ADELAIDE MEDICAL STUDENT'S SOCIETY
EST 1889

A GUIDE TO THE CLINICAL YEARS

About this Guide

This is a document proudly produced by the Adelaide Medical Students' Society (AMSS) for medical students entering the South Australian healthcare system ("SA Health"). The Adelaide Medical Students' Society would like to acknowledge the efforts of all who contributed to this document, in particular the lead author Victoria Langton (Vice President Education, 2019). This has since been updated in 2025 to reflect any changes since its creation.

So, congratulations, and welcome to the clinical years! It is an exciting time to finally join the clinical environment on an (effectively) full-time basis, and in many rotations, become part of the treating team that takes care of patients day-to-day. Make the most of this opportunity to apply textbook theory into learning "real-life" medicine. While initially it may be scary, the clinical years are also very enjoyable. To make the transition from pre-clinical to clinical a little bit easier, please find below some general tips (anecdotes, guidance, comments – *opinion*). Take on board some or all of the suggestions – they are meant to help you on this exhilarating ride that is clinical medicine. You may take or leave the advice as you see fit (note the disclaimer).

Above all, the clinical years are about learning the clinical environment and getting a taste of what "real-life" medicine is about. Every team is different. Every patient is different. Learn from all the experiences, good and bad. And hopefully by the end of it, you will grow a little bit more to appreciate the privilege that is medicine.

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The first days

"This is one of the defining times in your career!"

Introduce yourself

The first day of any rotation is always 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, make an effort to introduce yourself in the first few days – **do not wait for someone to ask "who are you and what are you doing here?".** Important people to meet are: consultants, fellows, registrars, RMOs and interns, as well as the clinical nurse consultant (CNC) and nurse unit manager (NUM) from the ward. **The intern (or a 6th year already on the team!) is normally the best person to start with**, as they will be able to quickly point you to the rest of the team, get you linked into the groups WhatsApp chat (if used) and show you around.

Introduce yourself with your preferred name and that you are a Year 4/5/6 medical student. Wear your name badge visibly, so you are easily identified. **Write names down! You will have plenty of new faces to remember!**

Address your bosses correctly

Unless specifically instructed, consultants are never addressed on first name basis. Find out beforehand if it is Prof or Dr (Ask the male if they prefer Mr or Dr, and female surgeon Mrs or Dr). Fellows, registrars, RMOs and interns will normally insist on you are addressing them on a first name basis but make an attempt to use their title in front of patients and when meeting them for the first time.

Clarify your role

Your responsibilities will differ with each rotation, and additional variability may exist between hospital sites. **Find out who is assessing you during your rotation and what is expected of you – ask explicitly**. When the dust settles and you have some quieter one-on-one time with your consultant (e.g. in first tutorial), registrar (e.g. after first ward round), RMO or intern (e.g. in between jobs during the day or after a paper round) a question like "What's the best way to maximize my learning on this rotation?" is often beneficial.

Become part of the team

On many rotations you will be allocated to one specific clinical team. The most successful rotations are those that allow you to integrate as a valued team member. As part of that clinical team, you should endeavour to help out, as befit your comfort level and ability.

- Spend the first day or two observing the atmosphere of the day-to-day running of the ward, and keep an eye out for ways to contribute. Initially, this may involve simple things e.g., on ward rounds you could find the patient notes/chart for the doctors to write in, **Find a WOW for the intern** and pull the curtains/door open and closed, while you observe the rest of the team in action. If you have never performed venepuncture ("bloods") or intravenous cannulation ("jelcos") before, **always observe one first**. Or if you are in a surgical theatre, you could ask whether you may observe from the corner of the operating room.

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- **As you find your feet a little bit more, and as the doctors get to know you a bit more, you may wish to ask to contribute in increasing amounts.** For example, you might ask if you could try writing the note for a patient on a ward round. Similarly, if you have seen one or two Jelcos, you could ask to do the next one under close supervision (with the patient's consent). Or if you are in a theatre list with four patients for the morning, after observing one or two operations, you could ask if you are allowed to "scrub in" for the next patient (but do not be disheartened if the surgeon declines).

It is worthwhile noting that, if someone has asked you to do something, or if you say you will do something, it is very important that you actually do it! For example, if a doctor has asked you to take blood from patient X, then please ensure you do so in a timely manner. If you are unsuccessful for whatever reason (e.g. the patient declines consent, **you have two unsuccessful attempts (this is the maximum attempts**), or the patient is off the ward), then you MUST let the doctor know (ideally immediately) so that alternate arrangements can be made. In addition, if your intern/RMO/registrar/fellow/consultant has asked you to be at a certain place at a certain time, be there. (e.g. "Go have lunch and come back at 2pm" – actually come back at 2pm, do not just bail and go home!)

- Try to participate and contribute to your team.
- Appearing keen and using positive language will aid immensely in obtaining opportunities to help, and therefore learn.
- It is generally unadvisable to demand anything.
- <u>If the team invites you to go for coffee, make sure you go along too – even if you do not like coffee, enjoy being part of the team.</u>

Bring the right things

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

- Something to write on: clipboards/notebooks to scribble down tasks/learning issues.
- Book to read: it is often handy to have something small like Oxford Handbook of Clinical Medicine nearby to read when waiting for a tutorial or an outpatient clinic.
- Clinical equipment: this will vary during your rotation and you will find out what you need to bring. Stethoscopes are usually required.
  - *There is an old adage "if you don't have them, you'll never practice them" meaning that if, for example, you do not have a tendon hammer with you, you will not practice reflexes and therefore you will not 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.*
- Bags and lockers: carry as little with you as possible as there are not many convenient places to store your bags safely. Ask where you can put your bag and if there are lockers available.
- Phones: everyone has a phone. Do not let yours go off during anything remotely involving patients or teaching – outpatient clinics, ward rounds, tutorials, meetings - it is disrespectful.

Come prepared. The bare minimum is correct clinical attire, a pen and your stethoscope.

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Be punctual

Punctuality is extremely important, particularly as one of the most junior members of the clinical team. **It is also one of the most noticeable aspects of a student's behaviour, and tends to be equated to the professionalism of that individual**. If you do not know the answer to a hard question, or if you miss taking bloods, that may be easily overlooked. However, if you are late, especially consistently, it will be noticed and frowned upon. As to how early one should arrive, it is safe to arrive at least five minutes prior to the designated start time (safest would be ten minutes prior). **Sometimes, being late is inevitable; in those cases, it is courteous to inform your team and apologise** (e.g. via text message to your intern).

Maintain confidentiality

Patient confidentiality is of vital importance. Indeed, breaking patient confidentiality (even unintentionally) is grounds for termination of employment. ALWAYS dispose of confidential information (e.g. patient lists, notes you have taken of patient's that do not require filing in the case notes, etc.) in the "confidential bins" on each ward, **they are blue with a slot in the lid. DO NOT put confidential information in normal, medical waste, or any other bins other than the specific "confidential bin". DO NOT lose confidential notes.** If you do not know where the confidential bin is, then ask. For example, if your team's intern helpfully prints out lists for everyone (including students) for the morning ward round, then absolutely make sure you dispose of the patient list in the confidential bin that afternoon before you go home. (If you lose the list, you could potentially face punitive action – or worse, you could get *them* fired.) Similarly, **always be careful discussing patients orally, but especially in non- clinical public areas** such as the corridors, the stairwell or in cafes. Minimize discussion of patients in those public areas, and if absolutely necessary to discuss then good practice is to use the patient location (e.g. ward X bed Y) or initials when referring to patients when in public instead of their name. Even then, however, be careful.

Adhere to the infection control standards

Ensure you adhere to all relevant clinical guidelines on infection control. This includes but is not limited to: no acrylic nails, no lanyards, hand hygiene, cleaning of stethoscopes between patients, and contact/droplet/airborne precautions as appropriate. **Avoid COVID Patients and do not visit covid wards. Do not enter patient rooms with respiratory symptoms/enhanced precautions UNLESS they have returned a negative covid swab**

NEVER compromise patient safety. The patient comes first, ALWAYS.

Be respectful to fellow students

Often there will be other students on your rotation with whom you will spend several weeks, often for long periods each day! You do not need to be best mates but if you get along well with other students you are more likely to enjoy your time at hospital.

- Exchange phone numbers on the first day.
  - If you hear of a tutorial being cancelled or scheduled differently, send everyone a message. If you are going to be unavoidably late or unable to make something at last minute, at least you can inform your peers.
- **NEVER talk badly about another student behind their back, and most certainly**

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NEVER throw another student under the bus.

  - For example, if you are asked where your fellow student is, and you are unsure, then say you are unsure. (*Maybe they could be at a tutorial?)*
  - DO NOT compete with the other students. DO NOT try and trump the other students by attending things in secret. If you and your fellow students have mutually agreed on something (e.g. to study in the library that afternoon, or if you will take turns alternating between being in theatre and being on the wards), then stick to what has been agreed – do not go behind your colleagues' back (e.g. attending theatre yourself when you know they will be there). 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, but let others know what you are doing and give them the option of joining you.

- Help each other out: share resources, advice, etc.
  - 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.
- Spend time with medical students from other year levels – they will often have plenty of tips about exams and handy resources. *It is 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.*

- Swap numbers.
- Communicate with each other if you're late, if tutorials are cancelled, etc.
- DO NOT compete with other students.
- Spend time with students from other year levels.

Be respectful to nursing and allied health staff

You are a medical student training to become a doctor, so 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. Furthermore, do not treat nursing or allied health staff as "inferior" to you – not only is that kind of sentiment completely incorrect, but also that sort of attitude if maintained into when you are a doctor will simply lead to resentment and/or breakdowns in communication which will ultimately negatively impact the patient. Most of the time, nursing, allied health staff and pharmacists have much greater knowledge and experience than you, even after you become a doctor. Listen (albeit critically) to what they have to say!

"People will forget what you said, people will forget what you did, but people will never forget how you made them feel." Maya Angelou

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Making a schedule of key activities

Early on, find out from the interns, RMOs, registrars and fellows everything that your team does (students who just finished this rotation are a good source too) from surgical lists to multidisciplinary meetings, outpatients clinic and 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. Some units will already have a timetable for you.

> You can be expected to be in the hospital for full clinical hours (i.e. 8am-5pm or longer some days if you are "on take"). If you get let off early it is a privilege, not a right.
>
> However, these hours should be in line the AMSS fair hours guide, which details a 30-hour clinical week.

Potential activities to schedule include:

- Ward rounds (morning)
- Outpatient clinics
- Theatre
- Meetings
- Tutorials/other teaching sessions (e.g. registrar teaching sessions, RMO teaching sessions)
- Grand Rounds

When you have a list of all the things you can possibly attend on the rotation, write them down and work out a timetable and schedule for each day. *You may have to divide up the outpatient clinics with other students on your rotation so that there are not too many of you sitting in on consultations.*

> - Find out about all team activities at the start of your rotation.
> - Ensure your attendance at any unscheduled activities is welcome.
> - Allow for adequate personal study time.

Ward rounds

The ward round is one of the most variable learning opportunities in all of clinical medicine. The variation between hospitals, disciplines, consultants, and even days of the week is phenomenal. Some will be informative, valuable and full of golden nuggets. Unfortunately, others will be long, with limited learning opportunities.

Some general advice:

- 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 be seen by the consultants assessing you for that rotation**. If you do not attend the morning ward round it may be assumed you did not turn up for the whole day. Additionally, many of the management plans are made on rounds and absence may result in you missing key decision-making steps.
- Be early (and if you cannot be early, at least be punctual)

  Arriving early will enable you to look over relevant progress notes/lab results etc. for your patients, speak to the nursing staff who have looked after your

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patients overnight, and print out sheets for the team (*you will be credited f 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*). **Find out whether your team uses OACIS or EPAS lists.**

- Concentrate
  - During a long ward round it is easy for your mind to start wandering and to lose concentration – often this happens just before you get asked a question and you look silly!
  - **Tips to keep concentrating:**
    - Try and stay one step in front – if the intern is asked a question, be ready to answer it if they do not 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, ask a question (if appropriate)
    - Listen carefully to how experienced doctors sort through diagnostic possibilities before coming up with a plan – you cannot learn these gems from textbooks
    - Critically evaluate the consultant's communications skills – is it how you would explain something to a patient?
    - Write down the names of patients who are interesting/classical or have good signs to revisit later
    - 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 do not feel brave enough to ask questions in front of the whole team, write them down and ask between patients).
- Have a designated small task you always complete for each patient
  - A ward round contains is a multitude of small tasks for each patient – history, examination, checking obs/test results, liaising with nursing staff, writing in notes and treatment orders, charting medications/IV fluids and speaking with family members. This process runs seamlessly when the roles of each person are known, shared and reliably carried out. **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.** – this will be noticed and appreciated!
  - Wheeling a 2nd WOW around is an excellent opportunity to write notes OR have results/Observations up ready to read out when the consultant asks
- Present a case
  - **Ward rounds are a terrific opportunity to show that you have spent time speaking with and examining a patient**. Speak to the registrar/RMO/intern beforehand and check that it is okay 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 is to practice!)
  - Judge the content that is required for the round, as different teams will want

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different things – ask on your first day!

- Bedside case presentations are usually in the ISBAR format
  - Identity – Patient Profile including demographic
  - Situation – one sentence presenting complaint
  - Background – Past Medical History, Meds
  - Assessment – HOPC, exam findings, investigations
  - Recommendations – Treatment plan, additional investigations etc
- More formal case presentations may follow a similar format but delve into greater detail, always check what's expected!

- Take time to read up about your patient's condition, as when presenting their progress, you will be asked questions, so be prepared!
  - If you do not know the answer to a theoretical/knowledge question, that is okay, but look it up later.
  - If you do not know the answer to a clinical/patient question, (e.g. an investigation result), say you do not know – **NEVER make anything up, it is dangerous for the patient** because real clinical decisions are being based on what you say.

- Write the notes **(and always get a doctor to counter-sign with name and contact details)**
  - Writing notes is a skill that takes some time to learn. If your team allows you, try to give it a go during a quieter ward round (e.g. a day without a consultant ward round). Consider asking whether one of the doctors can go through your note in detail and give feedback. In the first instance, they may need to completely re-write it, but do not worry, it is all an iterative learning process.
  - For the most part, you will be dealing with Progress Notes, generally in the "Hashtag + SOAP" format – **the most important parts are assessment and plan!**

Date and Time (*mainly on paper notes, as epas does it for you*) **Clinical Context** (e.g. ward round, clinic) – Consultant Last Name + Team (or add team members last names from Reg – RMO – Intern – Student #current issues ▪ S (subjective) • Patient history or other self-reported/subjective information (record descriptions of any counselling provided to the patient or family here) ▪ O: Objective. • Any objective clinical data, mainly examination findings and investigation results ▪ A: Assessment (Impression). • What the most senior person on the team (usually Consultant or Registrar) is thinking about the case (if you are not sure, ask!) ▪ P: Plan • What is the management plan from here e.g. nursing and allied health input, investigations, medications and/or procedures, discharge planning, etc.	*Example* 1/1/25 10:30AM General Medicine Ward Round – Consultant + Team #Lobar Pneumonia #Gout of R first MTP S/ - patient feeling much better today - nil respiratory symptoms - gout resolving, educated on low purine diet O/ - HR 61, RR 12, BP 120/80, Temp 36.5, SaO2 99% on RA - HSDM, Chest Clear, Calves SNT, R first MTP remains inflamed - CXR 1/1/25 shows marked improvement A/ - Clinically well for discharge with resolving pneumonia and gout flare. P/ - Prepare for discharge today - Give meds as charted - GP to follow up titration of allopurinol

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"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"

Outpatient clinics

"For a consultant, a medical student sitting quietly in the corner staring into space is no more useful than a pot plant."

Some outpatient clinics are well equipped and geared towards efficient learning opportunities whereas others are not. On your first day, it is polite to introduce yourself and ask whether it is appropriate to sit in on the outpatient clinic. After the first couple of patients come through and you have a feel for the structure of the outpatient clinic, show some initiative and contribute.

Some hints:

- Prepare
  - Know what the clinic is about and read about the common conditions. A good understanding of the variation in severity of the disease as well as basic treatment algorithms will make you look polished.
  - Subtly look in the case notes of the upcoming patient. Try and present (no more than thirty seconds) the patient and their reason for attending and have the notes open to the relevant page. (You could also type their UR number into OACIS/EPAS).
- Be punctual
  - Allow time to find the clinic.
- Ask questions after patients leave the room
  - Obviously this might get tedious 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. You may be asked to do a brief literature review by a senior doctor should a case be complex without a clear management pathway, this is a valuable opportunity to be involved directly in patient care.
- See patients independently and present them
  - Once you have been to at least one outpatient clinic and learnt the lay 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 and use this opportunity to refine your presentation skills and ask for feedback. Show autonomy and initiative – provide a working diagnosis and a management plan. (This will be anxiety provoking, but the only way to get rid of nerves is to practice!)
    - **Remember your role as a medical student and refer all patient queries to the supervising doctor. Do not ever dispense information that you are not 100% sure about... there are no SPs anymore.**
  - Judge the content that is required, as different outpatient clinics will want different things – ask on your first day!

Theatre

You will receive plenty of orientation support about how to attend your first surgical cases so this is just the basics:

- 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 procedures. 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 am 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 are pursuing a surgical career but the applied, surgically relevant anatomy can be useful even if not surgically inclined.*
  - If you have got ample time before heading to theatre, try and read through the patient's admission note and find out why they are having the procedure and a little about their past medical history – it will add significantly to the learning experience.
- Be punctual
  - Allow time to find your way to the change-rooms, try on a couple of sizes of scrubs, and find a hat that fits. Allow plenty of time to get lost finding the correct theatre! (Theatre suites are massive and often very busy so it is 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 – a fantastic opportunity to practice your cannulation skills**.
- Emphasise you are a beginner
  - When you first arrive, introduce yourself as you normally do, but **impress upon everyone that you are new to this**. Ask if they could assist you in learning how the theatre works – be polite and attentive and try and get one of the nurses to look after you assist you when scrubbing, gloving and gowning.

"If you muck up – like brush past a sterile surface, they are less likely to destroy you if they know you are only new."

- Conduct
  - The environment of operating theatres is varied but some universal principles include: not touching sterile surfaces (anything blue) unless scrubbed, asking questions at an appropriate time (i.e. not during a particularly intense aspect of the procedure), and turning your phone off. Help with tasks you feel comfortable with, e.g. be an extra pair of hands to assist in moving the patient after the operation. **If you feel faint at any time (not uncommon), do not be embarrassed and speak up and sit down** – it is better to avoid fainting and cop some friendly banter from the theatre staff than potentially keeling over

headfirst into an open wound!

Tutorials

Normal tutorials

- Attend and be punctual
    - Turn up and participate. **There is nothing more infuriating for a consultant/registrar to arrive for a tutorial and see that half the students have not turned up yet or have forgotten that the tutorial is even happening**. This is incredibly disrespectful and you also threaten future learning opportunities for the students who will follow you on that rotation.
- Be grateful
    - Most consultants/registrars teach in their own "free" time. Show them respect and at least turn up on time...even if you are caught in outpatient clinic or in theatre. Similarly, show some understanding if tutorials are cancelled at last minute – this is often out of their hands too.

> If a senior (e.g. a doctor or 5th/6th year student) offers to give you an impromptu tutorial on a topic, take up the offer! More often than not it will be very useful. (And also you will almost certainly demoralise them if you decline, as they would only offer if they were keen to teach.)

- Be mindful
    - Teaching is rarely "taught". You will come across some outstanding teachers throughout your rotations 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 medical students and it is not as easy as it looks.
- Prepare
    - If there are set questions or topics for each tutorial make sure that you have read over them and are familiar with the content of the tutorial before arriving.
        - The tutor will be disappointed if you have not put in the time or effort to prepare. If you do not know the answer to a question – try and think through your answer using a structure.
- Be proactive
    - Confirm the day before with the consultant/registrar that the session is still at the same time and the content is the same. 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. Stay away from straightforward areas that can be read out of a book and **aim more at clinically focussed problems that you will deal with as a junior doctor. "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 episode of psychosis...
        - Management of: heart failure, atrial fibrillation, renal stones...
        - Interpretation of: ABGs, chest x-rays, fractures, ECGs...

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Bedside tutorials

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 taking you to see a patient and asking one of the students to demonstrate a physical examination – e.g. “examine this patient’s abdomen”.

Some hints:

- Attend and be Punctual
  - Turn up and participate. **There is nothing more infuriating for a consultant/registrar to arrive for a tutorial and see that half the students have not turned up yet or have forgotten that the tutorial is even happening**. This is incredibly disrespectful and you also threaten future learning opportunities for the students who will follow you on that rotation.
- Prepare
  - Revise the examination the night before! In a group of four or five it is very difficult to hide if you do not know what you are doing in front of a REAL patient.
- Contribute
  - If the consultant/registrar asks for a volunteer and you have prepared, get in there and have a go – they are 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 will 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 team. 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 RMOs/interns/students from other teams if needed.
- Ask questions
  - 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... so 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”

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Making the most of your time on the wards

After the morning ward round, there is often a period when the team does their "jobs". Often you will be able to help them with administrative clinical tasks like chasing blood/imaging results, or by performing procedures (e.g. taking blood/putting in catheters/jelcos etc.), whereas other times you may not be able to. **There will be 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.** So if you have no outpatient clinic, no theatre, no meetings, no tutorials and it is truly "free" ward time, here are some suggestions for ways to maximise your learning.

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Practice for OSCEs

Form pairs (one to be the "student" and the other to be the "examiner") and introduce yourselves to the patient. The "examiner" goes in first (alone), pulls the curtains and says, "Good morning, my name is <FirstName> and I am a 4th/5th year medical student. My friend <FirstName> is around the corner and has his/her exams coming up soon, would it be ok if he/she did a brief examination of your heart/chest/tummy/etc. while I watch? If anyone comes to visit or you would like to stop, please let us know.". Then the "student" comes in (just like an OSCE) and completes the examination while the "examiner" watches. Afterwards, make notes and write down the feedback you got from your "examiner" (*make sure you mix up your pairs so you are not getting the same feedback/points of view each time*). This notes act as record of what you have practiced, and it is also nice at the end of the year to see how prepared you are already!

"Many OSCE assessors will comment that they can determine within the first fifteen seconds how well a student will do in any given station."

Persistence is key

- It is too easy to decide to go and see "bed 104", arrive there and find she is at x-ray and then say, "oh well, it was not meant to be" and forget about it. Don't! Try again later, come back tomorrow...learning opportunities, especially from patients, need to be sought.
- Think outside your team to complete your learning. **If you are having trouble finding patients, ask other teams in the hospital** – "I am looking for a patient to do a respiratory examination on, is there anyone under your team with chest pathology?" If you are keen to do a neuro exam, ask the intern on the stroke ward if they could suggest or introduce a patient to you. This goes for all specialty teams: 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 team but only with permission – do not impede the learning of other students who are already, and supposed to be, on those teams.** Take a walk around the wards and peek into each room. If the patient is alone, awake and appears to be comfortable they may be the perfect choice for a 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 will come across.
- If you are having trouble finding patients who will let you do a complete examination, just ask if you can listen to their heart and do something more focused and less

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invasive. You may be the fourth group of students who has asked to examine Mrs Smith this morning so do not be disappointed if 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 from patients, need to be sought!"

Follow the registrar

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

See something cool

Watch something interesting

There is never a shortage of activities to watch in the hospital. You can rock up at any number of departments, introduce yourself, and ask whether it would be okay to observe x, y or z. Such activities include: Radiology (x-rays, ultrasound, CT, MRI, interventional procedures, etc.), the Lab ("SA Pathology" – learn what goes into doing a CBE or blood culture etc.), nuclear medicine (whole body bone scans, thyroid scans, etc.), dialysis, pulmonary function testing, endoscopy/colonoscopy suite, radiotherapy...the list goes on!

Interact with Allied Health

Spend time with allied health staff – if you order chest physio for your patient then hang around and see what is 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. Same goes for social work and occupation therapy. You might not be tested on this during an exam, but unless you know what is involved with these, you will not effectively integrate multi-disciplinary care as an intern.

Attach to a patient

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.** If there is time, follow your patient through their admission to discharge – if they go to have an x-ray, ask if you can go too. If they go to theatre, ask if you can attend +/- scrub in. The same applies for allied health appointments and family meetings. 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**. Not only will you find this fulfilling but the patient will often be grateful for the company and continuity that you will provide.

“It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has.” William Osler

Other outpatient clinics

There are frequently far more outpatient clinics than there are students. **If you would like to brush up on one particular area, find out when they are having outpatient clinics and ask the consultant if you can sit in or see some patients independently.** 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 outpatient clinics – again, do not let your presence impact on the students who are attending their “scheduled” outpatient clinics.

Independent study time

Despite what you might think of CBL, the clinical years are actually even more self-directed than what you have previously experienced. Make sure you are self-disciplined enough to do your own study. **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/assessments, which requires plenty of time for studying. Remember that **the objective of your clinical rotation is to *learn clinical medicine*,** which includes “textbook” or “exam-relevant” knowledge, clinical skills, bedside manner (e.g. how to talk to patients/their families), the art of medicine, and procedural tasks (such as doing bloods, catheters, et.).

Clinical exposure in the hospitals alone is usually NOT enough to pass your exams (both rotation assessment and end-of-year assessments), so schedule adequate time to study both at home and during quieter times on the wards. If you are able to use your time in the hospital fruitfully during slow days, by all means stay there. But **if your day is finished, ask to go home and study,** because there is no point waiting 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.

> Learning clinical medicine <u>does not</u> include administrative tasks such as discharge summaries. Preparation of discharge summaries would generally be considered non-contributory to learning (one or two is fine, but not many more than that). If you are asked to do (an excessive number of) discharge summaries, you may wish to consider demurring with something along the lines of: “I was told 6th years tend to do discharge summaries because they are post-barrier exams” or “Sorry, I understand that doing these discharge summaries will help out the team, but I have my rotation assessments coming up soon. Would it be okay if I went to study instead?”
>
> *It may be appropriate for a 6th year student (who is post-barrier exams) to prepare many discharge summaries, as the purpose of their rotation is to learn how to be an intern.*

Many rotations have a large list of things (“important conditions”) that you are expected to have learnt by the end of the rotation. The sheer amount of material will seem daunting at first, but it is very important that you **do not get overwhelmed with the quantity of material (many medical students have faced the same challenge and overcome it before you).** For example, you may see sixteen patients on a ward round with sixteen different conditions – you cannot expect to master all of these overnight or even over a couple of days. Similarly, you have nine weeks to learn “General Medicine”, so you must be pragmatic. Just make sure you slowly but steadily chip away at the list, and eventually you will get through all those “important conditions” (last minute cramming is not enough). **For each diagnosis encountered you need to know: the clinical features (symptoms/signs), the diagnostic**

investigation, the first line treatment, and the second line treatment (e.g. if there was an allergy/other contraindication to first line treatment).

Remember the philosophy "common things occur commonly" and **focus on the "bread and butter" conditions of a specialty/rotation and the common treatment/decision-making algorithms/hospital protocols/guidelines.** While it is an unbelievable feeling assisting in operations, remember that the 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 do not let it compromise your "theoretical" learning** (you will not be asked how you would approach an anterior bowel resection).

Keep your learning clinically oriented. Rather than just learning about "pancreatitis" from epidemiology through to pathogenesis through to management – try "approach to abdominal pain" and think about how you would evaluate a patient to distinguish between the different causes and direct your management. **Try using topics like "Approach to the patient with..." and "Management of a patient with..."** Similarly, imagine you are an intern on the ward and are asked to see a patient with breathlessness – what are your differentials and how will you manage it?

Keep you learning linked with clinical encounters. CBL is based around a patient scenario for a good reason; it is easier and more 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 a DVT treatment guideline. You will find that you retain new knowledge very well by being able to categorise and associate it with the patient you saw. **Despite real patient scenarios being the best mode of learning, unfortunately patients are not able to tell you everything you need to know about their conditions, and so cases you come across should stimulate further self-directed learning.**

"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

- Invest your time in what is most valuable for your learning.
- Keep your learning clinically oriented.
- Structure your learning around clinical encounters to ensure you apply your knowledge and help you remember it.
- It is worth investing some time in finding quality resources (of which there are many!)
- **Inform the team if you are going home!**

Staying after hours

It might seem like an unappealing idea to stay beyond 5pm or come to hospital on the weekend, however the learning opportunities can be invaluable. The hospital is a very different place out of hours, as with fewer staff overall, more responsibility is placed on junior staff. Not only does this translate into better learning opportunities for medical students 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 other after-hours sessions, consider attending some extra ones. In the end, you also have to feel refreshed for your hospital commitments the following week, so make sure you also prioritise down time. Soon enough you will be in the hospital system six-seven days per week and you will regret not having made the most of your med school free time!

Some benefits:

- Independence
  - When it is not too hectic or out of control, often the intern, RMO or registrar will let you see the patient first – whether it is a ward consult or an admission in the Emergency Department. This will allow you to take a history, examine the patient, start writing up a note and then present the patient. **This is a great 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 have 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 lines or lumbar punctures, as well as a greater likelihood of doing the regular things like nasogastric tubes and urinary catheters. Additionally, if you are on a surgical rotation and someone is taken to emergency theatre, there is every chance that you will be able to attend and potentially scrub and assist.

"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."

- Gain more opportunities to learn practical skills.
- Gain more opportunities to practice admitting new patients.
- **Ensure you still enjoy some free time.**

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Going the extra mile

It is wonderful to do some extra things on the rotation but ONLY if you complete the required assessment tasks – do the crucial 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 is to ask the registrar or consultant for advice.

- Unit presentations
    - Offer to present an interesting patient or case at the weekly/monthly meeting. Not only will this demonstrate your enthusiasm but will also be another opportunity to hone your presentation skills. If you are anxious about doing one all by yourself, offer to help the registrar 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 to 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.
        - Aim to use your presentation as a tool to generate discussion amongst the bosses who will be listening to you! (*This will also take the heat off question time for you!*)
        - 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!
        - Stick to your time limit.
        - Minimise text on the slides and try to find some interesting photos/graphs.
        - If you are keen for advice, practice the presentation or show the slides to one of the interns beforehand.
- Research projects
    - Many departments will have some sort of ongoing research or at least an interest in research that you can be involved in. Make your career inclination known 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, offer to conduct an audit, which can be presented at the end of your rotation. **Tailor the topic to something that YOU find interesting**.
        - e.g. "I was wondering if there are any audit topics that I might be able to do some work on and present at the end of my rotation?"
        - e.g. "I have noticed that pancreatitis is a relatively common presentation on this team – I would be interested in doing an audit of the aetiology and type/volume of fluid resuscitation, is this okay?"
- Case report
    - Occasionally your team may be involved in caring for a patient who has a very rare/unknown condition, or a patient who presented very unusually with a common condition. These may present themselves as a unique opportunity to

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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.

Health and Wellbeing (including Bullying and Harassment)

As with every year in medicine, remember to look after your mental health! It is important to realise that the clinical years are a step up and can be demanding. The new challenges take some getting used to and maintaining life balance can be difficult, which can create stress, anxiety and burnout. In addition, on the wards medical students can be victims of various forms of bullying and harassment, which can make you feel powerless.

Strategies to reduce stress/burnout:

- Talk to your peers – debrief about your day/week
- Try to keep a healthy sleeping pattern
- Continue other hobbies so you can take a break from the hospital environment
    - **Don't be afraid to seek help if you're not coping, and take a mental health day if you need it**

Criticism from supervisors

- Some supervisors might not be familiar with your curriculum, knowledge level, and what you are expected to know – they may expect too much
- There is nothing wrong with not knowing the answer to difficult questions – you will learn better
- Expect to make mistakes, but learn from them and try not to make the same mistake twice.
    - *You will naturally be nervous when performing a physical examination in front of your peers and colleagues and will probably stuff up a few times – everyone has been there – and practice makes perfect.*
- Be aware of your limitations and don't be afraid to give gentle reminders about your capabilities if asked to do tasks you are unsure about
- **It is very important to develop strategies for accepting criticism** – you are here to improve your skills, and clinicians, though sometimes harsh, are giving feedback to help you – and it is not personal
    - *Some consultants take pleasure in highlighting the knowledge gaps in students. Rest assured that most enjoy your company and do not exist just to humiliate you. Take the criticism if it is fair and remember that everyone has been in the exact same situation before...EVERYONE.*

Options for addressing bullying and harassment

- Consider contacting a member of your hospital team you trust (e.g. intern/RMO) or university staff member you trust – this can be a good first step to bounce ideas/brainstorm what options are available.
- Consider contacting your GP or Doctor's Health SA to help support yourself through the difficult period.
- Consider contacting the University counselling service to help support yourself

through the difficult period.

- One of the responsibilities of your Year Level Advisor is to support students' wellbeing and help resolve issues/complaints.
- The Dean of Medicine is also always keen to support students' wellbeing and help resolve issues/complaints
    - the best way to access the support of the dean can be escalating concerns
- **The AMSS is always available to help!**

Assessment

Each rotation will have different assessment tasks, so be sure to clarify exactly what is required of you during your rotation. **Read the Course Outline and introductory information on MyUni/CANVAS.** Where there are things that need to be "ticked off" for a "log book", try not to leave them to the last minute. Have a chat to students who have just completed the rotation – they will have plenty of advice about how to approach the assessment tasks and what sort of material is important for the rotation assessment, end of semester assessment, and end of year assessment.

Some tips:

- Attend and be Punctual
    - In order to for someone to assess you they have to have actually seen you. This sounds obvious but if you do not turn up to the meetings and do not make the ward rounds – you will very easily receive a poor assessment regardless of your actual clinical ability. Remember that punctuality equals professionalism and influences your reputation.
- Practice and Prepare
    - A lot of your mark will be based around discrete tasks – e.g. a case write-up. Additionally, case 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 do not 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 did not receive enough feedback when the writing was probably on the wall for quite some time. **If you do not 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.

- Assessment depends on both attendance AND clinical ability.
- Practice will boost your performance in assessments such as case presentations and observed cases.
- Get feedback and take it on board. Everyone has areas in which they can improve.
- **Keep an electronic copy of all your assessment forms, it's a nightmare if they lose it and blame it on you.**

Feedback

Formal

Many teams will ask for feedback through surveys. Yes, you do not have to fill it out, but it means a great deal to these teams to get feedback – positive and negative – from students. Be constructive with criticism and suggest improvements – avoid simply derogatory comments. **There are also opportunities throughout the year to nominate supervisors for prizes and awards which recognise excellence in teaching**.

"Many teams will ask for your feedback through surveys...take the time to fill this out and help improve the program"

Informal

If it is appropriate, do not hesitate to provide informal feedback if you found something particularly useful or valuable – the staff will appreciate your acknowledgement. Similarly, do not be afraid to provide the team and/or your education representatives with feedback when things are not working too well, and **consider using the "compliment sandwich" model to ensure it is well received**.

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 need to be extravagant or expensive) although not expected by any means, will be appreciated by your team (preferably given after your assessment has been completed).

"Wherever the art of medicine is loved, there is also a love of humanity."

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Clinical Terminology and Acronyms

Paging and Switchboard

- **Paging**:
  - Pagers are carried by almost everyone in the hospital. 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 – find them through "switch".
    - To page using a hospital phone, dial #89, wait a few seconds for the tone change (or voice), dial in the pager number (e.g. 1234 or 21234), then press * (at the RAH, it is a # instead of an * for the last bit, i.e. #89 → pager number → #)
    - Sometimes you will hear a voice saying that the message has been validly received (or not validly received) and sometimes you will not. Hang up. Then wait by the same phone for the person to return your page by calling that phone.
  - Paging etiquette:
    - Make sure you do not use a phone that someone's just "paged" from
    - For non-urgent pages, wait 15-30 minutes before trying again (it is impolite to page repeatedly in short succession, as if they are not returning your page it means they are busy doing something else and will get to you as soon as possible)
  - Returning pages: sometimes the intern might be busy or otherwise unable to answer a page they receive (e.g. gowned up in a contact precautions room); they may ask you to answer their page.
    - Firstly, you need the number that paged them (e.g. 29999). This number is displayed automatically for a brief period of time when receiving the page (if the number has already disappeared, press the Power button to display it – NOT the arrows, which generally start scrolling from the very first page, instead of the latest page)
      - On older pages, the displayed number will be in the format of, e.g. 29999 – 1. The – 1 (or – 2) etc. refers to how many times that number has paged the pager recently (it is not part of the actual number). So if the display says, e.g. "21234 – 1" then the number is 21234
      - The display may also show the time and date of the page, which will confirm that the number is indeed the latest
    - Secondly, find a phone. Most of the time you will use a hospital phone. Simply dial the number in (without any additional buttons), e.g. 29999.
      - In the rare case you need to return a page and a hospital phone is not readily available, you can return the page from an outside phone (e.g. a mobile) by adding in an extra prefix in order to make it a full 8-digit phone number.
    - o For example, if you have to return a call to number 41234 at the RAH from the outside, then call 7074 1234. Or if you have to return a call to number 9999 at the RAH, then call 7074 9999. Thirdly, when the person on the

other end of the phone picks up, introduce yourself along the lines of: "Hi, I am [first name], 4thYear medical student returning a page on behalf of [Intern name], the [e.g. Colorectal] Intern. Sorry they are busy at the moment but can I please take a message?" Then take their message.

- **Speed dial (SD):**
  - Pick up a hospital phone and type the numbers (e.g. 81234) directly – no need to press anything else and it will go through to the phone/mobile like a normal phone call.
- **Switch**: Means switchboard. Will be able to connect or page anyone in hospital.

Types of doctors

- PGY 1/2/3: Post-Graduate Year 1/2/3
- **Intern** (PGY1): first year doctor who has provisional registration with AHPRA (must be supervised by a more senior doctor).
- **Resident Medical Officer/Resident/RMO** (at least PGY2): a doctor with general registration – more senior than an intern.
  - They do not usually communicate directly with the consultant and do not usually make clinical decisions when the consultant is absent (*that is the domain of the registrar*). RMOs make clinical decisions if they are the most senior doctor present (e.g. when the consultant/registrar is not available).
  - *RMOs are usually NOT in a specialty training program.*
- **Registrar** (at least PGY2, usually PGY3+): a doctor who is enrolled into a training program
  - They are the main conduit of communication between the consultant and the rest of the junior doctor team. When the consultant is absent, the registrar tends to make clinical decisions as the most senior doctor present.
  - *Registrars are USUALLY in a specialty 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*

A confusing point is that sometimes, a Basic Physician Trainee (BPT) may be put in an RMO position in some hospitals. Hence they are an RMO even though they are actually in a specialty training program. However, in these cases, the BPT will usually be working under an Advanced Trainee in that specialty who works in the Registrar role (e.g. the BPT is the Neurology RMO and the Advanced Trainee in Neurology is the Registrar – already passed BPT). *Do not worry if you do not really understand the difference.* To make it even more confusing, sometimes Registrars are NOT in a training program (i.e. "Service" Registrars). This is because there is a mismatch between the number of trainee positions available via the relevant College, and the healthcare service needs of the hospital. For example, a hospital may need to employ X number of Registrar jobs in order to keep the hospital service running, but the Royal College will only accredit the hospital for Y number of training positions (where X > Y). The difference (i.e. X – Y) will be filled by doctors who are not in the Royal College training program, but yet are still doing the (same) job as a Registrar. Usually these "Service Registrars" are aspiring to enter the relevant training program, and are therefore undertaking the unaccredited Registrar job as a way to improve their future application(s) for that specialty training program. Most commonly, but not exclusively, seen in surgical specialties.

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process.

- **Fellow**: a doctor who has already finished a specialty training program but is now undertaking further subspecialty training to improve their skills. (*Fellows are basically Consultants and should be respected as such*.)
  - *An Orthopaedic Surgeon may want to subspecialise only in hands, and hence do a Hand Fellowship for a year. During that year, they will be the "Fellow".*
- **Consultant**: a fully qualified and independent specialist, employed by the hospital as such (*the bosses*).

Other staff

- **RN/EN**: RN = registered nurse. EN = enrolled nurse. The ENs have done less training. *Their uniforms may be slightly different*.
- **TL**: (Nurse) Team Leader. A relatively senior RN who is rostered to be the clinical leader of the nursing staff for that ward on that particular shift. Depending on the hospital, the TL may or may not also have their own individual patient allocation. However their predominant role is to lead and manage implementation of patient care.
- **NUM**: Nurse Unit Manager. They are highly trained nurses with an excellent understanding of how the ward works. NUMs are the managers for the nursing staff on their respective wards (sort of the nursing 'Head of Unit' for their particular ward).
- **ANUM**: Assistant Nurse Unit Manager. A deputy (or deputies) to the NUM. Senior RNs who have been promoted to do some administrative work assisting the NUM in addition to usual clinical RN duties. When ANUMs are rostered on clinical shifts, they usually work in the TL capacity.
- **CNC**: Clinical Nurse Consultant. They are highly trained nurses with an excellent understanding of their area of expertise. CNC's usually are subspecialised in one particular area or condition. For example, a "Heart Failure CNC" is a nurse subspecialist in managing patients with severe heart failure.
- **Allied Health**: physiotherapists (PT), occupational therapists (OT), speech therapists (ST), social workers (SW), etc.
- **Orderlies**: 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 department).*
- **Ward clerk**: Primarily an administrative role assisting in organising patient documentation (retrieving patient notes/records) and transfer between departments.
- **Security staff**: often present if the patient is an inpatient from a correctional facility or if they are detained under the Mental Health Act.

Types of patients

- **Inpatient**: means a patient admitted onto a ward inside the hospital.
- **Outpatient**: means somebody from the community that is just coming to the hospital outpatient clinic for an appointment.

"On take" and "Home Team"

- **"On take":**
  - The first thing to understand is that virtually all inpatients admitted to hospital must come through the Emergency Department. The Emergency Department then decides where they go – broadly, whether they are medical (i.e. needs

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someone with expertise in optimising medications and/or lifestyle management) or surgical (i.e. needs someone to cut something).

  - Within each medical or surgical division, there is usually a team that is designated to take all the patients from the Emergency Department with medical or surgical problems within a 24-hour period. When a team is "on take" it means all eligible patients that come through the Emergency Department will be admitted under their care for that particular calendar day (i.e. appendicitis will be admitted under the "taking" Gen Surg Team). On general medical and surgical teams, this responsibility is rotated on a regular basis so that the work load is shared evenly. Some subspecialty teams are "on take" all the time with certain criteria, e.g. Endocrinology will always take DKA no matter what day of the week it is.
    - Being "on take" means you will have the best opportunity to see patients by yourself and work them up.
- **"Post-take":** this is the day after being "on take". This is usually when the patient list is the longest (as the team just got an extra load of patients, on top of their pre-existing patients), and may also be the first time the patients are being seen in person by the Consultant. Therefore, the "post-take" ward round tends to be the most thorough and takes the longest amount of time.
- **"Bed card":** the Consultant that is responsible for the majority of the patient's care.
- **"Home team":** The specialty team of the "bed card" Consultant (e.g. General Medicine team of that particular General Medicine Consultant) is the "home team".
- **"Consult":** a request by the home team for another specialty to provide advice on an aspect patient care (e.g. the team orthopaedics home team may request an endocrinology consult for optimising a patient's diabetes management)

After hours

- **"Cover":** the evening shift in which a smaller number of junior doctors "cover" additional wards, as well as their own, on behalf of other home teams. The specific start and end times vary by hospital and specialty, but generally speaking is from the end of normal business hours until the start of the night shift. For example, two interns (e.g. colorectal intern and vascular intern) may be rostered on to cover the surgical wards from 4:30pm to 8:30pm. They would be supported by an on-call Surgical Registrar or RMO. On weekends and public holidays, cover may begin as early as 11am, if for example the usual day teams are rostered to work only from 8am to 11am.
- **"Nights":** the night shift, staffed by a small number of junior doctors, taking care of the patients for the home teams. Specific start and end times vary by hospital and specialty, but generally is from 8:30pm to 8am.

Ward round types

- **"Ward round":** go around the hospital to see patients on your patient list.
- **"Paper round":** go through your printed list of patients without actually seeing them in person, e.g. to update everyone on which patients need what jobs done today.

Note types

- **Admission note**: the very first note, written by the doctor on the inpatient team that "takes" the patient from the Emergency Department – very comprehensive history, physical examination, preliminary investigations, assessment/working diagnosis, and

plan.

- **Progress note**: subsequent notes after the admission note, which update the progress of the patient since the last time a note was written, e.g. since yesterday – usually do not contain a complete history or examination (as that was covered in the admission note), but rather a targeted history and targeted examination.

- **Consult note**: written by a specialty team other than the main treating ("home") team, in order to provide advice on a specific aspect of a patient's care, where they record their evaluation of the patient and their recommendations
- **Discharge summary**: A written account of the important details during a patient's admission. This is written by a member of the treating team – often the intern or RMO. It is then sent to the patient's GP and other members of the patient's care team.

Electronic System Types

- **OACIS**: The computer system facilitating access to radiology/laboratory results as well as discharge summaries. There are important rules that must be followed when using OACIS. *OACIS is a legacy system designed prior to EPAS implementation; once EPAS ("Sunrise EMR and PAS") is fully implemented in the next few years, OACIS is expected to be transitioned out.*
- **EPAS ("Sunrise EMR and PAS")**: Enterprise Patient Administration System (Sunrise is the brand of the software). EPAS was the software designated to be South Australia's future clinical program. It contains two components, the electronic medical record (EMR) and the patient administration system (PAS).
  - The EMR component is what doctors and nurses use instead of the previous paper-based case notes, paper-based nursing charts, paper-based investigation/radiology requests, etc. As of early 2025, the EMR will be fully implemented at all SA health networks including, CAHLAN, NAHLAN and SAHLAN. This only excludes the Eyre, Far North Health network, which will have EMR implemented in early-mid 2025.
  - The PAS component is not used by doctors, but is used by ward clerks, finance, and other staff to perform administrative functions such as inserting and discharging patients off the system, billing, etc.

Emergency types

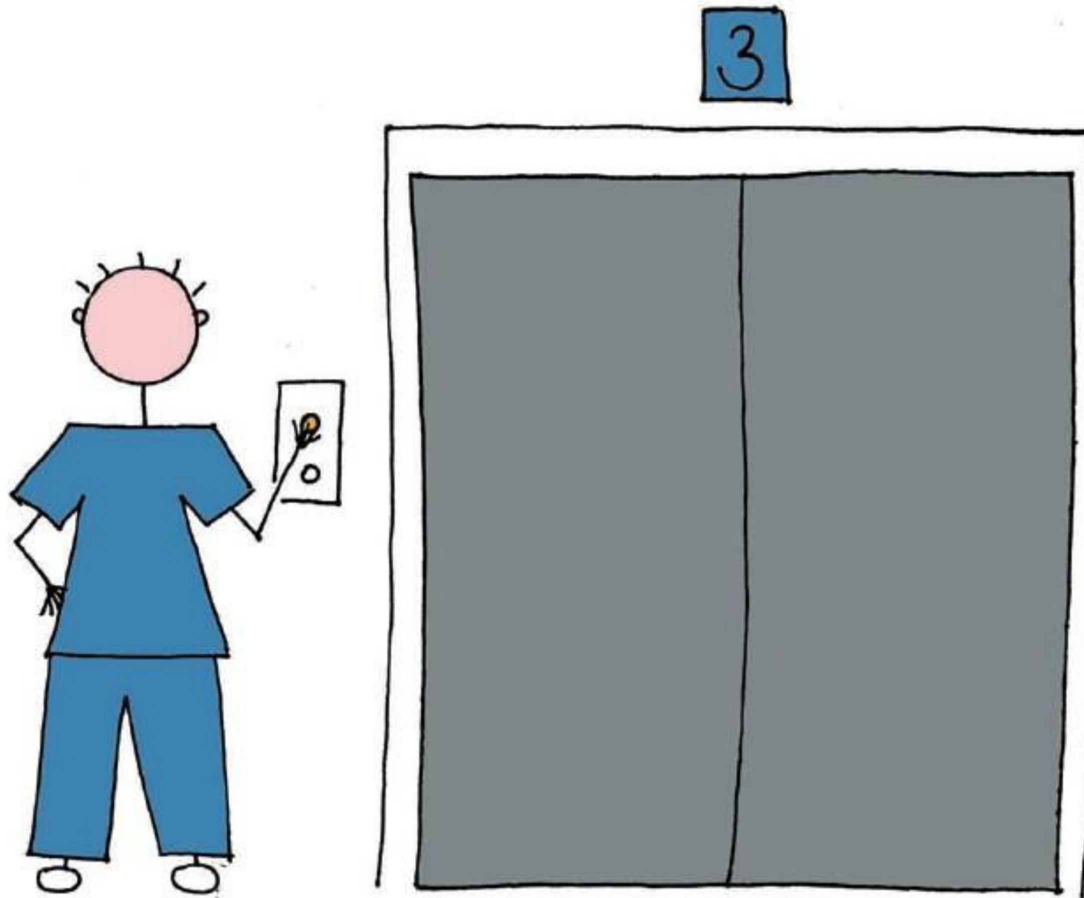
- **MET call/MER call**: a medical emergency as defined by the RDR (observation) chart criteria or if someone is worried the patient is sick, and so the MET team attends. Different hospitals will have different staffing of their MET teams, but will usually include at least either a Medical Registrar or an Intensive Care Registrar, plus an Intensive Care Nurse. (*MER stands for Medical Emergency Response whereas MET stands for Medical Emergency Team.*)
- **Code Blue**: a medical emergency as defined by impending cardiac or respiratory collapse. The Code Blue team will always include at least an Intensive Care Registrar and an Intensive Care Nurse. *Some hospitals have a "one-tier" system, in which a MET call and a Code Blue are the same thing (with a Code Blue defined using the RDR MET Call definition) and some hospitals have a "two-tier" system, in which MET calls and Code Blues are different.*

Blood test types

- **Venepuncture/"Bloods":** to draw blood from a vein in order to perform blood tests.
    - *After applying a tourniquet to the upper arm, and finding a suitable vein, the site of needle inserted must be cleaned using an alcohol swab.*
    - *The blood can be drawn via vacutainer, needle and syringe, or butterfly, into various coloured tubes (certain tests can only be done in certain colour tubes).*
- **IV cannulation/"Jelcos":** to insert a tube of plastic into a vein so that fluids and/or medications can be given intravenously. (*Jelco is the original brand of IV cannulas, hence the moniker)*
    - *After applying a tourniquet to the upper arm, and finding a suitable vein, the site of needle inserted must be cleaned using a Chlorhexidine + Alcohol swab (NOT alcohol only).*
    - *Jelcos are usually removed within 72 hours of insertion to minimise risk of infection –*
- **ABG**: Arterial Blood Gas. Collection requires a special needle/syringe set. Painful for patients. Requires analysis in a special machine found only on certain wards.
- **VBG**: Venous Blood Gas. Venous sample in an ABG syringe. Not painful like ABGs. Requires analysis in a special machine found only on certain wards.
- **PICC line**: Peripherally Inserted Central Catheter line. An option for those requiring long term IV medication (can stay in for much longer than a Jelco).
    - *Bloods (except Blood Cultures, unless explicitly specified as PICC cultures) can also be taken from a PICC line – remember to use at least 3x syringes with a blunt cannula attached: alcohol swab the hub, take 10mls of blood to discard first, then take the volume of blood for testing required, then flush the PICC with at least 10ml of normal saline.*

Locations

- **CALHN**: Central Adelaide Local Health Network, comprising (amongst others) the Royal Adelaide Hospital, Queen Elizabeth Hospital, Glenside and Hampstead
- **NALHN**: Northern Adelaide Local Health Network, comprising (amongst others) Lyell McEwin Hospital and Modbury Hospital
- **SALHN**: Southern Adelaide Local Health Network, currently comprising (amongst others) Flinders Hospital, Repat Health Precinct, and Noarlunga Hospital



enjoy the ride!
(not long to the top)

Illustration by Dana Rudaks 2011

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