel. Of course, this also makes this clerkship very challenging, so lean on your classmates and support systems when you need it.

## **Resources**

**UWorld.** As always, UWorld questions should be your primary resource. There are 1100+ medicine questions, so you should not expect to get through all of them in 6 weeks – don’t worry, many students before you have not finished medicine UWorld and have done just fine. Do try to do at least some questions from each organ system.

**Step Up to Medicine.** If you’re interested in using a book, this is the one for this clerkship. It’s free online through the library, or you can buy a physical copy for about \$50 on Amazon. This book remains a great resource through

ACG and neuro as well; you can also consider starting out with **Step Up to Step 2** right away – it's basically the same as Step Up to Medicine but with a few extra chapters covering psych, peds, OB/GYN, and EM. For students who learn well by writing, a helpful strategy is to annotate your copy of Step Up as you go through UWorld.

**OnlineMedEd.** These free videos can provide a nice overview of the material if you're a video person. Alternatively, you can try the comparable products from Sketchy, Osmosis, or Boards & Beyond if you are a lover of any of those series.



## AMBULATORY CARE-GERIATRICS

The Ambulatory Care-Geriatrics rotation is 6 weeks long. This includes 1 week of inpatient palliative care, 1 week of outpatient geriatrics, 1 week of inpatient geriatrics, and 3 weeks at your ambulatory site. The details and schedule of this rotation vary greatly with site. Generally, the hours tend to start at 8-9am until 4-5pm, but keep in mind you may have a commute to and from your site as they are scattered all over the city. Didactics are all day on Fridays, and weekends are completely free.

### **Clerkship Information Summary (CIS)**

Review this document before you begin: ([ACG Clerkship Information Summary](#) – currently updating)

### **Focus**

One theme of this clerkship is the importance of biopsychosocial aspects of disease. You should take extensive social histories and be sure to present a thorough socioeconomic portrait of the patient when you present to preceptors. Social determinants of health are also key for your case conference presentation (see below).

**Geriatrics outpatient:** You will generally work with 2 attendings during your geriatrics days, one in the morning and one in the afternoon. You're usually expected to email your attending in advance to introduce yourself and to read up on the patients that you are scheduled to see. Show your enthusiasm by taking thorough H&Ps, asking lots of questions, and when appropriate looking up EBM/articles to help with your differential. Become comfortable with the mind and mobility tests outlined in the competency and skills checklist provided (e.g. Get Up and Go test, MoCa) – these will serve you well on the geriatrics OSCE, as well as on psychiatry and neurology clerkships. As always, ask for feedback when appropriate from everyone you work with.

While the patients are less sick than those in the inpatient units, the challenge comes in gathering the relevant information, organizing it into a logical presentation, and coming up with a plan for the attending — **all in a limited amount of time**. Elderly patients often have multiple medical conditions, making organizing and gathering information in a short amount of time even more difficult. Generally, attendings see patients in 10 or 15 minute slots, but as a student you are certainly allowed more time. Another key is to get a grip on managing common primary care problems: hypertension, diabetes, high cholesterol, colon cancer screening, and

smoking cessation.

You may have a half-day of Visiting Docs, where you get a chance to see patients in their home environments and spend a lot of time one-on-one with an attending. This is also a good time to practice the Mini-Mental State Exam and/or Geriatric Depression screen.

**Geriatrics inpatient:** Very similar to your inpatient medicine rotation, but with more of a focus on issues specific to older adults, such as preventing and addressing delirium, safe transitions between hospital and home, and de-escalating medication regimens. Good resources to be familiar with include the CAM (Confusion Assessment Method) for delirium and the tests of attention (e.g. days of the week backward or months of the year backward).

**Palliative care:** This is an intense week that can be emotionally difficult—be sure to talk with friends or faculty and seek support if you need it. You'll be following a team of attendings, fellows, social workers, and/or nurse practitioners as they help patients suffering from terminal or chronic illnesses. Mount Sinai is one of the only medical schools with palliative care built into the third-year curriculum that is not a hospice rotation. You'll be mostly observing this week, but use it as a chance to learn from the experts tips for using sensitive vocabulary in breaking bad news, running a family meeting (learn the SPIKES protocol), and just generally being a good listener who is attentive to patients' and families' needs in difficult times. You will also learn about pain management and patient controlled analgesia (PCA) dosing as well as advance directives and their use in real life medical decision making.

**Ambulatory care:** This tends to be a fun 3 weeks as you get to stay at the same site with the same preceptors for 3 weeks in a row. You will be expected to see 2-3 patients per clinic half-day, including presenting them to your preceptor and writing their notes. You will get very comfortable with the outpatient management of common conditions such as hypertension, diabetes, and hyperlipidemia as well as appropriate screening tests for your patients (important examples include colon cancer screening, lung cancer screening, mammography, CKD screening in patients with diabetes, STI screening). Use the USPSTF app to easily see what screening tests your patient is due for. Also, think about cardiovascular risk in every single one of your patients (MDCalc has a super useful ASCVD risk calculator) and whether they should be on a

statin or getting other preventative care.

**Humanistic Tips:**

- Begin your conversation by asking what most concerns the patient and have a discussion about it (even if you don't have a lot of time and it is non-medical)
- Ask about barriers to receiving medications/making appointments
- Take the time to explain a patient's medical condition to them in lay terms (use drawings, diagrams, etc.) and ask if they have any questions

**Case conference:** Your main non-clinical assignment in ACG is to create a 45-minute presentation for your small precepting group as part of Friday didactics. You will choose a patient and discuss how the patient's social, economic, educational and environmental factors influenced their health problems or access to medical care. The point of this is definitely NOT to talk about pathophysiology; it should be all about the social determinants affecting your patient and his/her care. It also should be engaging, so people like to use PollEverywhere, make up games to play, or use other creative strategies to help your classmates engage with the material. You will also submit a writeup on the same patient which should go into a lot of detail about their social history, social determinants of health, and screening needs.

**Resources**

**UWorld.** Start with the "Ambulatory Care" questions and, if you finish them, move on to internal medicine questions.

**Step Up to Medicine.** The Ambulatory Care chapter provides an excellent overview of the most common medical problems treated in the outpatient setting and a health maintenance section detailing screenings and vaccinations.

**NBMEs.** Of note, the shelf you take for ACG is the Ambulatory Care shelf, not the Family Medicine shelf (this is a good thing because if you haven't done peds and OB yet you will not know anything about those aspects of family medicine). Unfortunately, there are no practice NBMEs for Ambulatory Care, but you can consider taking one IM NBME and one FM NBME (and feel free to ignore any peds/OB questions).

## **SURGERY-ANESTHESIOLOGY**

### **Introduction**

Many students worry about the surgery-anesthesiology clerkship, but most end up enjoying this rotation. The hours are long and it can be hard to get enough sleep, but you will have many unique experiences on this rotation that make it worthwhile. This may be one of the only times in your career that you will be in the OR, so make the most of it.

### **Clerkship Information Summary (CIS)**

Review this document before you begin: [S-A Clerkship Information Summary](#)

### **Structure**

The entire clerkship is 5 weeks long. You will spend 2 weeks on a core general surgery service (you'll be assigned to a specific team - options include vascular, colorectal, surgical oncology, bariatric, and others), 2 weeks on a surgical subspecialty selective, and 1 week on anesthesiology.

For the 2 weeks of core general surgery, you will stay at the same site and on the same team. While the sites are similar overall, they do offer slightly different experiences.

## **SURGERY CORE**

### **Team**

Team makeup varies by service and hospital, but your team will typically be led by a chief resident, with one or two senior residents and several interns. This may also be the case with your surgical subspecialty selective. You may work with more classmates than on other rotations, but this varies. For example, the vascular team at MSH typically has 1 student, while surgery at Elmhurst may have >5 students (combined with students from St. George's). The chief and senior residents assist with the major surgical cases, while the interns do the minor ones. The interns also take care of patients on the floor; they are a good resource for you if you have questions. If you are assigned to the vascular surgery team, you will also

work with interns from other specialties who are rotating through (anesthesia, ortho, general, etc). Unlike most other rotations, the attendings do not round with you in the morning.

### **Preceptor**

You will be assigned a surgical preceptor for the 2 weeks of your core surgery rotation. In general, you are expected to spend at least one day a week with that person, either in the OR or in clinic, though many students prefer to scrub with their preceptor more often than that. This longitudinal relationship is among the most time you will get to spend with an attending during all of third year, and many students, regardless of whether they choose to pursue surgery, have enjoyed the opportunity to work with a preceptor for an extended period of time. Also remember that your preceptor is assigned to evaluate you.

### **Schedule**

The exact starting time will vary depending on your training site. In general, you can expect to be in the hospital by 5-6AM. Check in with your team each night to find out exactly when rounds will start the following day as this tends to change slightly day-to-day. The end of the day is highly variable, and can be from 5-8PM (more rarely you may occasionally get out around 2 or 3 PM if your team doesn't have much going on), depending on the team's census and which cases are running.

### **Call**

**Note: Overnight call is suspended for AY 2025-2026.** At Elmhurst only, you will take overnight and weekend call, but you are post-call the following day (you get to go home). At MSH and other training sites, you are required to take part in 4 evening (extended day) calls (until 9PM). There are no overnights, but you do have to show up the following day. Check the orientation slides for any changes to these requirements.

Students at all locations are required to take part in 1 weekend call shift (either Saturday or Sunday) during their core surgery month. There are no weekend requirements during your surgery selective or anesthesia rotation.

### **Morning Conferences, Grand Rounds, Attending Rounds**

Depending on your training site or team, there will be various other events through the course of the week. Your residents will generally keep you apprised of the schedule.

## A typical day on surgery

The day on surgery begins early. The morning is very busy as there is a limited amount of time for your team to see all the patients (and for the interns to write all the notes) before the rest of the day starts. Surgical teams usually have a higher census than medical services and much less time to round, so be prepared to walk and talk quickly. During rounds, you are expected to present patients and to help with dressing changes (this includes having tape, gauze, etc. on your person - see below). After rounds finish, you'll be heading in one of three directions – the OR, clinic, or conference. In the afternoon when you are done with cases or clinic, you should check in with the intern covering the floor and see what needs to be done, and go check on your patients before afternoon rounds, which happen whenever clinic or the last case is done. After rounds, you go home! Here are more specifics about certain parts of the day:

1. **Prerounds.** Arrive in time to see any patient whose case you scrubbed in on and be prepared to present them to your team. Do a focused physical exam and always inspect the wound or dressing, noting any discharge from the wound (e.g. serosanguinous or purulent) and other signs of healing or infection. Note the presence of drains and catheters and the quantity and type of fluid they are putting out (e.g. bile from a JP drain after a cholecystectomy is an ominous sign). The interns often don't see all the patients before rounds, so the information you collect is very important. Keep in mind that certain teams are extremely busy and may not have you present patients in the morning, but you should still be prepared. If you are at Elmhurst, everyone gets on the same shuttle and arrives at the same time, so there is no expectation for you to preround before rounds with the team. Similar to medicine and other rotations, you should also be chart checking in Epic to see what your patient's vital signs, labs, input/output, etc have been since yesterday.
2. **Presentations.** On surgery rounds, presentations are very brief and structured. Your presentation should be the tip of the iceberg of what you know about the patient. **Your one-liner should include the patient, age, sex, very pertinent PMH that affects post-surgical management, post-operative day, operation, and indication.** Next, report any overnight events, the patient's pain level and pain regimen, diet, nausea or vomiting, if the patient is passing gas or has had a bowel movement, and if they are ambulating. (Before you send a post-op patient home, your chief resident wants to know **5 things: are they eating, walking, peeing, and pooping, and is their pain controlled?**) Vitals and inputs and outputs are very important in the post-surgical patient. Important components of the plan are pain management, diet,

when to stop fluids, drains, catheters, and when the patient will be discharged. Many of these points will also be covered during sign-out, which often occurs right before rounds. This is a process by which the overnight intern or PA goes over any significant overnight events for each patient and will briefly re-cap the plan for the day.

3. **The Bucket (or white coat).** A mainstay of the rounds, there is often a bucket of gauze, tape, and other dressing change supplies carried into each patient's room to aid in dressing changes during rounds. If you don't have a physical bucket, make sure to have your white coat stuffed with 4x4s, kerlex, and tape (at a minimum) to be ready to chip in! During the beginning of the rotation, you can ask other students or the interns where and how to get supplies (you're not expected to know this on day 1). This is especially important if you're on the vascular team!
4. **Evening rounds.** These are fast-paced sit-down rounds that have three main goals: ensure that the to-do list on every patient is complete, briefly review each patient for any changes in status during the day, and discuss the management plan for the following day for any complicated patient and new patients. Depending on how long the day has been, the intern covering the floor will often present all the patients rather than letting the students present, but if you can, feel free to see your patient beforehand and have updated vitals and input/output. Also, depending on what time evening rounds take place, your team may send you home before they even start if your cases and other tasks are done for the day.

## **The OR**

**Try to scrub in on a variety of cases, and prep for them.** Ask your intern to show you how to see the status board in Epic - this is the master schedule of upcoming surgeries. Your chief resident will usually let you know which cases you'll scrub into the next day, or you can divide cases among the students on your team before you leave for the day. Read up on the basics about the surgery the night before, and review the patient's chart so you know why they are having the surgery done (this is probably pimp question #1 that you will get in the OR).

**Meet your patient in the holding area** at least 15 minutes before the case starts, and introduce yourself to the patient, the attending, the scrub nurse, and anyone else who may be involved with the case.

**Help get the case moving** by helping to get the patient on the table, putting on SCDs - sequential compression devices (tell the patient they

are “squeezy boots to help with blood flow”), and offering to shave the patient or insert the foley catheter as needed. Ask the scrub tech if you can bring them your gloves (usually 2 pairs) and if they need another gown. **The scrub tech will typically NOT have gloves or a gown on their table for you**, so you want to give them your materials before you leave the room to scrub. Do **not** just drop your gloves anywhere on the table because you may accidentally un-sterilize it, which creates a massive problem for the entire OR.

**During surgery.** Your role will mostly be limited to observing and retracting, but you will probably have a few opportunities to drive the camera during laparoscopy and to suture. Your inclination will be to try to help the surgeon as much as possible, but don’t be overly aggressive or try to take over the scrub tech’s role. **This is where you have to read to the room (situational awareness)**. Too many questions may be distracting or annoying to the attending. Try to pick low-stress moments to ask thoughtful questions. When in doubt, err on the side of being a quiet shadow rather than a distraction. Take any critiques that people have for you and try to understand where they're coming from. Some people may tell you that you did something wrong when you may be sure you didn't -- just say thank you and move along. The OR can be a place where people are initially hyperaware of the student for the sake of patient safety, and people may initially be hyper-critical. Just go with the flow and accept the coaching. People will quickly warm up once they realize you're a coachable student who is excited to learn.

**Be nice to the scrub tech.** They are the guardian of the sterile field and will admonish you if you do anything to compromise it. Apologize, offer to rescrub if necessary, and don’t make the same mistake twice. Though they sometimes get a bad reputation, most are very understanding that students are learning and will help you when you need it.

**Be careful.** The OR is a busy place and can be quite crowded. Protect yourself, always keep an eye on sharps, and maintain sterility. Some of the equipment is very expensive - you never want to be responsible for contaminating it. If you do break scrub by accident, don’t worry. It happens to everyone once in a while. Just say you’ve become unsterile, step away from the table, get a new gown and gloves, rescrub, and get back in there!

**Stay with your patient** until they are in the PACU (post anesthesia care unit). While you are waiting for the patient to wake up from anesthesia,



you can offer to write the brief op note (the residents will teach you what to write, though they often prefer to write this note themselves) or bring the stretcher into the room. Some anesthesiologists can be very particular about the timing of bringing in the stretcher, so you can ask them “Hey, is it ok for me to bring in the bed?” At the end, do not unlock or move the bed out of the room until the anesthesiologist gives the final okay.

**Suturing.** Interns and residents will often give you an opportunity to help close skin. You can steal some sutures from the OR and practice knot-tying in the team room during down time so you are ready to go when asked. Take a look at the “General Resources” section of this guide above for some helpful how-to videos. Residents are also usually happy to walk you through it once. Important skills to learn are the two-hand tie, one-hand tie, instrument tie, and subcuticular suture. Keep in mind that tying with gloves on is a lot trickier than doing it bare handed. Also, when someone else is suturing, they will often expect you to cut the suture for them, so be ready with a pair of suture scissors.

## **Clinic**

The structure of your day in clinic will vary depending on your preceptor and where you are assigned. There are two types of patients in clinic: pre-op and post-op. At Elmhurst, they occasionally perform minor procedures like I&Ds during clinic.

Post-op follow-ups are straight-forward, fast visits. The main purpose is to look for any red flags that might indicate complications, ensure the patient is adhering to discharge instructions such as medications or wound care, and perform follow-up care such as removing staples or repacking an I&D.

Pre-op patients have usually been referred to the clinic from another provider because that provider thinks the patient has a complaint that requires surgery. Use your H&P skills to lead a problem-focused encounter that will allow you to construct a differential. Be efficient but complete - unlike in ASM, surgeons only care about the social history if it is relevant to the differential or surgical risk (usually keep it to smoking, alcohol, and drugs). At the end of the encounter, form a differential and plan. Does this patient need a further work-up to establish the diagnosis? Does this patient need surgery? Does this patient need any pre-op work-up or clearance based on their surgical risk? Before your first clinic day, you may want to research the most common pathologies your preceptor treats so that you can have an illness script in mind when you see patients. For

example, if your preceptor is a general surgeon, you are likely to see a lot of hernias and gallstones. UpToDate is a great resource to learn about clinical presentation, risk factors and management for these pathologies.

### **Overnight Call**

**Note – Overnight call is suspended for AY25-26.** Students at Elmhurst will have overnight call, which many find to be an enjoyable time. The overnight team is a chief, a senior resident, and a couple of PAs. There is usually some downtime to socialize with your team and get dinner together. At the start of the evening, there are usually several ER consults to see. Go see these with the PA or on your own. It can be easy to lose track of the PA, so get the number of the phone they carry so you can find them when you get separated. Scrub in on any cases going to the OR. If all the consults have been seen and there are no cases going on, you can go sleep in the call room. Don't wait for someone to tell you to go to sleep—they probably won't. If there is nothing going on, just go. Sometimes you can sleep the entire night, while other nights you may never see the call room. Make sure you know your way to the ER trauma bay so you can quickly get there when you get paged for a trauma. The students on overnight call compile the vitals and I/Os on all the patients for the service before the rest of the team arrives on the shuttle the next morning. After morning rounds, you get to go home. It is usually faster to take the subway than wait for a shuttle.

## **ANESTHESIOLOGY**

### **Structure**

The day usually starts a little before 7AM, when you can help your resident or attending set up their room for the day. Depending on your site, there may be morning report (residents discuss an article) or grand rounds (resident presents a case and discusses a subject). Before each case, you meet the patient in the holding area and do an anesthesia history and physical. You (personally) may also start IVs at this time (they'll refresh your memory!). Then, when the OR and surgery teams are ready, you bring the patient to the OR and get started. You will be directly involved in the preparation for induction (drawing up of anesthetics into syringes, placement of blood pressure cuff/pulse ox/EKG leads, bagging). Depending on your attending, you may also be invited to intubate, start arterial lines, and do other more difficult procedures. (If these are experiences you really want and your attending hasn't offered, ask. If they say no, you can ask Dr. Chietero to pair you with an attending who might let you get more hands-on practice.) Once the patient is anesthetized, the resident or

attending will probably talk with you about the physiology and pharmacology of anesthesia. When the surgery is over, you will help wake up the patient and transfer them safely to the PACU. You will get scheduled breaks for coffee, lunch, etc. Most days end around 4PM. There is no evening or weekend call.

**Be proactive.** If you have a specific interest, you can ask to spend some time with that type of anesthesia/surgery (e.g. on OB anesthesia you see C-sections and epidurals all day, on peds anesthesia you will work with kids, etc). Just make sure to spend enough time (~2 days) with a single attending so that they can evaluate you.

**Get oriented.** Use this time to get oriented in the ORs. Observe the surgeons and nurses. See how students make themselves helpful in the OR; learn where you can find common items used in the OR.

**Anesthesia skills.** This clerkship is the best time to become comfortable at inserting IVs. You get to observe the IV experts (they can find a vein in ANYONE), and you get so many opportunities to practice. Try to solicit advice from a lot of residents and develop a routine that works for you. Don't forget to log all procedures you do on PxDx in one45. You need these to graduate!

**Anesthesiology app.** <http://gas.careteamapp.com> Contains useful information to orient yourself to the OR, the structure of the day, links to the various schedules, and commonly discussed topics and questions during your anesthesiology days.

## **Logistics**

**Shuttle schedules.** Look on Blackboard for the latest schedule. Don't miss the shuttle. If you miss it, get on the subway as fast as possible. You may still make it to rounds.

**Footwear.** Make sure you have comfortable shoes or sneakers that you don't mind getting dirty. Non-absorbent materials are easier to wipe fluids off, although usually your shoes won't get too bloody. Most surgeons operate in clogs or Crocs.

**What to wear.** You must be in scrubs, mask, and a **bouffant cap** in the holding areas and ORs. **The FIRST thing you should do when you pass through the main doors is don a bouffant cap.** You will not get 10 feet before someone stops you. You can obtain clean scrubs from GP3 or

Annenberg 7 when you are at Sinai (the color of the scrubs does not matter - whatever the machine gives you is fine for you to wear in the OR). Students currently get 2 scrub credits, so drop dirty scrubs in the scrub machine at the end of each day. At Elmhurst, they are dispensed from a machine in the operating suite lounge, and you need to have card access. They give you a card at the beginning of your 3 weeks there. **At WEST, you must wear blue scrubs.** If you don't, you will be stopped and admonished on the OR floor. The scrub machines at MSH occasionally dispense blue scrubs, but it's easier to obtain these scrubs at West. Contact your resident BEFORE starting your rotation and tell them you need help obtaining blue scrubs so that you are all set on the first day.

**Meals.** Carry granola bars or other food with you that you can eat between cases, as there may not be time for lunch. In between cases, you will likely be waiting a while for the room to be cleaned, so that can be a good time to sneak off and grab a bite (just let your resident know). In general, be sure to eat before going to the OR, and stay hydrated to prevent vasovagal episodes. (If you do get vasovagal, there's no shame in it! Just step away from the sterile field and let the scrub tech know you have to go sit down.) You can also chat with the nurses and the scrub techs! They love to chit chat while they're waiting for the case to start and if the patients already being taken care of, work on bringing the good vibes to the OR!

**Humanistic Tips:**

- Once you've prepped the case, strike up a conversation with your patients in Pre-Op/in the OR; it is an especially vulnerable/nerve-racking time with lots of waiting
- Surgical gowns are thin and ORs are cold, so always offer your patients a warm blanket
- Help keep the patient covered in the OR with sheets and/or a gown when appropriate (which is most of the time) before and after surgery

## **Studying**

**Before cases.** Most questions asked in the OR focus on the disease processes, risk factors, and indications for surgery; anatomy; and potential complications. Amboss is very helpful for reading brief outlines of topics before cases, and Surgical Recall goes over commonly asked pimp questions. Questions usually do not focus on technical details of the operation.

For the shelf exam. NOTE THAT FOR ACADEMIC YEAR 2025-2026, STUDENTS WILL TAKE A CUSTOMIZED NBME ASSESSMENT THAT IS DIFFERENT FROM THE SHELF EXAM. The questions on the surgery shelf are often of a medical nature. If you haven't had medicine before your surgery clerkship, you may have to learn some of these topics on your own. Common topics include the initial work-up, diagnosis, and management of common presentations of surgical conditions. Other questions are bread and butter medicine topics including dyspnea, chest pain, anemia, fever, fluids, acid-base, etc. Questions about anatomy or surgical technique are rare.

## Resources

**UWorld.** There are about 600 surgery questions, so aim to finish them by the end of your 8 weeks. People used to talk about adding medicine questions or adding Amboss, but there are now enough questions in UWorld that you shouldn't feel obligated to do that.

**Pestana's.** A super quick and easy read that can help set up a good foundation for you. Make sure to do questions afterward as it is really only a starting point. You can likely buy a really cheap copy of this off an upperclassman.

**DeVirgilio's.** A good reference book, but don't expect to read the whole thing before the shelf.

**Surgical Recall.** This book covers commonly asked questions on most common procedures. Good for a last-minute review before going to the OR, but NOT a good resource for shelf studying; this book is really only to prepare for cases you are going to see.

**Surgery: An Introductory Guide for Medical Students.** Each chapter in this book is focused on a single procedure. It includes an introduction, surgical technique, complications, a classic case vignette, and questions and answers to common OR questions. This is also a great resource if you have a few minutes to do a quick review before a case.

## Surgery Pearls:

- Very little is expected of the student in the surgery rotation. If you can't suture well, no one will be disappointed or expect better. This allows you to let your

personality shine. Most students get praise for having a good attitude and cheering up and supporting the people around them. This is part of why residents love working with medical students! It's refreshing and exciting to work with them!

- Patients are usually scared/anxious about their surgeries. Often times, just letting them vent and reassuring them that their surgeons are amazing goes a long way. Remind them that your attending is in charge of teaching surgeons how to operate!
- The mornings are early, and the hours are long. A good caffeine source and a filling breakfast makes a world of a difference.

## OBSTETRICS AND GYNECOLOGY

### **General Advice**

If you're not going into OB/GYN, some take-home messages: learn how to conduct a good GYN history (including sexual/physical abuse), GYN exam with Pap smear and breast exam, and at least one delivery! And never forget to do a pregnancy test (hCG) on any woman in the ER with abdominal anything! Many people are nervous for this rotation but just remember your experience is your own - just because someone didn't like it doesn't mean you won't also. Each rotation is a new set of residents and therefore a different dynamic, so go in just as you would any other rotation. Be helpful to the residents when you can be and don't be afraid to ask questions! Remember to feed yourself and ask to grab lunch if you haven't been told to do so - especially on L&D it can get busy and residents often default to snacks.

### **Clerkship Information Summary (CIS)**

Review this document before you begin: [OB/Gyn Clerkship Information Summary](#)

### **Orientation**

Dr. Chen is one of the most organized and student-oriented clerkship directors at Sinai. She runs a great orientation to OB/GYN and will go through what to expect for each phase of the rotation. She will provide you with very detailed information on what to expect at your training site and does her best to make sure all logistical issues are addressed beforehand so that you can solely focus on learning while on rotation. She is a strong student advocate and has implemented several practices that have made this rotation better, including teaching awards for residents who take the time to teach medical students. Pay attention to the lectures during orientation as she touches on high yield questions that you may be asked during the rotation. The lectures are also just generally helpful going in given we do not have a great foundation in ObGyn during pre-clinical.

### **Schedule**

The 4-week OB/GYN rotation is divided into roughly Labor and Delivery (L&D) days, Labor and Delivery nights, a few days of clinic, GYN or gynecologic oncology surgery, and a 1:1 week with a preceptor.



### **Typical Day on Labor & Delivery**

Arrive at 7AM (some earlier, some later, depending on your site). The first thing you do is get signout from the overnight team. This is a whirlwind of information spoken in an acronym- and abbreviation-laden language that is barely recognizable at first (don't worry, you will get the hang of it!). They will tell you who is waiting to deliver and where they are in the process. You will either be assigned to a delivery or be expected to choose a patient who may be delivering soon. On nights or when there is downtime see if someone can help teach you how to read "the board" as this will help you to know when people are close to delivering. At MSH/MSW you will most likely be participating in the Sinai groups deliveries so look for those on the board. The rest of the day is mostly floorwork: triage, admitting women in labor, helping out at deliveries or C-sections, and waiting around (a.k.a. reading time).

A major thing you'll be doing is seeing patients in triage, so it may be helpful to ask your intern on the first day if they have any structure for questions they ask, and to get feedback on your first triage patient. **Never forget to ask about contractions, vaginal bleeding, if their water has broken, and if the baby is moving!** In terms of deliveries, depending how comfortable you are and the residents are, you will likely be able to deliver a number of placentas and hopefully help with parts of the vaginal delivery with your hands over the resident's or attending's. During the course of labor, you can be helpful by holding mom's legs back, encouraging her while she pushes, and getting her anything she needs like water or ice chips. Before attending a delivery, you should make sure to introduce yourself to mom and ask if it's okay for you to help/observe. You can also help the attending with repairing vaginal lacerations after delivery. During C-sections, you will usually get to close skin with the resident, so review your suturing and knot-tying skills (they will go over with you if you don't get a chance to before), especially if you haven't had surgery yet. The day ends at 7PM when the overnight team comes back.

Students do 3 overnight shifts (7pm-7am), where the focus is more on admitting laboring patients, addressing emergency conditions that may be pregnancy-threatening, starting the process of induced labor, and doing magnesium checks. For tips on flipping your sleep schedule, see the **night float-specific tips** in the **IM clerkship** section of this guide.

## Typical Day on GYN Surgery

Arrive at ~6:30am to pre-round on any patients whose surgeries you witnessed. Key things to ask are the ones you ask on your surgery clerkship: urine output, bowel movements, pain, and take a peek at the wound dressing - never remove without the resident present. Then, follow the team to their morning didactic (ranges from journal club to rounds where the chief resident presents cases to the attendings). Then head to the ORs! You'll usually be told to stay with one attending for the day, and scrub on all the cases they do. This means the end of your day varies with the number and length of the cases. Ask your chief resident what their expectations are of you i.e. how you can best be of assistance during morning work rounds and in the OR. Also, since you only have 2 weeks, ask EARLY for feedback on your performance from your chief resident (before the end of the first week). Pack snacks in your jacket pockets that you can leave outside the OR to eat in between cases.

## Typical Day in Clinic

### Humanistic Tips:

- On L&D, introduce yourself to all the laboring mothers and their families and ask if there is anything you can get to make them more comfortable
- Respect the mother and family's wishes during labor (if they do not want you there, leave)
- If present during a procedure for a spontaneous or elective abortion, spend time with the patient and be respectful of her mood and feelings, whatever they may be

Times depend on the site. Most clinics start at 9am and end by 4 or 5pm if not earlier. You'll spend time in both resident-run clinics and private clinics (attendings only) outside of the hospital. This is a mix of GYN and OB. Common procedures: pap smears, colposcopy, terminations, IUD placement, and prenatal visits. You may need to be assertive about asking to do pelvic exams, but most attendings will be happy to walk you through them once you ask, and this is your main opportunity to get comfortable with this more sensitive type of exam.

## Resources

**UWorld.** As always, your primary resource. Don't be upset if you do very poorly at first - most of this information is not anything you've seen in preclinical, and many of the same topics will come up over and over as

you do more questions.

**uWise.** This is another online question bank that you will be given access to at the beginning of the clerkship. Overall, not as good as UWorld, but another source of questions.

**Casefiles or Blueprints.** These are two review books; pick one or the other, not both, if you're a textbook person. They are free online through the Levy Library. Most students don't use any textbook resource for this clerkship.

**OB/GYN clerkship app.** <https://ismmsobgyn.glideapp.io> Has tons of helpful information for this clerkship, notably including a sample birth certificate (you will usually be expected to fill out the birth certificate for any delivery or C-section you attend).

## **PEDIATRICS**

### **Introduction**

Pediatrics is a popular rotation. You get to interact with children, and it is less demanding than medicine, but it can still be time-consuming, especially during the inpatient weeks, and there is a substantial amount of new material to learn. Many students cite their well-baby nursery experience as one of the highlights of third year. Your experience on peds will depend on the time of year you do the rotation – during the winter you will be overrun with RSV, while during the spring and summer, respiratory illness will be less common, but the patients who are there will be quite sick.

### **Clerkship Information Summary (CIS)**

Review this document before you begin: [Pediatrics Clerkship Information Summary](#)

### **Structure**

The exact structure varies between clinical sites, but the clerkship is split into a few weeks of inpatient floors (days plus/minus evenings), a weekly outpatient clinic, and some time in the peds ED and the newborn nursery. As a result, you will be working with a number of different people during this rotation and may only spend a few days in a particular setting.

## General Advice

**Bedside manner counts.** On peds you are evaluated as much on your interaction with your patients and their families as you are on your medical knowledge. Learn how to do a creative physical exam - buy a sparkly toy for your stethoscope, pretend to "blow out" the light of your otoscope like a candle, or let the child examine you or a toy first.

**Learn the pediatric H&P.** Pediatrics is not medicine for little people; learn to focus on the unique components of the pediatric history. **Always elicit a birth history, developmental history, immunizations, and social history (including HEADSS assessment for adolescents).** Also, head circumference, height, and weight are as important to include as vital signs!

## Inpatient Experience

The team in peds typically consists of 1 resident, 2-3 interns, and 1-2 medical students. You will generally follow 2-3 patients in a similar fashion to inpatient medicine. It can be a good idea to try to carry patients with the same intern so that one person gets to know you well, though the resident may assign you the more interesting patients, which may not all belong to one intern.

**Daily schedule.** Inpatient days are similar to medicine and vary depending on your site. You will arrive early in the morning for signout, preround on your patients, go to morning report (at some sites), round with the team, some days go to MS3 noon conference (recently has been over Zoom, eat your lunch while you listen), and then finish up your work for the day. Days end anywhere from 3-6PM. When you're on inpatient nights, you should expect to be on the floors from ~5:30PM - 11PM.

One of the challenges of inpatient pediatrics is that normal values depend on the age of the patient. Pediatric patients also tend to deteriorate and recover more quickly than adult patients. Length of stay is often much shorter than on medicine, but the patient's status can change quickly, so keep a close eye on them – this is possibly the only rotation where you are expected to check on your admitted patients multiple times throughout the day. Many of your patients can't communicate with you, so your physical exam is very important, especially their general appearance.

## **Well-Baby Nursery Experience**

One of the highlights of third year, the well-baby nursery gives you the opportunity to test the Moro reflex to your heart's content. The experience is very relaxed, and you may only spend a few hours in the nursery each morning. This is the time to get comfortable handling infants and perfect your newborn exam. You also get practice talking to new moms and teaching them what to expect from their baby in the first few weeks of life. Make sure you complete the newborn exam form while you are there.

## **Outpatient Experience**

A relatively new feature of the peds clerkship is a weekly continuity clinic – you go to clinic one afternoon a week and work with the same preceptor and group of residents each time. Clinic is where you will see most of the bread and butter pediatrics (well-child exams, common colds). This is the stuff emphasized on the shelf. Try your best to see patients on your own and practice presenting to the attending (remember to include the peds-specific info when you present). This is also a great time to get familiar with the developmental milestones and vaccination schedules!

## **ED Experience**

Once you get to the ED, you'll assign yourself to patients as they come in; you'll be the first to get a full history from the patient and their family, before presenting to an attending or resident, who will then go and see the patient with you. If you're interested in more procedural fields, you can offer to see any kids who need sutures placed or removed! You'll rotate shifts with the other third-year students who are also in the ED the same week as you (you will have some daytime shifts ~9AM-4PM and some evening shifts ~4PM-11PM), so you may not get a chance to work with the same attending more than once. Keep that in mind because you need to get 2-4 evaluations from attendings/residents in the ED, but you may only get one shift with someone.

### **Humanistic Tips:**

- Get to know the family of your patient and involve them in the history taking when appropriate (parents know their kids best most of the time!)
- Listen to your patients, no matter how little/young
- Brush up on your cartoons/comic books/tv shows
- Come prepared to celebrate holidays (Halloween, Valentine's Day, etc.), play along and make it fun for the kids
- A touch of patience goes a long way as children learn how to verbalize what/how they are feeling

## **Logistics**

**White coats** aren't worn on peds.

**Paperwork.** There are a lot of forms you need to get filled out during this rotation, be aware of these so that you aren't scrambling at the end of the rotation. This is also one of the rotations where you choose who evaluates you, so think about evaluators early so you're not scrambling to remember who you worked with 5 weeks ago at the end of the clerkship.

## **Resources**

**UWorld.** The shelf emphasizes bread and butter pediatric topics. Know your developmental milestones, genetic syndromes, toxic exposures in pregnancy, and poison control/toxicology. There are surprisingly many topics that come up regularly in pediatrics but not in adult medicine, so be prepared to learn new material.

**BRS, Casefiles, or Blueprints.** These are the main options for students who like textbooks, but most students don't use a book for this rotation.

## PSYCHIATRY

Many students enjoy the psychiatry clerkship, and most psychiatrists are very happy to talk with you about their field if you have any interest in it. Even if you aren't interested in pursuing psychiatry as a career, the clerkship is an excellent opportunity to learn how to connect with patients with psychiatric disorders and to practice asking patients about sensitive topics.

### **Clerkship Information Summary (CIS)**

Review this document before you begin: [Psychiatry Information Summary](#)

### **General Advice**

**Get comfortable with the psych interview and mental status exam.** The mental status exam is like the psychiatrist's physical exam—a formal assessment of mood and thought. There are also specific historical questions you need to ask on psych, such as substance use history, a detailed psych history, and experiences of hallucinations or delusions. There are templates for the psych H+P and the progress notes available to help with your notes, but you should familiarize yourself with them as well so that you can conduct a fluid interview. The clerkship directors have developed an excellent Powerpoint review of this, which they go over on the first day of the clerkship.

**Practice interviewing.** Depending on the attending and site, medical students are often invited to perform admission interviews for new patients in front of the team. While this may feel intimidating at first, try to focus on the patient in front of you. Ask a resident about what information is important to elicit on the admission interview, since often a full H&P has already been conducted in the Psychiatric ED prior to floor admission. In general, allow the patient to tell the story of how they were admitted. Remember to conduct a psychiatric review of systems (discussed during orientation). If your team allows it, take charge and interview often! Frequent practice makes for great practice and for constructive criticism.

**Learn by listening to other clinicians.** Sometimes it won't be appropriate for you to take the lead on an interview with a specific patient, but listening to someone else first may be a great learning opportunity! Every doctor that you encounter is going to have a different interview style. You'll notice that everyone has go-to phrases that they use to set up a



conversation, to ask about sensitive topics, etc. When you hear someone say something that you find effective, write it down, and then pull it out in an interview yourself later on.

**Know your drugs and disorders.** Extremely high yield for the shelf as well as clinical practice. You may also be asked to differentiate between similar disorders based on DSM criteria, so re-familiarize yourself with the criteria you learned in Brain & Behavior.

**Work with the team.** The psychiatry team includes nurses, psychologists, social workers and occupational therapists. Get to know the team well - including their names! Find out what they are doing, what they have learned from your patients, and how you can get more involved.

**Be safe.** Though it can be difficult for students to think of patients as potential sources of harm, in psych, it's good practice to interview patients in common areas or with your body closer to the door. Keep a few feet of distance between yourself and the patient and be attuned to any signs of agitation from your patient.

**Spend time with your team.** Your residents want to see that you take the rotation seriously, and the psychiatrist's day is typically 9am-4pm, so not much of a burden compared to the rest of third year.

**Lean on your classmates and support systems.** This can be an emotionally difficult rotation as you see patients seriously suffering from mental illness and, often, severe psychosocial effects. Debrief and decompress, and don't feel ashamed if you have a hard time seeing some of what your patients go through.

## **Services**

Depending on your site, you may have the chance to pick which type of service you'd like to be on. Think about this carefully, as you will stay on the same service and team for the whole month. Options may include:

**Adult inpatient.** (This unit is called Madison 5 at MSH.) This is a locked unit where you will see the highest-acuity, most decompensated psychiatric illness. Patients are often admitted involuntarily.

**Geriatric inpatient.** This does not necessarily mean you will only have

geriatric patients; rather, it's a psych unit with slightly lower acuity patients.

**Consult/Liaison (C/L).** This is a consulting service for the rest of the hospital; when a patient is admitted for a medical illness and the medical team has a psychiatric question, they call you. Expect to see lots of hyperactive delirium, medication management, and (at MSH) transplant evaluations.

**Psych ED.** You will see patients with primary psychiatric disorders who present for a psychiatric reason as well as perform consults in the main ED and (overnight) the rest of the hospital.

**Child and Adolescent Psychiatry.** You will see patients under age 18 for primary psychiatric illness. This is one of the few child/adolescent inpatient units in NYC. Expect to see depression, suicidality, OCD, borderline and be involved in many family meetings.

## **Schedule**

Though your schedule will be highly variable depending on your site and the service you're on, days start between 8-9AM and usually end around 3-4PM for students (though sometimes you will stay until 5 or 6PM). Preround, take note of overnight events (agitation, mood, sleep etc.) and medications (including PRN) given, and take a quick history and do a mental status exam. Talking to the nurses when you preround is particularly important, since a lot of patients can't or won't give you a full account of overnight events.

Team rounds on psych units are interdisciplinary (physicians, psychologists, nurses, social workers, and occupational therapists). Psychosocial issues are overwhelmingly important for inpatient psychiatry, as discharge planning is rarely a straightforward task. After team rounds, the team may conduct a group interview with new admissions (which can be led by medical students, depending on the site and attending).

Weekends are free. Late calls and ER calls are performed at Sinai. Enjoy your free time, but take the clerkship seriously when you are in the hospital. If you are not going into psych, learn as much as you can about how to talk to patients with psychiatric disorders—you will encounter them in every field of medicine.

**Humanistic Tips:**

- Be aware of counter-transference, and how it may be affecting your view of the patient
- Incorporate psychoeducation (i.e. tell patients why you are asking certain questions about mood, mental status)
- Ask about your unit's policy on patients wearing clothing from home, and advocate for letting them do so
- Inform patients about their right to a 72-hour letter requesting discharge (if they are on the inpatient unit voluntarily)

**Resources**

**UWorld.** You will likely be able to get through all the psych questions during the month. There is a lot of overlap with what you learned in Brain & Behavior, with some additional nuance thrown in. This tends to be one of the easier shelf exams, though this can be a double-edged sword as the criteria for passing/honoring the shelf are also higher.

**First Aid for Psychiatry.** This is the gold-standard textbook for psych. Students find it easy to read, digestible, and worth spending time on in preparation for the shelf.

**NEUROLOGY****Introduction**

Neurology is very similar to inpatient medicine in many ways, but something helpful is that the discipline is pretty self-contained, so it is more approachable than some other specialties. The physical exam is very important in neurology, so this rotation is a great opportunity to hone your exam skills.

**Clerkship Information Summary (CIS)**

Review this document before you begin: [Neurology Clerkship Information Summary](#)

**Structure**

Neurology is an almost entirely inpatient rotation. You may be assigned to a stroke service, general neuro floor service, consult service, or some combination of the above. At BI, you will also have a faculty preceptor who you will meet with throughout the rotation. There are weekly didactics and

1-2 outpatient afternoons where you leave the hospital after rounds and join a resident or fellow in their outpatient clinic.

## **Schedule**

**Daily.** The typical day is similar to most other inpatient services. The day usually starts around 7-8AM and ends around 4-5PM. There is usually morning report (where a resident presents a case and the group talks through their differential together) and noon conference (more formal lecture on a specific neuro topic; get lunch ahead of time so you can eat during conference). Like on inpatient medicine, you will preround on your patients, present them on rounds, and follow up on any tasks that need to be done for them (with the help of your junior resident) in the afternoon.

**Call.** Everyone has to do two evening calls at Sinai, regardless of which site you are assigned to (with the exception of BI students who take call at BI). You'll see consults, stroke codes, and ER patients with the night float team. They'll usually let you go early if nothing is happening. You have weekends off.

## **General Advice**

**Learn the neuro exam.** This is the main competency they expect you to learn during the clerkship and will be an extremely valuable part of your presentations on rounds. The key to success is repetition. It is also a very objective and repeatable exam if done properly, so you will want to get good at it so your exam matches your attending's. Stay organized while doing your neurology exam to make sure you complete the entire exam in an efficient and effective fashion. This is one rotation where you do need your supplies: stethoscope, penlight, reflex hammer, tuning fork, and possibly pins to assess pinprick sensation depending on your attending. If you feel rusty on the neuro exam, the ASM physical exam videos are a great refresher.

**Rounds.** You'll start off presenting just one patient, but eventually will probably be following and presenting 2-3. If there are new patients, the resident may tell you to drop an older patient so you can present a new H&P. It is important that you allow yourself enough time in the morning to preround on your patients and do a full neuro exam + barebones heart, lung, abdomen exam – you may need to allow more time per patient than you did on other services. At MSH, there is usually time between morning report and rounds to pre-round, but if you want more time to pre-round (especially at the beginning of the year, and at least during the first couple

days of the rotation so you know how much time you need) you can also do part of your pre-rounding (even just the chart-checking component) before morning report. Neurology is a cognitive specialty, so most attendings want you to give an impression and come up with a differential, though as in any other rotation there will be some attendings who prefer it very brief.

**Exclude other causes.** Many neurologic diseases present with symptoms that can also be due to non-neurological processes such as metabolic abnormalities, cardiac etiologies, or psychiatric conditions. By including these in your differential and workup, you'll show that you're thinking broadly and critically rather than jumping to conclusions based on where the patient is admitted.

**Offer to give brief topic talks.** There can be a fair amount of downtime on neurology depending on your site and how busy the service is. Show your interest in the subject by offering to give a brief presentation on a topic.

relevant to one of your patients or that you found interesting while studying. Attending rounds are often less rushed than on other services with a lot of teaching, so your contributions will be welcomed. Your team will appreciate you going into the primary literature for your presentations.

**Don't underestimate the shelf.** The neurology shelf has a reputation as one of the hardest of third year, and just like the other four week rotations, it comes up fast. Start studying the first week of the clerkship. Many questions are about localization of lesions – you don't need to know neuroanatomy in the excruciating detail of Brain & Behavior, but you will probably need to brush up on some basics. Know your spinal cord pathways, functional organization of the brain and brainstem, and brainstem stroke syndromes. Peripheral nerve questions are fair game as well even though they don't come up much on the floors.

**Humanistic Tips:**

- There can be a lot of overlap with psychiatry; do not default to a psychiatric diagnosis initially
- Be mindful of patients with conditions that are degenerative or progressive (e.g. multiple sclerosis, Parkinson's) as they can become frustrated with lack of good treatment options

## Resources

**UWorld.** Are you noticing a theme here?

**Divine Intervention Podcast** multi-part series aimed at the Neuro Shelf: Episode 211, 45, 46, 47, 48, 49, 58 and 59. This is especially helpful to solidify topics during the final two weeks.

**Casefiles or Blueprints.** If you're a textbook person, both of these review books get good feedback (choose one or the other to use and get it for free through the Levy Library).

**Clinical Neurology (Lange).** Probably too much to read before the shelf, but neurologists love it as a medical student-appropriate reference book. Each overarching topic (i.e. stroke, dizziness, seizures) is 30 pages, but there are neatly organized subsections within each that are about one page (ie. 1 page about Meniere disease). If you have a patient with a given disease or differential, it is a well organized way to learn about the disease.

**High-Yield Neuroanatomy.** Excellent for a quick review of the anatomy. Does a great job of correlating anatomic lesions with the resulting neurological disorder. A very valuable read.

## ONLINE RADIOLOGY COURSE

### Introduction

The Online Radiology Course (ORC) is a collection of radiology learning modules and quizzes which are integrated into the core clerkships. The purpose is to teach students to recognize significant radiological findings in each core field. The case-based learning modules are hosted by MedU (<https://icahn-md.meduapp.com>), and each case typically consists of 15-25 slides covering patient presentation, next steps, outcomes, and reading radiological scans. Each case is followed by a 5-7 question quiz, also created by MedU. The MedU quizzes may help you synthesize your knowledge, but they are not required for course credit. **To get credit for completing your ORC modules, you must complete the quizzes found on Blackboard.**

### Clerkship Information Summary (CIS)

Review this document before you begin: [ORC Clerkship Information Summary](#)

## Structure

5 of the 7 clerkships have required ORC modules (psychiatry and ACG do not). In total, there are 11 required learning modules: 3 to be completed on Medicine, 2 on Pediatrics, 2 on OB/GYN, 2 on Surgery, and 2 on Neurology. There is 1 quiz per clerkship, covering all of the modules for that clerkship. **All modules must be completed, and the Blackboard quiz submitted, by 5pm on February 13<sup>th</sup>, 2026.**

## Grading

**To pass the ORC module, you must achieve a score of 65% or higher when combining the individual scores received on each quiz.** It does not matter if you get 65 on each quiz, or 100 on 3 quizzes and 30 on the other 3, as long as your average is at or above 65%.

## Tips

If you can, do all of the modules for a given rotation in the same day (or same weekend) and do the quiz immediately after, so everything is fresh in your mind. Definitely do the post module quizzes available at the end of the module on Aquifer; they don't count for anything but are excellent preparation for the real quiz.



## ELECTIVES

Elective blocks are a great way of exploring your interests, getting more exposure in a field you're interested in, pursuing research opportunities, or pursuing other non-traditional experiences. Elective time can also be helpful for vacation time and taking care of other personal obligations that may come up during third year.

### General Advice

**Schedule electives early.** Popular electives tend to fill up quickly; try to schedule them as far in advance as possible.

**Ask for advice.** If you're not sure about what electives to sign up for, reach out to clerkship directors or specialty advisors in the field you're interested in for suggestions. They can help guide your elective search based on their past experience with students.

**Dr. Singh.** The point person about all things related to electives. If you are not sure where to start when trying to set up a tailor-made elective or are looking for an experience not already in the elective catalog, Dr. Singh can help you with logistics and figuring out the details.

**Need a letter?** Electives are also a great time to work closely with an attending in case you are looking for a clinical letter for your residency application. Be sure to ask your specialty advisors and past students for suggestions as some electives lend themselves to letters more easily than others.

**Electives towards the end of third year.** As you get closer to fourth year and start figuring out what your future career might look like, it is helpful to reach out to specialty advisors for advice on how to best use elective time you may have at the end of third year. Especially in the surgical subspecialties, this time is often used to schedule SubI-like experiences or to schedule time with a particular attending you may have worked with before.

**Evals.** Don't forget it's your responsibility to send the preceptor an evaluation form when the rotation ends for them to fill out. This is found at <https://icahn.mssm.edu/education/students/registrar/medical-forms>. You

may, unfortunately, have to pester some attendings to get them to fill it out – don't be shy, it's their job.

**If any electives bring you to the ED earlier than Fourth Year here are some humanistic tips:**

- For patients who ask about wait time, apologize and explain the delay (sicker patients get triaged to be seen sooner)
- If it is meal time (and they are not NPO) get a meal from the meal cart (usually located near the security desk at MSH)

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