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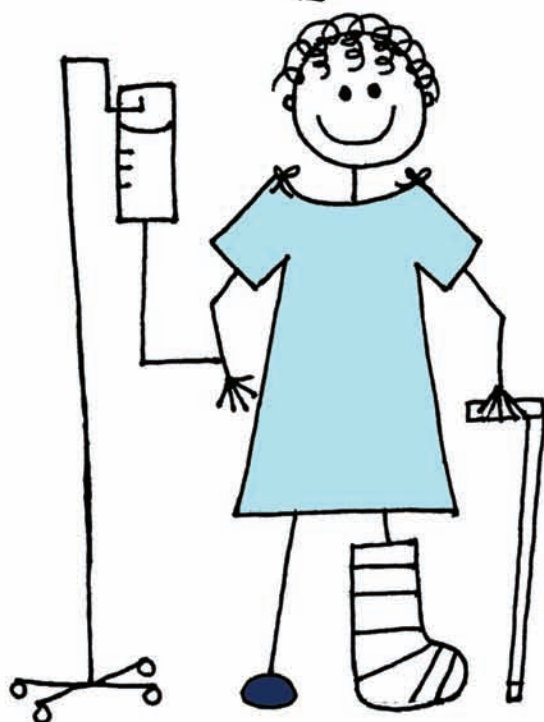
consultant



you



Patient



AN ADELAIDE MEDICAL STUDENTS' SOCIETY PUBLICATION



**ADELAIDE MEDICAL
STUDENTS' SOCIETY**
— EST 1889 —

ABOUT THIS GUIDE

This is a guide written by a collective of consultants, junior doctors and present students from the SA health system. It is full of anecdotes, guidance and comments, and thus by its nature...opinion. This is its greatest strength and its inherent weakness. We encourage you to take on board some or all of the suggestions included within these pages: we hope it will help you on the exciting road that is clinical medicine.

As you progress through the clinical years, through your internship and residency and onto taking up a consultant post, we hope you can reflect on your experiences and contribute to new versions of this guide by sending your comments through to vpe@amss.org.au.

COLLATED AND EDITED BY ADAM NELSON ARTWORK BY DAINA RUDAKS FORMATTED BY KATHERINE WATSON

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TABLE OF CONTENTS

FOREWORD	5
THE FIRST DAYS...	6
MAKING A SCHEDULE	8
SHARING ROTATIONS	9
WARD ROUNDS	10
OUTPATIENTS	12
SMALL GROUP, DIDACTIC TEACHING	13
BEDSIDE TUTORIALS	14
OUT OF HOURS...WEEKENDS, LATE NIGHTS...	15
WHAT DO I DO 'ON THE WARDS'?	16
A WORD ON ASSESSMENT	18
FOLLOW THE REGISTRAR	19
GOING TO SURGERY	20
IN YOUR SPARE TIME	22
THE EXTRA MILE	23
HOW TO LEARN DURING A ROTATION	24
FEEDBACK TO UNITS AND TEACHERS	26
GLOSSARY OF NEW TERMS	27
HIPPOCRATIC OATH	30

' The student begins with the patient, continues with the patient, and ends his studies with the patient, using books and lectures as tools, as means to an end. To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all '.

WILLIAM OSLER, 1903



FOREWORD

‘This is one of the defining times of your medical career’

PROFESSOR RANDALL FAULL
DEAN AND DIRECTOR OF THE MEDICAL PROGRAMME
UNIVERSITY OF ADELAIDE

EXPERIENCE-BASED MEDICINE:

A NON-RANDOMISED APPROACH TO THE CLINICAL YEARS

I still have vivid memories of commencing clinical attachments in the second half of my medical course. Full of knowledge, yet knowing little about the approach to clinical medicine and how the medical system worked. Exciting possibilities combined with a deep fear of making a fool of myself, or of being incompetent, or of not being dressed appropriately, or of not really liking the work, or of...

This is one of the defining times of your medical career. Your first practical exposure to what the future holds, and a chance to really decide what you want to do for the rest of your working life.

I am fond of telling people that the most useful thing I did as a medical student was my elective at the end of fifth year in a small country hospital in New Zealand. I was employed as an ‘intern’, and so for the first time I was forced to truly take some responsibility for patient care. Being left alone to staff a small country emergency department was quite daunting, but I learnt an enormous amount, and returned to Australia much more confident about my abilities and my career choice.

The point of that personal anecdote is that the best way to learn clinical medicine is to do clinical medicine. Students have far more control over their clinical learning experience than most realise. You have moved past the stage where medical study is simply an intellectual, exam-passing exercise. It is time to move on to the ‘getting your hands dirty’ phase. Get involved, watch and learn, integrate yourself into the system. I can tell you as a long-time teacher that the students who show interest and initiative are a pleasure to be with, and brighten my day. There is really no excuse for saying ‘nobody taught me anything’ – a maturing student will always find ways to learn.

Multiple contributors have put together this invaluable practical guide for students commencing their clinical careers in the South Australian health system. Inside you’ll find tips, invaluable advice, and sensible suggestions about how to ‘get on’ as medical student and how to maximise your learning opportunities. You won’t regret taking a few minutes to read it, and will quickly realise how relevant the content is to your daily activities.

THE FIRST DAYS...

INTRODUCTIONS

The first day of any rotation is a little nerve-wracking. There are lots of new faces and a new hierarchy to understand and negotiate. Without forcing or imposing yourself on everyone from the cleaning staff to the head of the unit, make an effort to introduce yourself in the first few days of starting...don't wait for someone to ask 'who are you and what are you doing here?'. Important people to meet are consultants, registrars, RMOs and interns as well as the clinical nurse consultant (CNC) from the ward. Include first name, last name, year level and university, as well as the fact that you are a medical student in your introduction – there are hundreds of students from all disciplines in the hospital. Wear your name badge visibly, (maybe even with your AMSS lanyard) so you are easily identified as a medical student.

Expect that people might remember your name (one new face) compared to your ability to remember them (twenty new faces) – write their names down in your notebook! Address your 'bosses' correctly. Unless specifically instructed – consultants are NEVER addressed on first name basis. Find out beforehand if it is A/Prof, Dr or Mr. If in doubt, err on the side of over-addressing (i.e. Associate Professor and Emeritus Professor are mouthfuls, just call them Professor). Fellows, registrars, RMOs and interns will normally insist on you addressing them on a first name basis but make an attempt to use their title in front of patients.

FIRST IMPRESSIONS

First impressions count. It goes without saying that rocking up late, poorly dressed, without a pen/paper/stethoscope speaks volumes about your commitment to the rotation...don't let this be their first, and lasting, memory of you.

CLARIFY YOUR ROLE

Your responsibilities and expectations will differ with each attachment and additional variability may exist between sites for any given rotation. Find out who is assessing you during your term and what is expected of you: ask explicitly. When the dust settles and you have some quieter one-on-one time with your consultants (first tutorial), registrar (after first ward round), RMO or intern (in between jobs during the day or after a 'paper round') often a question like 'how do you feel I could maximise my time and learning on this rotation?' does not go astray.

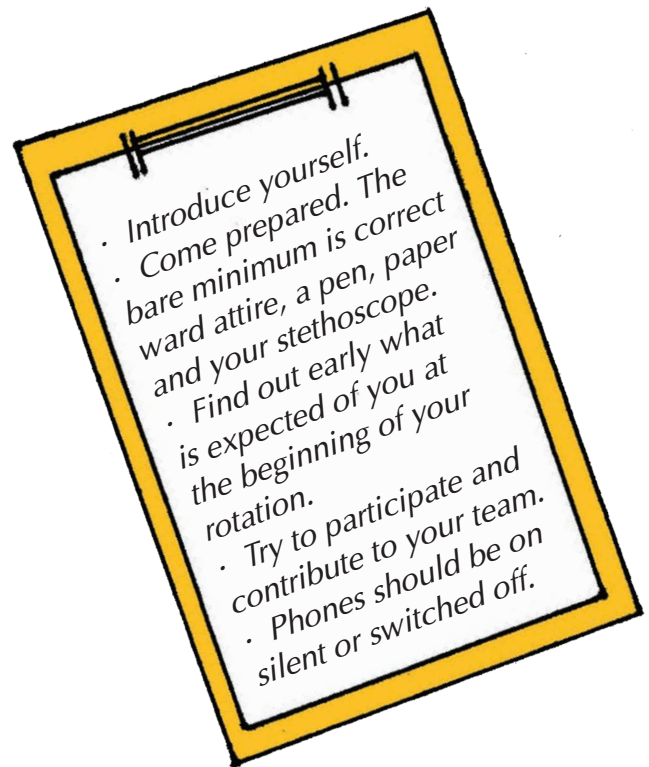
BECOMING PART OF THE TEAM

The most successful rotations are those that allow you to integrate as a member of the team. The first day or two is spent observing and soaking in the atmosphere of the day-to-day running of the unit/ward: keep a keen eye out for ways to contribute to the 'team' or unit. Make the most of the opportunity of being 'new'. The start of clinical medicine is daunting and there is always a plethora of what may seem stupid questions to ask – asking four weeks into the rotation about the location of the outpatients department will be met with disapproving looks. This is the perfect time to unleash them. 'How do I print my patient list? Who do I call to order that? How do I page someone?'. It all counts as good learning, especially at the start of fourth year when everyone in the hospital assumes you know nothing. Although you are a medical student training to become a doctor, take the time to speak to the nursing and allied health staff and learn what their role is within the team – not only is this rapport building but vital to understanding how everyone's roles interact. If the team invites you to go for coffee, make sure you go along too – even if you don't like coffee; enjoy the break from ward commitments.

WHAT TO BRING

You will find out what works for you very quickly. Look at what the other med students and interns do for some tips.

- Something to write on: clipboards or notebooks to scribble down tasks/learning issues.
- Book to read: it is often handy to have something small like OHCM (Oxford Handbook of Clinical Medicine) nearby to use when waiting for a tutorial or a patient in OPD.
- Clinical equipment: this will vary during your rotation and you will find out pretty quickly what you need to bring. Stethoscopes are required on most (psych and ortho less so). There is an old adage 'if you don't have them, you'll never practice them' meaning that if, for example, you don't have a tendon hammer with you, you won't practice reflexes and therefore you won't improve. This is probably true to some extent although most wards will have some clinical equipment, even if the kits are incomplete and/or hard to find. The clinical studies offices are a good place from which to borrow equipment. Get used to practicing with the ward ophthalmoscopes...you won't get panophthalmoscopes in the OSCE.
- Bags and lockers: carry as little with you as possible as there aren't many convenient places to store your bags safely. Ask where you can put your bag and if there are lockers available for loan: turning up with a massive suitcase on the first day and dumping it in the intern's office will not make you any new friends.
- Phones: everyone has a phone. Don't let yours go off during anything remotely involving patients or teaching – outpatients, ward round, tutorials, meetings - it is obviously disrespectful and shows a lack of concern. Consultants may answer their phone at any time. That is the privilege of being a consultant – they're probably saving someone's life.



WHAT TO WEAR

There is some guidance from the medical school regarding appropriate attire which can be found on the MLTU website. It's worth keeping in mind that many of the consultants are old-school so being more formal rather than less is safe.

- Guys: shirt, pants and neat shoes are the norm – tie on the first day is a good idea and judge whether you think it is appropriate for the remainder of the rotation. Some units and disciplines are more formal than others.
- Girls: less skin rather than more – skirts to the knees. Do not make yourself memorable by your dress code...
- White coats: ask if they are required. The med school does not stipulate although some units will enforce it: e.g orthopaedics and some general surgical units.

MAKING A SCHEDULE

Many of your rotations will be heavily scheduled and well timetabled for you to move from one clinical activity to the next without a lot of space in between. Many rotations however, will be fairly unstructured and considerable time given to 'ward time' or 'individual study'. Early on, find out from the interns, residents and registrars everything that your unit does...from surgical lists to multi disciplinary meetings, pre-admissions clinic to morbidity and mortality meetings. It is important to make sure your attendance at these sessions is appropriate, so ask permission beforehand. Potential clinical activities include:

MEETINGS. Intradepartmental and interdepartmental. They might seem boring but you are PART OF THE TEAM so learn what happens off the ward as well as on the ward.

CLINICS. All of them. Consultant/registrar etc.

STUDENT TEACHING SESSIONS. Small group tutorials, bedside tutorials, observed cases.

WARD ROUNDS. There are often morning rounds but there can also be paper rounds in addition to after-hours and weekend rounds.

GRAND ROUNDS. these may be disciplinary (eg. Medical Grand Rounds) and specialty based (eg. Cardiology Grand Rounds).

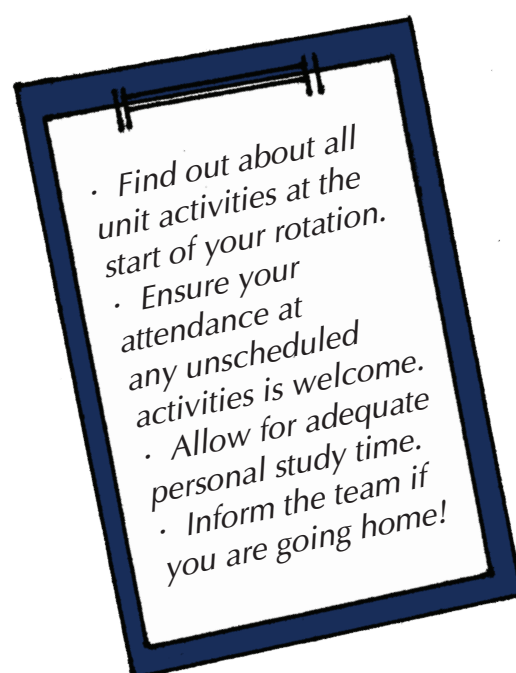
JOURNAL CLUBS. don't knock it til you've tried it. Being able to critically evaluate evidence is key to any evidence-based specialty.

TEACHING SESSIONS. Registrars, RMOs and interns have teaching sessions too. Make sure it's appropriate for you to attend beforehand.

When you have a list of all the things you can possibly attend on the rotation, (students who just finished this rotation are a good source too) write them down and work out a timetable and schedule for each day. You may have to divide up the clinics between other students on your rotation so that there aren't too many of you sitting in on consultations.

Time on the wards is vital to understanding how the hospital works and you will pick up lots of gems, but equally important is passing exams, which requires plenty of time for studying. Schedule adequate time to pour over the books both at home and during quieter times on the wards.

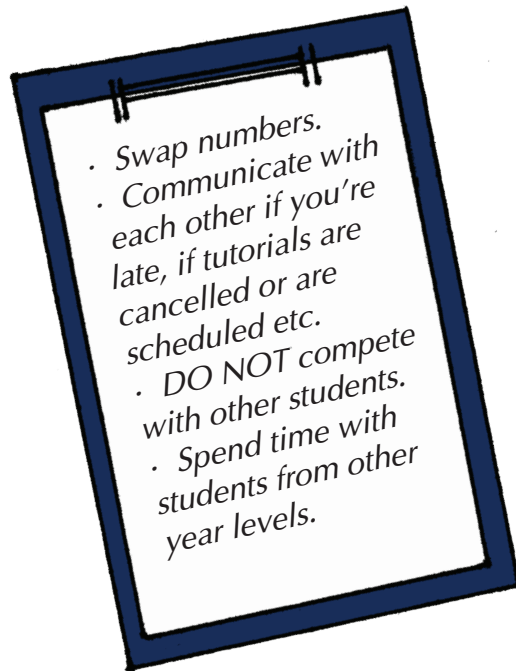
If your day is finished, go home and study, or chill out. There's no point waiting around at hospital for hours on end if time could be better spent studying at home or in the library. Just make sure you let someone on your team know as attendance is part of your assessment on most rotations.



SHARING ROTATIONS

‘Doctors will more often remember your participation as a group, rather than individuals’

There will often be other students on your rotation with whom you will spend several weeks – often for long periods of each day! You don’t need to be the best of mates but if you get along well with the students on your rotation you are more likely to enjoy your time there. This might all seem self evident but several people thought it should be included...



- Exchange numbers on the first day. If you hear of a tutorial being cancelled or scheduled differently, send everyone a text message. If you’re going to be unavoidably late or unable to make something at last minute, at least you can inform your peer(s).
- Take note of interesting patients / clinical signs that you have seen with your registrar and take the other students to see them. Teach the other students what your registrar taught you about the case. This is what we learnt in PBL/CBL didn’t we?
- DO NOT compete with the other students. DO NOT try and trump the other students by attending things in secret. These behaviours achieve very little and the doctors will more often remember your participation as a group, rather than as individuals. It is fine to do your own thing sometimes – it’s even encouraged - but let others know what you are doing and give them the option of joining you.
- Spend time with medical students from other year levels – they’ll often have plenty of tips about exams and handy resources. It’s also nice to meet those who will be your future colleagues in the years to come – so often you hear, ‘ah yes, I remember now, you were my fourth year when I was an intern’ etc.

WARD ROUNDS

The age old ward round is one of the most variable learning opportunities in all of clinical medicine. The variation between hospitals, disciplines, consultants, days of the week is phenomenal. Some will be informative, valuable and full of golden nuggets. Unfortunately, others will be long, irrelevant and a waste of time. Some general advice applies to most though.

ATTEND

It might seem like you are going through the motions by simply walking from one bed to the next without anyone noticing your presence. However, the ward round may be the only opportunity for you to see the consultants on that rotation, and perhaps more importantly, for them to see you as they are assessing you for the rotation. That aside, consultants generally love to have students on their ward rounds and it is a good team-building exercise to have everyone come along. Many of the management plans are made on rounds and absence may result in you missing key decision making steps. If you don't attend the morning ward round it may be assumed you didn't turn up for the day. It's a vicious circle spending time away from a team, as they get to know your peers better, and forget you, which results in all the more scrutiny once you return. If you are genuinely unable to make a particular ward commitment (round, tutorial etc) make sure that you inform the consultant ahead of time – this is common courtesy.

BE EARLY

And if you can't be early, at least be punctual. There is nothing that says more about your lack of application and commitment than rocking up late to a team activity such as a ward round. Getting there early will allow you to:

- look over relevant progress notes/lab results etc for your patients

- speak to the nursing staff who have looked after your patient(s) overnight
- help the intern/resident prepare for the ward round
- print out results/OACIS sheets for the team: you will be credited for this as your name will appear at the top of everyone's sheets – an astute clinician will notice this and your interns will love your initiative.

PREPARE

Ward rounds are a terrific opportunity to show that you have spent time speaking with and examining a patient. Speak to the registrar/resident/intern beforehand and check that it is ok for you to present a patient or two that you have been following. This will be anxiety provoking, but the only way to get rid of nerves in front of consultants is to spend more time around them. Judge the content that is required for the round – a ten minute dissertation on a patient's social history may not be appropriate for a surgical ward round and will not win you any friends on the team. Take time to read up about your patient's condition prior to presenting their progress – you will look good if you can answer questions on the spot! If you don't know something on a round, write it down and read about it THAT day – contextualising your learning around a patient or scenario is vital.

PARTICIPATE

If you feel you have something worthwhile to add to the discussion, and the setting is appropriate, speak up and contribute. No one will criticise you for trying to assist if your comments are thoughtful, although be careful not to over contribute – you are not a consultant. If you don't feel brave enough to ask questions in front of the team, write them down and ask between patients.

CONTRIBUTE

A ward round, despite appearing as a simple process of checking up on each patient, is a multitude of small tasks – history, examination, checking obs/test results, liaising with nursing staff, writing in notes and treatment orders, charting meds and IV fluids and speaking with family. This process runs seamlessly when the roles of each person are known, shared and reliably carried out. If your intern/resident is overwhelmed or you think you can help: YOU can be the person that pulls the curtain for each patient, locates and opens the observation chart at every bedside, carries clean pairs of disposable gloves in your pockets for the registrar, checks whether a new drug chart or additional note pages are needed that day etc...it will be noticed and appreciated!

CONCENTRATE

It is easy at the end of a long Ward round for your mind to start wandering and to lose concentration – often this happens just before you get asked a question and you look silly. Try and stay one step in front – if the intern is asked a question, be ready to answer it if they don't know it. Work through in your own head what your management plan would be if you were the consultant – if your plan differs from the one being used is different, ask a question if it's appropriate.

Listen carefully to how experienced and senior doctors sort through diagnostic possibilities before coming up with a plan – you cannot learn these gems from textbooks. Additionally, write down the names of patients who are interesting/classical or have good signs - if not just for your own benefit to visit after the ward round, you can suggest them to your peers as well.

HARDEN UP

Some consultants take pleasure in highlighting the knowledge gaps in students. Rest assured that most enjoy your company and don't exist just to humiliate you. Expect to make mistakes, but learn from them and try not to make the same mistake twice. Take the criticism if it is fair and remember that everyone on that round has been in the exact same situation before...EVERYONE.



OUTPATIENTS

The 'outpatients experience' is as varied as the 'ward round experience' when it comes to learning. Some clinics are well equipped and geared for learning opportunities whereas others are not. Be prepared for different types.

On your first day, it is polite to introduce yourself (if not already) and ask whether it is appropriate to sit in on the clinic. After the first couple of patients come through and you have a feel for the structure of the outpatient department (OPD), show some initiative and contribute. For a consultant or registrar – a medical student sitting quietly in the corner staring into space is no more useful than a pot plant. Students have been known to fall asleep in the past, much to the disapproval of the consultant or registrar. Some hints:

- Subtly have a look in the case notes of the upcoming patient. Try and present (no more than thirty seconds) the patient and their reason for attending clinic, have the notes open to the relevant page, put the x-rays up on the light box, type their MRN/URN into OACIS.
- Ask questions after patients leave the room. Obviously this might get tedious and time intensive if done for each patient, but for new or complex patients – ask away. You will be

surprised how quickly it might turn into an academic discussion regarding management that is beneficial for both you and the consultant/registrar.

- If there is a complex case or one with contentious management options, offer to do a brief literature review that evening to assist guiding further care. This will evolve into a learning experience for you as well as contributing directly to the care of the patient.
- Once you have been to at least one clinic and learnt the lie of the land, ask if you are able to see the patient first (or better still, if you can be observed seeing the patient). Try to see patients with varied presentations – chest pain clinic is going to be fairly consistent but many clinics have huge variety. Use this opportunity to refine your presentation skills and ask for feedback. Show autonomy and initiative – provide a working diagnosis and a management plan. Presenting patients is scary – everyone feels like this. Get practice. You are allowed to make a fool of yourself in 4th year but in sixth year there will be no excuses for a sloppy presentation.
- Remember your role as a medical student and refer all patient queries to the supervising doctor. Do not ever bluff a patient, or dispense information that you are not 100% sure about... there are no SPs anymore.

'Do not ever bluff a patient, or dispense information that you are not 100% sure about...there are no SPs anymore'

SMALL GROUP, DIDACTIC TEACHING

Turn up and participate. There is nothing more infuriating for a consultant or registrar to arrive for a tutorial and see that half the students haven't turned up yet or have forgotten that the tutorial is even happening. This is incredibly disrespectful and apart from not doing yourself any favours, you also threaten future learning opportunities for the students who will follow you on that attachment. When attending a tutorial:

BE GRATEFUL

Teaching in our current health system is extremely undervalued and most consultants and registrars are not paid for time they take out of their day to teach – it is often in their own 'free' time. Show them respect and at least turn up on time...even if you are caught in clinic or in theatre. Similarly, show some understanding if tutorials are cancelled at last minute – this is often out of their hands too.

BE MINDFUL

Teaching is rarely 'taught'. You will come across some outstanding teachers throughout your terms in the hospital and by the same token you will have tutors that are inexperienced and a little uncertain – not everyone is a born teacher. Be mindful of this before canning someone's tutorial. Before you know it, you will be up there teaching the next batch of bright eyed, bushy tailed medical students and it's not as easy as it looks.

PREPARE

If there are set questions or topics for each tutorial – whether provided the week before or in the briefing document at the start of the rotation – make sure that you have read over them and are familiar with the content of the tutorial before arriving. The tutor will be disappointed (read: angry) if you haven't put in the time or effort to prepare. If you don't know the answer to a

question – try and think through your answer using a structure. For example, you will always get asked 'what are the causes of x?' Learning lists of the most common and most dangerous conditions is vital but beyond that, using a surgical sieve such as VINDICATE (see below) is often a good approach.

Vascular
Infective, inflammatory
Neoplastic
Drugs, degenerative
Iatrogenic, idiopathic
Congenital
Autoimmune
Traumatic
Endocrine/metabolic

BE PROACTIVE

Confirm the day before with the 'tutor' that the session is still on and the proposed content. Many consultants and registrars will teach on-the-fly and ask you for some topics to cover during these sessions – 'what do you want me to teach you?' Brainstorm some important topics and questions beforehand as a group. Stay away from straightforward areas that can be read out of a book or rote learned (eg. 'aetiology and pathophysiology of atherosclerosis') and aim more at clinically focussed problems that you will deal with as a medical officer. 'Approach to', 'management of' and 'interpretation of' topics are a good way to start.

- Approach to: hyponatraemia, the confused patient, neck lumps, post operative fever, first psychosis, antibiotic choice...
- Management of: heart failure, atrial fibrillation, haematuria...
- Interpretation of: blood gases, chest x-rays, fractures, ECGs...

BEDSIDE TUTORIALS

Absolute gold mine. Make the most of these opportunities – they may occur only once per week but are always full of gems. These tutorials will often involve the consultant or registrar (or intern) taking you to see a patient and asking one of the students to demonstrate features of pertinent history or examination – ‘examine this patient’s abdomen’. They generally go for an hour or so and will often be in groups of four or five students.

PREPARE

This is a recurring theme throughout this guide, but again of critical importance to the bedside tutorial. In a group of four or five it is very difficult to hide if you don’t know what you’re doing in front of a REAL patient. There are very few things more humiliating than not doing your homework, being selected in front of the group and completely stuffing it up, only to have your peer take over and destroy you because they took thirty minutes to read over it the night before. Don’t let it happen to you. Also, toughen up. This will not be the last time you will have to demonstrate an examination in front of your peers. You will naturally be nervous and probably stuff up a few times – everyone’s been there – practice makes perfect.

CONTRIBUTE

If the tutor asks for a volunteer and you’ve prepared, get in there and have a go – they’re often a bit more lenient on the student that goes first! The opportunity to be observed taking a history or examining a patient is rare and if you keep letting others volunteer in front of you, you’ll never improve. It is very easy to be a passenger and let everyone else have a go first. Tutors may ask if you know of any good patients on the wards – keep abreast of the patients that are around the place, not just on your unit. Revising the respiratory examination will be far more fruitful if you can find a patient with some good respiratory signs for the group – ask other residents/interns/students from other units if your service is quiet.

ASK QUESTIONS

Despite Dr Kildea’s revolution of the clinical skills programme in years one and two, many senior clinicians’ expectations of your examination skills will be modest – take the bedside tutorial opportunities to ask plenty of questions: how to assess the JVP, how to test for shifting dullness, etc. Remember there are many ways to skin a cat...learn all the different ways to assess ‘power’ in the neuro exam.

‘There are very few things more humiliating than not doing your homework, being selected in front of the group and completely stuffing it up, only to have your peer take over and destroy you because they took thirty minutes to read over it the night before’

'Additional time will allow you to learn practical skills normally reserved for junior doctors'



It might seem like a very unappealing idea to stay beyond 5pm or come to 'university' on the weekend when none of the engineering students will be doing it, however the learning opportunities are second-to-none. The hospital is a very different place out of hours - less staff, less support, more responsibility placed on junior staff. Not only does this translate into better learning opportunities for you but it is important to get some experience about what it will be like for real in just a few short years. For this reason the medical school requires you to attend some on-call and after-hours sessions during most rotations, but if no one is rostered on during the other after-hours sessions, have a think about attending some extra ones.

INDEPENDENCE

When it's not too hectic or out of control, often the registrar or intern will let you see the patient first - whether it's a ward consult or an admission in ED. This will allow you to take a history, examine the patient, start writing up a note and then present the patient. This is a top learning opportunity and although you will feel out of your depth initially, the more you practice the easier it becomes. The nice by-product of this is when the team meets the next morning, or on Monday, you've got the upper-hand and can present to the entire group.

PRACTICAL SKILLS

Additional time will allow you to learn practical skills normally reserved for junior doctors such as arterial puncture, suturing, assisting in theatre, as well as a greater likelihood of doing the regular things like NGTs and catheters. Additionally, if you're on a surgical rotation and someone is taken to emergency theatre, there's every chance that you will be able to attend and potentially scrub and assist.

ADDITIONAL INSIGHT. As mentioned, on-call or after-hours attendance allows you to experience what it will be like as a JMO, but additionally provides you with a more accurate idea of what that particular vocation is like too. Spending time on call with the registrar allows you to ask about training programmes, time commitments and 'what it's really like' in some of these specialties. The dress code is also normally a bit looser on the weekends too.

In the end you also have to feel refreshed for clinic and hospital commitments, whether they be the next day or on Monday so make sure you give yourself plenty of down time. Soon enough you will be in the hospital system six-seven days per week and you'll regret not having made the most of your med school free time!

WHAT DO I DO 'ON THE WARDS'?

After morning rounds, there is often a period when everyone goes and does their 'jobs'. Often you'll be able to help them – chasing blood results, taking blood, putting in catheters/jelcos etc – whereas other times you may not be able to. So if you have no clinic, no meetings, no tutorials and it's truly 'free' ward time, here are some suggestions for ways to maximise your learning:

PRACTICAL SKILLS

Perfection at procedural skills comes with practice – even the most experienced anaesthetist does not have a 100% strike rate with jelcos. Ask if there are any that need doing, or let your intern know that you'd like some practice. Every patient going for surgery, endoscopy/colonoscopy and to CT needs a jelco so keep those in mind when doing some 'searching'.

ATTACH TO A PATIENT

When you feel a little bit more 'at ease' with how the ward runs, speak to your intern and offer to 'look after' one or more patients on the list. This is the best way to understand the role of an intern and a JMO. If there's time, follow your patient through their admission – if they go to have an x-ray, ask if you can go too. The same applies for allied health appointments, family meetings and discharge planning sessions. Not only will you find this fulfilling but the patient will often be grateful for the company and continuity that you'll provide.

PRACTICE, PRACTICE, PRACTICE

Many OSCE assessors will comment that they can determine within the first fifteen seconds how well a student will do in any given station. This is because it becomes evident very quickly how much practice you've done.

The following model is just one way for you to

1. Pair off. One to 'practice' and the other to assess, just like an OSCE. Make sure you mix up your pairs so that you're not getting the same feedback/points of view each time. This will improve everyone's skills.

2. OSCE-style. Introduce yourselves like you're preparing for exams. The 'assessor' goes in first, alone and pulls the curtains: 'Good morning, my name is <FirstName> <LastName> and I am a 4th year medical student. My friend <FirstName> <LastName> is around the corner and has his/her exams coming up shortly, would it be ok if he/she did a brief examination of your heart and chest? If anyone comes to visit or you would like to stop at all, please let us know'. Then the other student comes in just like an exam. This is ultra nerve-wracking but there is NO substitute for this sort of practice.

3. Record it. If you're serious about this, make notes about EVERY examination you do and write down the feedback you got from your 'assessor'. This keeps a record of how many of the different examinations you've done and will also track your progress. It's also nice at the end of the year to see how prepared you are for these exams ALREADY!

PERSIST

It is TOO easy to decide to go and see 'bed four' and arrive there and find she's at x-ray and then say, 'oh well, it wasn't to be' and forget about it. Try again later, come back tomorrow...learning opportunities, especially patients, need to be sought. If you're having trouble finding patients, especially those with signs, ask other teams in the hospital – 'I'm looking for a patient to do a respiratory examination on, is there anyone under your service with chest pathology?' If you're having trouble finding patients who will let you do a complete examination, just ask if you can listen to their heart or something more focussed and less invasive. Further to that, take a walk around the ward(s) and peek into each room. If the patient is alone, awake and appears to be comfortable they may be the perfect choice for a practice history or examination. They will often appreciate the company and it provides a great opportunity to examine someone where the admission reason has to be sought from the patient, not from the notes, and to tailor your examination accordingly. You never know what

you'll come across!

BE RESOURCEFUL

Think outside your department to complete your learning. If you're keen to do a neuro exam, ask the intern on 'stroke' if they could suggest or introduce a patient to you. This goes for ALL specialty units: diabetic legs are found on vascular surgical wards, breath sounds are found on respiratory, chest pain histories are found in cardiology... move outside your general units but only WITH PERMISSION – do not impede the learning of other students who are already, and supposed to be, on those units.

SHOW UNDERSTANDING

You may be the fourth group of students who has asked to examine Mrs Smith this morning so don't be disappointed if they she says no to you. Although patients are learning opportunities, they are also human beings who are unwell and in hospital for a reason.

*'It becomes evident very quickly
how much practice you've done...
Learning opportunities, especially
patients, need to be sought'*

A WORD ON ASSESSMENT

Each rotation will have different assessment tasks, so be sure to clarify exactly what is required and expected of you during your rotation – especially with regard to attendance. An introductory or briefing document is provided for each rotation for good reason – READ it...they will assume you have. Where there are things that need to be 'ticked off', try not to leave them to the last minute. Have a chat to students who have just completed the rotation – they'll have plenty of advice about how to approach the assessment tasks and what sort of material is important for the exams/OSCE/VIVA at the end of rotation.

TURN UP

In order for someone to assess you they have to have actually seen you. This sounds obvious but if you don't turn up to the unit meetings and don't make the ward rounds – you will very easily receive a poor assessment regardless of your actual clinical ability.

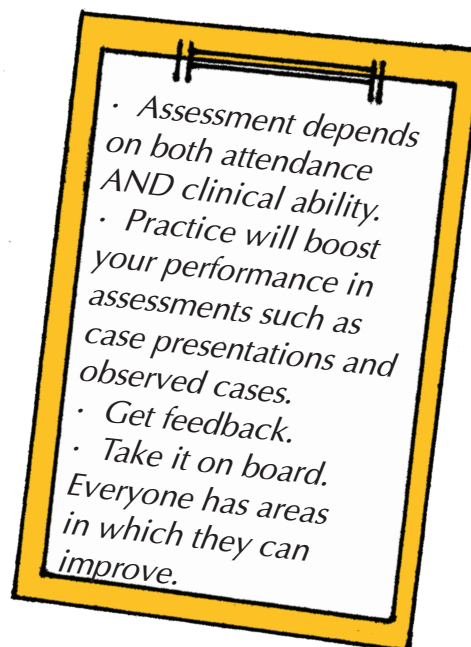
PRACTICE

A lot of your mark will be based around discrete tasks – like a case write-up or an observed case. Additionally, presentation skills are often a key component to a rotation assessment: they demonstrate several skills at once – accurate and relevant examination, salient and thoughtful history, and collating them all into a summary. This takes PRACTICE so don't let your assessment for an entire rotation be determined by your first attempt at a case presentation.

LISTEN AND ADJUST

Part of the assessment process is to get feedback about how you are going with your studies. Listen to your assessor's comments, particularly when they are critical. Many students claim they didn't receive enough feedback when the writing was probably on the wall for quite some time.

If you don't understand your assessment or would like additional feedback about how to improve, ask. End of rotation assessments are important, but they are not the be all and end all – there is normally plenty of time to work on your weaknesses and improve before exams.



FOLLOW THE REGISTRAR

If it is appropriate, ask the registrar if you are able to shadow them for a day or two. Depending on their specialty and their job requirements, you will often have the opportunity to see them offer consults to other disciplines, attend emergency calls, go to theatre, admit patients, and direct management with the treating team amongst many other jobs.

Whilst learning the role of an intern is important, the registrar is often the one who is doing more of the 'medicine' so make sure you have a good appreciation of what they do. Often you can be one-on-one with them so that you can ask questions and discuss topics/themes during and after individual jobs. They are frequently learning for (or fresh from) exams so are very

much on top of their game. It may be worth coming in after hours or on the weekends for this opportunity, particularly because they may have more time to talk to you.

Ask if you can be observed doing something... this is the BEST way to learn.

If a registrar asks you to do something (eg. cannula/jelco, catheter, NGT) ALWAYS ACCEPT. It is expected that you will stuff up as a student but in a few years time these skills will be expected of you and it will be embarrassing if you stuff them up then. The registrar will also appreciate that you are trying and interested in learning. These guys will also be your bosses one day...food for thought.

'It is expected that you will stuff up as a student but in a few years time these skills will be expected of you and it will be embarrassing if you stuff them up then'

GOING TO SURGERY

You will receive plenty of orientation support about how to attend your first surgical cases so this will be very brief:

ACKNOWLEDGE YOUR STATUS

When you first arrive in the theatre, introduce yourself as you normally do, but impress upon them that you're new to this and if they could assist you in learning how the theatre works and where you should and should not stand etc. Try and get one of the nurses to look after you – the surgeons are often very busy and don't have time to take you through everything but the nursing staff are often very happy to help, particularly if you are polite and attentive. If you muck up – like brush past a sterile surface, they are less likely to destroy you if they know you are only new. You will need to attend a theatre orientation and scrub session before going to theatre.

PREPARE

If you know you are going to theatre the next day, ask the registrar for a copy of the theatre list and read up the night before about the procedure(s). This does not mean you have to become a surgical registrar overnight but a good understanding of the aims of the procedure as well as the important anatomical landmarks

will make you look polished. For example, the common questions in theatre are: 'What is this layer I'm cutting through?', 'What do I want to be careful of here?', 'What does this structure form the border of?' These might seem esoteric unless you're pursuing a surgical career but the applied, surgically relevant anatomy is not actually that bad. If you've got ample time before heading to theatre, try and read through the patient's admission note and find out why they're having the procedure and a little about their past medical history – it will add significantly to the learning experience.

BE PUNCTUAL

Get there nice and early for your theatre session. Allow time to find your way to the change-rooms, to try on a couple of sizes of scrubs, to find a hat that fits and then PLENTY of time to get lost finding the correct theatre! Theatre suites are massive and often very busy so it's easy to get lost. Try and find someone to help you find the right place. If you arrive early, most theatre areas have a tea room you can wait in. Alternatively you might like to read the case notes of the upcoming case or observe the anaesthetist prepare the patient – the latter is a fantastic opportunity to practice your cannulation skills.

' [The nurses] are often very happy to help – particularly if you are polite and attentive. If you muck up – like brush past a sterile surface, they are less likely to destroy you if they know you are only new '

TIP: DO NOT refer to a surgical procedure as a 'surgery' - they should be referred to as an 'operation'. Some surgeons are VERY particular about this.

CONDUCT

The environment of operating theatres can be varied depending on the case and staff involved. Some universal principles include – not touching anything blue or green unless scrubbed (usually sterile surfaces), sense the right time to ask questions (ie. not during a particularly intense aspect of the procedure) and turn your phone off! Most theatres have stools intended for use to get a better view over the surgeon's shoulder. Nursing staff often appreciate an extra pair of hands to assist move the patient after the operation, but always follow the anaesthetist's or nurse's instructions.

SCRUBBING UP

You might be lucky enough to scrub up and assist in a procedure. If so, politely request the 'scrub sister' to assist you scrub, glove and gown. There is strict procedure to follow to ensure you arrive at the operating table as sterile as possible. Common errors are - not taking off hand or wrist jewellery, forgetting to put on a mask before scrubbing and incorrectly putting on your gown or gloves. Lastly, it is not uncommon to feel faint or claustrophobic when scrubbed for the first few times. Don't be embarrassed if this occurs: speak up and sit down – it is better to avoid fainting and cop some friendly banter from the theatre staff than potentially keeling over head first into an open wound!



IN YOUR SPARE TIME

As mentioned, most rotations will have 'hectic' days and 'slow' days and making the most of both is important: spending time in hospital if you are doing nothing is not a good use of time. If you have no ward jobs, no clinic, no tutorials and you've done history/examination practice for the day, here are some suggestions:

OTHER CLINICS

There are frequently far more clinics than there are students. If you'd like to brush up on one particular area, find out when they're having clinics and ask the consultant if you can sit in or see some patients. The success of this will depend on whether the consultant is happy to have you around and also whether there are already students present in the clinics – again, don't let your presence impact on the students who are attending their 'scheduled' clinics.

STUDY

Bring your text books with you. Read about the conditions your patients have on the ward, prepare for some 'grilling' on the ward round, in outpatients, in tutorials, read about an upcoming case in theatre, do some pre-exam revision. There are plenty of things only available at the hospital that you can make use of: clinical guidelines, up-to-date, reference books, the list goes on.

TESTING

There is never a shortage of things you can go and watch in the hospital. You can rock up at

any number of departments, introduce yourself, and ask whether it would be ok to observe x, y or z. Such things include: Radiology (x-rays, US, CT, MRI, interventional procedures), nuclear medicine (whole body bone scans, thyroid, cardiac stress), dialysis, pulmonary function testing, endo-/colonoscopy, radiotherapy...the list goes on! It's even worth seeing if you can spend a couple of hours in the IMVS – learn what goes into doing a CBE or a biochem...think how many we order every day!

GO HOME

If you are able to use your time in the hospital fruitfully during slow days, by all means stay there. However if the registrar tells you to leave, then just... go. There is no need to make a 'martyr' of yourself by staying till the bitter end on a day where nothing is happening. That time may be better spent studying at home, or just taking a break from it all.

ALLIED HEALTH

If you order some chest physio for a patient – hang around and see what's involved. Similarly if you order a swallowing assessment – find out how the speech pathologist makes the decision to move from liquids to a ward diet. You might not be tested on this during an exam, but unless you know what's involved with these assessments, or at least that they exist, you won't effectively integrate multi-disciplinary care. Same goes for social work, OT, discharge planning.

'There are frequently far more clinics than there are students. If you'd like to brush up on one particular area, find out when they're having clinics'

THE EXTRA MILE

At the end of the day, it is well and good to do some extra things on the rotation but unless you complete the required assessment tasks it will have been of no benefit to you - do the important things first, and do them well. There is no need to go the extra mile but if you are particularly interested in the discipline or are just enjoying the rotation, by all means do a bit extra. Your best bet may be to ask the registrar or consultant directly but some of areas suggested in the past include:

UNIT PRESENTATIONS

If this is not already a part of your assessment, offer to present an interesting patient or case at the weekly/monthly meeting. Not only will this demonstrate your enthusiasm but will be another opportunity to hone your presentation skills. If you're anxious about doing one all by yourself, offer to help the registrar or cover one aspect of the presentation like the 'literature review'. Some comments about unit presentations:

- Do not be the tenth student this year to present a case of pulmonary embolism.
- Tie your presentation in with a patient who has recently been under the care of your unit. Present a succinct case synopsis to set a contemporary scene to your presentation.
- Stick to your time limit – unit meetings are normally very busy.
- Minimise text on the slides. Let them focus on your verbal content instead.
- Aim to use your presentation as a tool to generate discussion amongst the clever heads who will be listening to you! NB: this will also take the heat off question time for you!
- Try and find some interesting photos or multimedia – it'll add a bit of interest to your presentation.
- Know some academic interests of the consultants on your unit. If you are presenting a topic that one of your consultants has published extensively in, it would be unwise not to acknowledge this!
- If you're keen for input, practice the presentation or show the slides to one of the interns or senior medical students beforehand. This can be done informally on the ward office computer.

RESEARCH PROJECTS

Many units will have some sort of ongoing research or at least an interest in research that you will be able to be involved in if you wish. Make your career inclination known (or general interest in doing something extra) and ask towards the start of the rotation if there are any ongoing or looming research projects that could 'use an extra pair of hands?' Alternatively, and less demanding, offer to conduct an audit to be presented at the end of your term. An example of how this might first be broached: 'I was wondering if there are any audit topics that I might be able to do some work on the present at the end of my rotation?' 'I have noticed that pancreatitis is a relatively common presentation on this unit – I would be interested in doing an audit of the aetiology and type/volume of fluid resuscitation'. Tailor the topic to something that YOU find interesting.

CASE REPORT

Occasionally your unit or team may be involved in caring for a patient who has a very rare or unknown condition, or they presented very unusually. These may present themselves as a unique opportunity to write up a 'case report' which could be submitted for publication. You will need guidance from the consultant or registrar as to whether they case is worthy of this but if the opportunity arises, learning to write a case report is a handy skill and the publication is a nice reward for a bit of extra work.

HOW TO LEARN DURING A ROTATION

Everyone's different and different approaches will work for different people. It is very important, however, that you don't get overwhelmed with the quantity of material that is presented to you. For example you may see sixteen patients on a ward round with sixteen different conditions – you can't expect to master all of these overnight or even over a couple of days. In the same breath, you've got nine weeks to learn 'General Medicine', so you've got to be pragmatic about what your learning objectives should be.

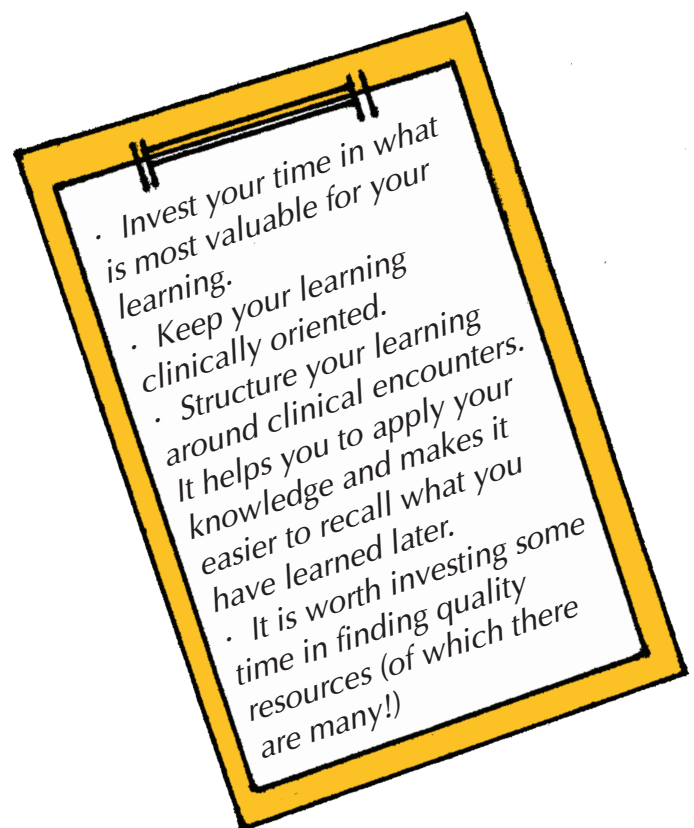
OBJECTIVES

Some units and rotations will provide you with a list of 'important conditions' or diseases to cover. Some of them may even prioritise them as A, B or C as far as importance goes. Remember the philosophy 'common things occur commonly' and focus on the bread and butter of a specialty/rotation and the common treatment and decision making algorithms. Learn the hospital protocols and relevant guidelines on day one!

DIRECTED

Keep your learning clinically oriented. Rather than just looking up 'pancreatitis' from epidemiology through pathogenesis to management – try 'approach to abdominal pain' and think about how you would evaluate a patient to discern the different causes. What are the important features of history to ask to differentiate it from other causes, what examination findings make it more or less likely, what investigations will establish or rule out diagnoses and direct your management. Try and direct your learning in the vein of 'Approach to the patient with..., management of a patient with...' Imagine you are a resident on the ward and are asked to see a patient with breathlessness, what are your differentials and how will you manage it? What are the important

complications that you need to watch for in a post-operative patient? NB. Whilst it is an unbelievable feeling assisting in or even just watching operations remember that the learning and knowledge return of watching fifteen laparoscopic cholecystectomies is low. By all means try and see at least one of everything – it is preferable to have actually seen the operation when discussing it with a patient – but don't let it compromise your 'theoretical' learning during the rotation: you will not be asked how you would approach an anterior bowel resection in November.



CONTEXTUAL

CBL is based around a patient scenario for a good reason: it is easier (and memorable) to learn about DVT if you speak to and examine a patient who has one and then follow their management, than it is just to read about a treatment guideline. Take the time to follow patients from their admission to their discharge. If they go for radiology – ask if you can go with them. If they go to theatre, ask if you can attend +/- scrub. If there's a family meeting, ask if you can observe. Following patients through their entire admission is extremely valuable. Following three patients at once for their complete admission is far more beneficial than half-following and sort-of-knowing fifteen patients.

Despite real patient scenarios being undoubtedly the best mode of learning, unfortunately patients are not able to tell you everything you need to know about their conditions. Cases you come across should stimulate further self-directed learning. You will find that you retain this new knowledge very well by being able to categorise and affiliate it with the patient you saw. Some texts and references are better than others depending on the rotation you are doing.

'HOW DO I KNOW WHAT TO READ?'

STAFF

Ask your intern or registrar. They have been there and probably used some of the books at your disposal. They might even have a spare copy lying around to lend to you.

STUDENTS

The students that just went through have completed the end of rotation and will have plenty of advice about useful (and useless) resources – don't forget to ask them!

HOSPITAL INTRANET

Look on the intranet for hospital protocols. They are all written by heads of departments specific to the hospital you are at - unlike many American, UK and even Australian texts which may offer conflicting management. There is a plethora of information out there: National guidelines: NICE (UK), ICSI (USA), NHMRC (Australian), NZGG (NZ) as well as organisation guidelines: Asthma council, Heart Foundation, etc...check the amss.org.au website for more information.

HOSPITAL COMPUTERS

Many useful reference tools are available for free through the hospital computers. Up-to-Date is one of these (use the free printing sparingly!) as well as a number of online databases. Check out the AMSS website for other links through the university.

FEEDBACK TO UNITS AND TEACHERS

FORMAL

Many units will ask for your feedback through surveys. Yes, you don't HAVE to fill it out, but it means a great deal to these units to get feedback – positive and negative – from the students. Take the time to fill this out and help improve the programme. Be constructive with criticism and suggest improvements – avoid straight derogatory comments. There are also opportunities throughout the year to nominate both teachers and departments for prizes and awards which recognise excellence and service.

INFORMAL

If it is appropriate to provide informal feedback, do not hesitate to do so if you found something particularly useful or valuable – the staff will appreciate your acknowledgement. In the same breath, do not be afraid to provide the clinical studies departments and/or your education reps with feedback when things aren't working too well.

THANKS

Thanking the members of your team, especially those who have taught you personally, is really important. A card and a small group gift (does not at all need to be extravagant or expensive) although not expected by any means, will be appreciated by the team – preferably done after your assessment has been completed.

'Many units will ask for your feedback through surveys...take the time to fill this out and help improve the programme'

GLOSSARY OF NEW TERMS

ACAT: Aged Care Assessment Team. Multi-disciplinary team which is often involved in discharge planning if patients need to be placed in nursing home or care facilities. You will be attached to this team in fifth year.

Allied Health: Can involve: occupational therapists (OT), physiotherapists (PT), speech therapists (ST), social workers etc.

ATSP: Asked To See Patient. Acronym used if asked to consult a patient when on call.

Clinic: Also known as outpatients, OPD. Patients seen in clinic are often referred from outside the hospital through GPs and other primary care providers or otherwise are being seen for follow up from a recent admission.

CNC: Clinical nurse consultant. Often the nursing 'Head of Unit'. They are highly trained nurses with a very good understanding of how the unit works and may help introduce you to nursing staff.

Consultant: The bosses. They have done extensive training to be where they are so give them the respect they deserve. Not all consultants are Professors.

DC summary: discharge summary. A written account of the salient details surrounding a patient's admission. This is compiled by a member of the treating team – often the intern or resident. It is then mailed out to the patient's GP and other members of the patient's care team.

Fellow: Generally a doctor who has completed their basic specialty training and is doing further sub-specialty training. They are essentially at consultant level and should be treated with the same respect. In some cases they are from overseas and are actually regarded as consultants back home. They are often great sources of teaching opportunities if they're not too busy.

Intern: First year as a doctor. Able to prescribe within the hospital system. Remember that at the start of the year they will be finding their feet. They do rotations like you so on the first days of their new rotations they might need your help too.

Jelco/cannula: Called different things in different hospitals - one of the original brand names was 'jelco' hence the name has stuck. Basically a tube that can be inserted into different body cavities, normally a vein, that allows fluid to be given, 'a drip'.

M+M: Morbidity and mortality. Often there are M+M meetings which discuss which patients have died over the last week or so and discuss situations where patient care could have been improved.

MET call: A call made to the Medical Emergency Team when a patient's vital signs deteriorate and fulfil that institution's criteria for immediate medical attendance. The MET members are usually the 'on call' team for that day and each carry a MET pager – intern/resident/registrar. Attend as many as you can without getting in the way.

GLOSSARY OF NEW TERMS

Metabolic Clinic: Mid-morning, post-round coffee break.

Mrs Brown: 'Going to see Mrs Brown (or Mrs White)' means going to have coffee.

Nerd box: Clipboards that you can purchase from Officeworks or the like that have the capacity to open and hold paper/notes etc within them. They may not be the coolest looking things (hence the name), but are very practical.

NGT: Nasogastric tube.

OACIS: The computer system facilitating access to radiology/laboratory results as well as discharge summaries. Get your username ASAP – this involves a training session which can be organised through your clinical studies office at the different hospitals. There are important rules that must be followed when using OACIS – do NOT break them. Breach of confidentiality is a SERIOUS offence.

Occam's razor: Famous principle that the simplest explanation for a given scenario is often the best. In medicine, that a patient's signs and symptoms are described by one condition or disease rather than multiple different processes acting simultaneously.

OHCM: Oxford Handbook of Clinical Medicine, or bible. Useful one page synopses of most of the common conditions you will see on general medicine/surgery. Not truly a 'pocket textbook' but definitely a lot more portable than Cecil.

On take: When a unit is 'on take' it means all eligible patients that come through the ED will be admitted under their care (i.e. appendicitis will be admitted under the 'taking' Gen Surg Unit). On General medical and surgical units, this responsibility is rotated on a regular basis so that the work load is shared evenly. Being 'on take' means you'll have the best opportunity to see patients by yourself and work them up.

Orderlies: Have different roles in different hospitals but whose general role is to transfer patients between wards and departments. If you organise for an inpatient to have an x-ray, an orderly will transport them to and from the radiology dept.

OT: Occupational Therapy. Often an important part of rehab and discharge planning.

Pager: Pagers are carried by almost everyone in the hospital except students. By 'paging' someone, their pager will ring and display the phone number from which you 'paged' them – they can then call you directly on that line. The paging codes are different for each hospital so find them out from 'switch'. There is plenty of paging etiquette – don't page more than twice in short succession unless it's an emergency or vitally important, make sure you don't use a phone that someone's just 'paged' from etc. You will learn.

PGY 1/2/3: Post-Graduate Year 1/2/3. PGY1=intern. PGY2=resident or registrar depending on whether they are in a specialty training program or not.

Pre-ad: Pre-admission clinic is attended by patients prior to their admission. This is often to optimise their condition prior to admission: check bloods, check medications, check pre-op instructions.

Registrar: Is a doctor who is at least PGY2 and is enrolled into a training program. A medical registrar is someone who is in physician training. A cardiology registrar will be someone who has completed basic physician training and is in the cardiology training program. The registrar status in surgical training is a little more complex with the SET process. Ask if you're unsure.

Resident: RMO or Resident Medical Officer. Not every unit will have residents.
JMO: Junior Medical Officer is a broad term to define anyone still in training but more specifically the PGY1 and PGY2 years.

RN/EN: RN = registered nurse. EN = enrolled nurse. The ENs have done less training and may not be able to dispense some medications. Their uniforms may be slightly different.

Security staff: It may seem odd to have security staff in the hospital but they are often present if the patient is an inpatient from a correctional facility or if they are detained under the Mental Health Act. Say hello to them because they must get bored.

SOAP/SBAR: SOAP is a common acronym used to help medical staff structure their clinical notes:
S: Subjective, O: Objective, A: Assessment, P: Plan
SBAR is another acronym that is used within the allied health professions to structure notes. It is often used for incident reporting as well.
S: Situation, B: Background, A: Assessment, R: Recommendations

Switch: Means switchboard. Will be able to connect or page anyone in hospital for you.

Up-to-Date: Amazing website which is a database of reviews written every 6 months on conditions and their current, evidence-based management. Available from most hospital terminals but unfortunately not from home yet.

Ward clerk: This person is primarily administrative and will often be found around a phone or a computer. Their role is to assist in organising patient documentation (retrieving patient notes/records) and organising their transfer between departments of the hospital.

Zebras: When you hear hooves, you think of horses not zebras. Analogy that common things happen commonly.

HIPPOCRATIC OATH

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

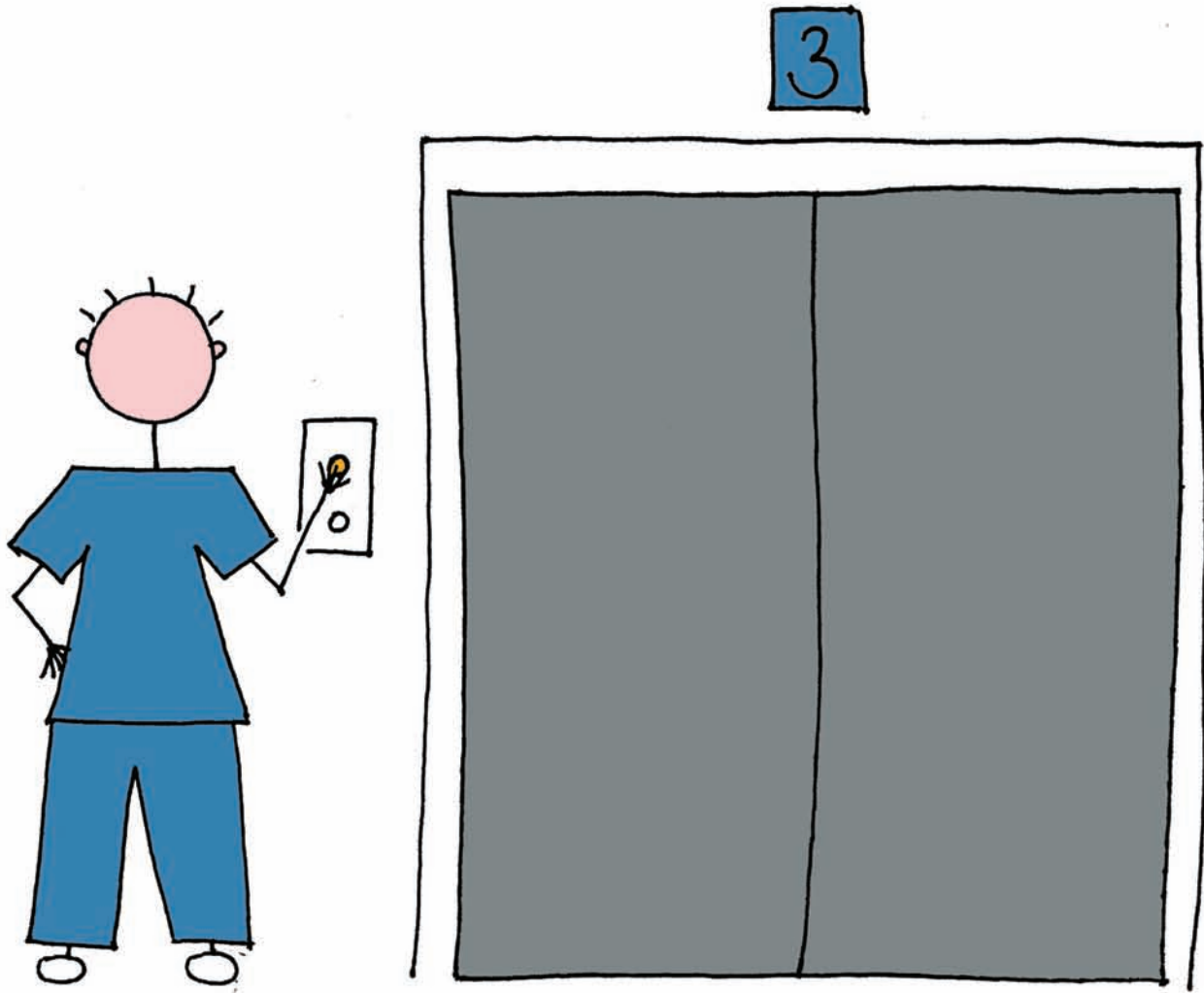
I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

‘ I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon’s knife or the chemist’s drug...I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being ’

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