SECTION I

Warning: Career Ahead

Before I even get into how to survive third year, a warning: It’s over pretty fast. Before you know it, it’s spring, third year’s almost over, and you have to pick your sub-internships and get ready for applying to residencies. It sounds like it’s far away, but it isn’t.

There are three kinds of people going into clerkships:

- People who have a strong idea of what they want to do
- People who have a few options in mind, but no strong opinions
- People who have NO IDEA where they’re going

Find an advisor. Or two. Regardless of which category you fall into, you will benefit from talking to someone who can advise you on reaching your career goal. Ideally, this would be someone working in your chosen (or prospective) field – a professor, a former preceptor, an attending you’ve worked with.

Notice I didn’t say “mentor.” The word “mentor” conjures the image of a god-like Mother-Father being, à la Tuesdays with Morrie: part Ward Cleaver, part Captain Kathryn Janeway, part Obi Wan Kenobi. Most students never find an advisor with this much benevolent parental mojo.¹ You can get great career advice

¹ Not that I have anything against mentorship. It’s just that the term “mentor” gets thrown around a lot in situations where it doesn’t really apply (sort of like “love” or “family values”). True mentoring is an organic relationship that grows out of circumstances – I don’t think it can be planned or forced (as anyone whose college assigned them a canned, official “mentor” has probably learned). Since we’re on the topic of mentors… there are usually two types of students: ones who have no
from normal mortals, and you don’t have to meet with them every Tuesday of third year to get it. Even meeting twice might be enough.

Also, don’t forget about your “big sibs” and senior students, who may be more helpful in sketching out your career terrain in the near-distance.

If you are a “no idea” person, it’s harder to know where to start finding an advisor. I would say your deans are your best bet. Some schools, such as UCSF, have a formal system of “colleges” or “big sib networks” to help junior students meet senior students and faculty. For people without a strong direction, it’s especially key to start meeting with an advisor early to get help on finding a career path. You might also consider reading a book such as Anita Taylor’s How to Choose a Medical Specialty, or check www.aamc.org/medcareers. Make sure your third-year schedule gives you some broad exposure to various career options early on (i.e., before you have to pick your sub-internships).

People with a strong idea of what they’re doing are released from the “Are you my mother?” agony that afflicts those looking for their niche. However, there are other issues. Again, your schedule should be arranged so you have a chance to try out your likeliest mentors, and ones who have gobs of them. I am in the latter group, and if you’re in the former group, I have some advice. Many of my mentor relationships evolved because I saw senior researchers or doctors at the medical center who seemed cool, and I would seek out ways to work with them (sometimes by arranging an elective; sometimes just by asking to meet with them). Big powerful folks don’t always make the best mentors, since they have less time. Enthusiasm and energy are more important to me than a person’s prestige, or even what they work on, although I tend to gravitate to people who share my interest in AIDS. Mentors should be thought of like nice outfits: You need different mentors for different occasions. I have “bench research” mentors, “clinical research” mentors, “academic career” mentors. . . . I have mentors totally outside my specialty. I even have “mentors in reserve” who I know I can seek out if I ever need advice on something I think they know well. Finally: The mentor relationship works both ways. It’s like the old adage, “You have to be a friend to make a friend.” People want to work with people with good energy and enthusiasm. Your success is your responsibility, not the mentor’s. So, if you want mentoring: Go to the energy, collect mentors for different occasions, and remember that it’s a two-way relationship.
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choices earlier rather than later (again, before spring of third year).

If you’re bound for a competitive specialty like radiology or dermatology, or a surgical subspecialty like ortho, urology, neurosurg, or the like, you may have to “shake the tree” a little to get exposure to the specialty early on. You should try to find a mentor in the specialty early to get help and advice. Your deans may be able to help you.

Finally, even if you know what you’re going into, keep an open mind. You may find you love something you never would have considered. Think: “I’m going into Ob/Gyn – unless something else tempts me away.”

Don’t wait until the end of third year to think about career choices. You don’t want to feel rushed when it’s time to arrange a schedule. It’s easy to be nearsighted during clerkships. Don’t make that mistake.
SECTION II

The Job of the Medical Student

1. Get a thorough history.
2. Do a complete physical exam.
3. Make a concise presentation.
4. Write a timely progress note in the chart.
5. Do whatever is needed to learn about your patient and ensure her well-being.

If at any moment you get confused about your role on the wards or in the clinics: There it is. It’s that simple. (Mind you, it may seem pretty intimidating at this point, but you can do it – even in the first week.)

In Appendix 3 I present “Patient Data Collection Cards,” which include an initial history and physical examination record card. These should serve as informal “training wheels” you can keep handy while doing your H&P to ensure you don’t miss any basic elements.

I also describe how to make a concise presentation – that is, how you’d summarize the daily update of your patient during routine bedside rounds (see Section V, “Pre-Rounding and Scut Basics”).

The rest of your job. In addition, on inpatient services you will be expected to help your team with “scut,” a term for “tasks related to patient care.” Examples: calling a consultant, writing orders for labs or medications, doing procedures, getting the read on an
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x-ray. Interns do the bulk of the team scut but will often need your help to cover it all, especially on a busy service (again, see “Pre-Rounding and Scut Basics”).

In surgery, you will also be expected to “assist” on operations. Mostly this means holding a retractor (referred to as “water-skiing” – if you don’t get it, don’t worry, you will) or suctioning blood or smoke produced by the “Bovey” (electric scalpel/cauterizer). If you’re lucky, you will help suture.

You will also be asked to give “Presentations” – either on your patient and her illness or on a special topic of interest to the team (see Section VIII, “Presentations: Here There Be Dragons”).

**What isn’t your job.** Your job is not necessarily to know up front the full differential for every presenting sign and symptom – but you will be expected to demonstrate your knowledge and, more specifically, that you have a systematic way of thinking about questions (see Section VII, “Pimping and the Art of Self-Defense”). This is not to say you shouldn’t try to learn as many differential diagnoses as you can ahead of time, but to emphasize that you can still do a good job despite (temporarily) not having this knowledge.

**Coping with “stage fright.”** If at any time you enter an exam room and think, “I don’t know what the hell I’m doing in here,” refer to the list at the beginning of this chapter. You don’t have to think – just follow that list. If you feel really stumped, ask a fellow student, an intern, a resident, or an attending for help.

Once, when I went into an exam room, I found a patient who was there for follow-up of an elbow sprain. The first thing I thought was: “ Hmm. I have no idea what’s involved in evaluating this patient.” If I’d only referred to the list above! Thanks to first and

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1 By the way, the word “presentation” is thrown around a lot, and deserves definition. There are several types of “presentation.” On daily inpatient rounds, or in the clinic, you will be asked to “present” the patient – either a quick update on their daily progress or a quick summary of their history and physical. In addition to these “presentations,” there are “Presentations,” which last about 30 minutes (sometimes longer) and may involve looking up several articles on a topic or your patient’s illness(es).
second year, I should have recalled that a patient with a limb injury should be checked for range of motion of the digits and for signs of nerve damage. A general physical would have also unveiled any additional injuries that needed attention, as well as other medical problems (that this patient had). All I had to do was 1) take the history, 2) do a full exam, and 3) present.

Bottom line: You have the knowledge to do at least the basic job. While it helps if you feel like you know the twelve different things that could cause your patient’s symptoms, you don’t have to know all of what’s going on to do your job. Nor are you expected to know it all, at this point.

Your mission. Don’t forget that, in addition to your “job,” you have a mission: to learn as much as possible about the various areas of medicine to help you as you ascend in your level of responsibility for patient care. Even if you’re not going to be a surgeon, you need to know how to recognize when your patient needs one.

No “boring” tasks or patients. I’ve noticed that most of our superiors, from attendings to interns, underestimate the role of “useless scut” as part of the educational experience. Presenting a patient to a consult service may be a “ten times a day” bore to an intern, but in your first months on the wards, it’s a new activity. It probably will get boring to you after you’ve done it ten times. But initially, it’s not a bore. So be willing to help with scut, and let your team know you’re willing.

Likewise, you may notice that residents will characterize a case as “boring,” as in: “Sorry you had to take the patient with the abscess – I wanted to give you something more interesting.” Hmm. How many abscess patients do they think you’ve cared for at this stage of the game? How many times have you done dressing changes, managed pain meds, or pulled housing out of thin air with the help of a savvy social worker? At this stage, it should all be fairly interesting.
SECTION III

Job Performance: The Big Ten

At most schools, clerkships use a basic set of criteria for evaluating student performance. Usually there are written remarks as well as specific grades for essential features of the student’s role. At UCSF, grades are 1 (very poor), 2 (needs work), 3 (good but still can improve), and 4 (excellent). The ten features usually go something like:

1. Fund of knowledge/mechanisms of disease
2. History taking
3. Physical exam
4. Case presentations
5. Record keeping (progress notes)
6. Problem solving
7. Professionalism and responsibility
8. Self-improvement and adaptability
9. Relationships with patients
10. Relationships with teammates

Notice two through five? Those are your basic job description from Section II. One and six have to do with having medical knowledge and applying it. I can’t help you there – but some advice may help you avoid coming off poorly when in fact you know your stuff. (See Sections VII through X.) Seven through ten mostly have to do with demonstrating that you care about doing a good job and using some emotional intelligence. Much of the advice herein applies to these evaluation criteria.

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SECTION IV

Gear Down: White Coats, Stethoscopes, and Other Fashion Accessories

So, what do you need to bring to the clinics and wards? I break gear down into three general categories:

1. Clothes
2. Tools
3. Books

Clothes: Whither the white coat? Rules vary by institution, but you can expect to wear the white coat on inpatient services, such as surgery, medicine, Ob/Gyn, peds, and surgical subspecialties. Often outpatient rotations – family, psych, and parts of peds and Ob/Gyn – will not require you to wear a white coat in the clinics, but you should have an ID badge or name tag displayed at all times. Even if clerkship directors don’t require you to wear a white coat, it’s prudent to wear one the first day rather than presume you don’t need one. Make sure your coat is not too small – it should be loose, comfortable, and easy to get in and out of. (Note for when you purchase your coat: They often shrink in the wash, so buy in larger sizes.)

A practical advantage of the white coat is its pockets – perfect for carrying crucial books and other necessities.

Scrubs vs. regular clothes. On inpatient services, especially on-call, your superiors will usually be wearing scrubs. It’s often
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It’s convenient to change into scrubs early in the day – especially if later you’ll be going to the OR. Thus, on such rotations you may not spend much time in “regular” clothes, and while it’s important to look nice, it’s not necessary to invest in an extensive, pricey work wardrobe. Still, if you’re not in scrubs you should dress professionally.

A personal plug: I tend not to dress in scrubs unless I’m going into the OR or on-call and doing messy procedures. While scrubs are practical, they can start looking sloppy – especially after 24 hours. Patients deserve professional treatment, which means dressing nicely when it’s not impractical. Dressing nicely shows a disciplined exterior, which hopefully reflects/encourages a disciplined interior. Part of looking smart is looking smart.

This also goes for outpatient services. Dress as you would for a formal occasion – meaning, something you’d wear to a friend’s wedding (except for the shoes, ladies). As I say to my medical students: “The hospital is the Temple of Healing, so dress in your Sunday best.” (Or Saturday best, depending . . . )

Shoes. There are two schools of thought. Some invest $100 in a good pair of shoes; others go cheap, or don’t bother with special shoes at all.

I’m normally a cheapskate, but I belong to the first group. I think it’s wise to invest in a comfortable pair of shoes – you’ll be wearing them constantly. In my class, many went with clogs for inpatient services. One student said she found it painful to spend that much money on shoes, but she has never regretted her decision. In fact, she now finds it painful to wear any shoes besides her clogs! (We will not digress into a discussion of “clog addiction” at this time.) For men, I recommend Ecco brand. They’re expensive as hell, but they look great, and they’re like walking on air. Despite long hours on my feet, I’ve never once been distracted by foot pain.

Other students bought inexpensive loafer-type shoes. One student bought no new shoes and wore her tennis shoes on surgery
and dress shoes for other rotations. To my knowledge, shoe purchases have had no bearing on evaluations.¹

Tools: The black bag. You'll need something in which to carry your tools and books. Some people put everything in their white coat pockets. Others use a small bag, mini-duffel, or similar item. At UCSF, many people use a small hiking fanny pack. Now, what to put in it?

You may be surprised to learn that medical students often act as the “caddy” of the team – which means your residents and attending often will not have their tools and expect to borrow yours.

Every medical student should always carry:

- Stethoscope.²
- Pen light.
- Reflex hammer – although in a pinch the edge of your scope’s diaphragm will work.
- 2–3 spare black ink pens – your superiors will often steal yours!
- Alcohol wipes – for wiping your scope’s bell between patients. Bugs are transmitted by dirty tools. If you’re going to wash your hands, wash your scope.

On inpatient rotations, it’s also convenient to have:

- Surgical shears.
- Tape – “Micropore” paper tape is the most versatile; other types may be too strong/sticky for human skin. You can “borrow” from the supply room.

¹ I have heard from admission committee members, however, that shoe selection has been raised in discussing prospective applicants to UCSF medical school. Don’t you find that flabbergasting? (Makes you wonder if the right clothing purchase will make you a “shoe-in” for admission. Sorry, couldn’t help the pun.)

² You may consider attaching a stopwatch to the end of your scope, or at least keeping one handy. I don’t know about you, but I have a hard time estimating a minute, or even ten seconds, when counting a heart rate. If an attending asks you to check the pulse, having a watch handy makes estimating the heart rate during auscultation much easier.