Rotation Guide for M3s

By: Mattie Oelschlaeger

General Advice:
- Be enthusiastic. You’ll get to do more, you’ll learn more, and you’ll get better evaluations.
- Be professional. Be on time, try to arrive before the residents if possible, work hard, and be nice to everyone. Not everyone will be nice to you; get used to this.
- Respect nurses (and other staff). I’ve learned that nurses can be your biggest allies, or, as I observed in the cases of residents who antagonized the nurses, can stand back and let you make mistakes without saying anything. Be deferential, polite, and respectful. This is oftentimes tricky as I’ve noticed some nurses have had negative interactions with medical students before and have a baseline dislike or mistrust of students.
- Ask your residents: how you can help them, what their specific expectations are, and how best to study for the exam. This advice can be quite valuable for scoring well on tests and evals.
- Don’t ever put down your colleagues. Take this opportunity to help a peer if he is floundering.
- Keep an open mind. Many people who come into medical school wanting to do a particular specialty change their minds after falling in love with another rotation.
- Don’t take criticism too personally. Ask almost any physician, and they can recall a resident or attending during their training who took an immense dislike to them and made their life rough for a while. In my experience, most of the people you will work with are relatively fair, willing to judge within the boundaries of meritocracy: if you work hard and are pleasant; they’ll like you. Do your best, and don’t spend too much time worrying about the inevitable outliers.

Core Clerkships: Community Based Primary Care, Family Medicine, and Outpatient Internal Medicine, Inpatient Internal Medicine, Obstetrics and Gynecology, Pediatrics, and Surgery

Also in This Issue:
Step 1 Action Plan
TJ Clark
Rachel Sandler

This rotation occurs in one of 6 cities in Iowa. You will be assigned to various sites in the community in addition to working with a primary care/general practitioner. Such sites include social work agencies, hospice services, centers for abused children, et al. A classmate felt that “this is a random rotation where you get to learn about community resources available for your patients. There is a lot of down time, but it can be used wisely to study for Step 2 if this rotation is near the end of your 3rd year.”

Exam: No. Rather, an end-of-the-rotation presentation is required on a topic reflecting general medical issues in the community. The grading for this course is pass-fail.

Family Medicine
Length: 4 weeks
Time Commitment: 8-12 hrs/day; 5-6 days/week; weekends off depends on preceptor

This rotation is complicated to schedule, and you’ll have to spend some time on the phone arranging a preceptor. Though some students claim it is the favorite of their third year, many others have found it to be their least favorite. If your preceptor is a stressed-out, angry, impatient person; well, you’re stuck with them (and their negative evaluations) for four weeks. If you suspect that there is a severe personality conflict or you’re being abused and belittled by
your preceptor, request reassignment.

A colleague’s perspective of the rotation: “Family Medicine has the potential to be a great rotation - just depends on who your preceptor is and where you end up. That said, you will get a lot of autonomy on this rotation and learn how to see and present patients. You get to work one on one with your preceptor and you can learn a lot from them if you put forward the initiative and effort. Ask them to let you do procedures - best way to learn is to do!”

Exam: Yes. Many medical schools use the family medicine shelf exam from the NBME. CCOM doesn’t, and the exam is notoriously difficult. Study hard for it. The text assigned to you for family medicine at the ambulatory block orientation should be sufficient for scoring well. Pay attention to specially assigned learning issues as these are emphasized on the exam.

**Outpatient Internal Medicine**

*Length: 4 weeks*

*Time Commitment: 4-9 hrs/day, 5 days/week (weekends off)*

*Lecture component: Yes, >1x/day on average*

This is the easiest month of ambulatory block and the third year in general. You will mostly work in outpatient internal medicine specialty clinics, which are self-selected. For this rotation, I opted to spend time in oncology, cardiology, and general internal medicine. You will have a lot of half days, with morning or afternoon teaching sessions a common occurrence.

Exam: Yes, a two-part exam, including a computer-simulated patient encounter in which the questions you want to ask, the tests you want to run, and the parts of the physical exam you want to do are selected from a super-list. Use of the family medicine textbook for the exam is traditionally more high-yield than using the assigned internal medicine text.

**Inpatient Internal Medicine**

*Length: 6 weeks*

*Time Commitment: 8-16 hours, 6 days/week*

*Lecture component: yes, several times per week*

This is a demanding rotation with long hours. For the 2010-2011 school year, medical students were expected to take two 24-to-30 hour call shifts per rotation. In general, you will spend 3 weeks at the VA hospital and 3 weeks at UIHC. Expect to see lots of heart failure, COPD, liver and kidney disease, vascular problems, and diabetes.

You will work on 4-day cycles with your team, which will include multiple residents and an attending. The first day will be long call, where your team takes call from 6 or 7 AM until 8 or 9 PM. The following day is post call, where your team will round at the usual 6 or 7 AM, but is generally finished by 6 or 7 PM. Then you will have a day of short call, which is similar to the 6-to-6 schedule of the post-call day. On the fourth day, or ‘golden day,’ your team doesn’t take any new admits, and you’re usually done by 2 or 3 PM. You’re allowed to take one day off per 7-day week, but it must be on a short call day or a golden day. You generally show up pretty early, around 6AM, to pre-round on your patients. You will then spend 4 or 5 hours rounding with your team. After this, you write notes on your patients.

A peer’s take: “Internal Medicine would be a great rotation to have first or very early in your 3rd year, as it gives you a strong knowledge base on common illnesses as well as how to treat them. Definitely try to do this before surgery as it would probably make the surgery shelf 100 times more manageable! Rounding is the most painful part of this rotation, besides the hours, but if you like rounding for hours or love knowing every detail about your patient - then you’ll have a blast.”

Exam: Like outpatient internal medicine, inpatient IM has a two-part computerized exam. The test exclusively covers 13 pre-assigned core topics, ranging from ‘heart failure,’ and ‘liver disease,’ to ‘hyperkalemia.’ Going over the page for each topic several times in Pocket Medicine (the Massachusetts General Hospital Handbook for Internal Medicine) is very high-yield review.

**Obstetrics and Gynecology**

*Time Commitment: 8-15 hrs/day; 5-6 days/week*

*Lecture component: daily lunch lectures and weekly morning conferences.*

Ob-Gyn is half obstetrics, half gynecology, and half inpatient, half outpatient. That means that you will spend approximately a week and a half in each. For inpatient obstetrics, you’ll be on labor and delivery, five days during the day shift, and four days working the overnight shift. The hours are generally 6:30AM to 6PM on days, and 6PM to 8AM on nights. You will pre-round on your patients, then present them in the morning to your team. During the rest of the shift, you will write notes and assist with deliveries. Depending on the volume of deliveries during that particular week on labor and delivery, you may see very few babies, or be running around all night trying to catch them all.

For inpatient gynecology, you will spend 10 days on gynecologic oncology, which many students find particularly tedious. This has long hours but sometimes you get to go to surgery.
Outpatient obstetrics is mostly prenatal visits, and you’ll get to measure fundal height and use a Doppler to detect the baby’s heart rate. The hours are nice, you’ll work with physicians on some days and with nurse midwives on others.

Outpatient gynecology clinic also has decent hours, and your patients will be more varied; from patients in the menopause clinic, to patients with STIs, to patients needing a regular check-up or birth control.

There is an optional day during the rotation to spend at the Emma Goldman clinic, assisting with elective abortion procedures. You may opt out of this assignment for religious or personal reasons with no questions asked. Some people have found the experience to be enlightening to their education; others have been upset by participating in sorting through the aborted tissues to find fetal parts (in order to assure no parts have been retained). An email is sent out before the start of the rotation allowing students to decline attendance.

A word of caution: this rotation is notorious for its snarky evaluations. I’ve heard from multiple male colleagues that they felt discriminated against on this rotation on the basis of gender. A male classmate described to me how he felt purposefully excluded from participating in births on labor and delivery: “Patients were prompted either by nurses or residents not to have male students in the room.”

Exam: You’ll take the shelf exam from the NBME on the last day of the rotation. Those people who used Case Files seemed to think it helped them perform well on the exam. Other classmates had some success with Blueprints. The assigned text wasn’t especially high yield.

**Pediatrics**

Length: 6 weeks

Time commitment: 8-12 hrs/day; 5 days/week (except on inpatient)

This rotation has been restructured to include one week of general pediatrics clinic here at UIHC, one week of general pediatrics at a community site, one week of newborn nursery, one week of a pediatric specialty clinic (such as cardiology, hematology-oncology, et al.) of your choice, and two weeks inpatient pediatrics on one of two pediatric inpatient teams or the neonatal ICU. This rotation has a big lecture component, with afternoon lectures about every other day. There are also teaching rounds, physical findings sessions, an ethics conference, many CLIPP cases to complete (an electronic system for simulated cases used by many rotations), and student presentations, where each student presents a patient encountered during the rotation.

During surgery, you’ll show up sometime between 5 and 6, usually, to pre-round on your patients. Then you’ll round with your residents. Surgeries start at 8AM on Monday and Tuesday, and at 7:45 Wednesday, Thursday, and Friday. Procedures can be short, less than an hour, or last all day. You may have one surgery or three or more per day. Look up your patients and read about the procedure the night before, because some attendings are mighty fond of pimping you on details about the procedure, especially the anatomy.

There is a major lecture component, with daily afternoon lectures. These can be useful and are required. However, attendance isn’t taken, and some might make the choice to stick with a particularly interesting case in the OR rather
than scrubbing out to attend lecture. You will also have to create and give a presentation to your peers during the rotation.

A colleague states, “I was on two not-so-surgery-heavy teams so I didn’t have the crazy hours that other people complain about. Rounding however is awesome on surgery! Short and to the point.”

Exam: You will take the NBME surgery shelf exam. Many people say that this is the most difficult shelf. I scored very well using Case Files (read it through twice), Blueprints (read the summary pages at the start of each chapter), and going over the Pestana guide (a 70-page Word document you can easily download on the internet) a few times. Grading is approximately 2/5 shelf exam, 2/5 evaluations, and 1/5 busywork (presentation, course evaluation, patient write-ups).

Required non-core rotations (M3 or M4): Psychiatry, neurology, orthopedics, dermatology, otolaryngology, EKG/Lab Medicine

Psychiatry
Length: 4 weeks
Time Commitment: 10 hrs/day; 5 days/week (weekends off)
Lecture component: Daily lunch or afternoon lectures

Most people love this rotation. As with surgery, prior to the rotation you’ll receive an email asking you to rank your team preferences. Options include med/psych, VA psychiatry, mood unit, eating disorders unit, child psychiatry, and consults. I was on Eating Disorders, which was a great and unique experience. As this is a very specific unit, you must request it specially, but you’ll get to work with a wide modality of therapeutic techniques; I was able to accompany my patients to aquatic therapy in the hospital pool (yes, we have one!), go on community outings, attend music and art therapy, and participate in multi-disciplinary social work and dietary meetings. On this service, due to the extremely sensitive nature of the illnesses, medical students have a more observational role than on other services. This lends itself to a lot of studying time in the afternoons, which in turn can earn one a great shelf score.

Exam: You’ll take the NBME psychiatry shelf. My study strategy involved reading through First Aid for the Psychiatry Shelf multiple times. That thing is gold! I didn’t use the assigned text at all other than for cross-reference.

Neurology
Length: 4 weeks
I have yet to complete this rotation. However, a classmate who honored the rotation informed me that “the stroke part of the rotation is the best part. You learn the most and the staff members are AMAZING teachers. Stroke rounds are great, but can be a bit intimidating at times. Outpatient and the epilepsy part of the rotation aren’t that great, but they have good hours. Overall, not the greatest rotation, but you’ll survive - especially with the test being fairly simple and easy to study for.”

Orthopedics
Length: 2 weeks
Time Commitment: 10 hrs/day; 5 days/week (weekends off)
Lecture component: Yes, daily lectures in the morning

This surgical rotation has one week each of two teams, which you can rank in order of preference prior to the start of the rotation. I was on peds team, which was great, and blue team (reconstructive team), which had the worst hours but I got to replace knees and hips with the guy who’d literally invented the knee replacement.

Exam: Half the time (literally), our morning lecturers didn’t show up, which made studying for the exam difficult. If you attend all the lectures and study diligently the last week of the rotation, you should do fine.

Dermatology
Length: 2 weeks
Time Commitment: 10 hrs/day; 5 days/week (weekends off)
Lecture component: Yes, morning conferences and lectures

This rotation will allow you to freeze, slice, and shave endless imperfections off the skin of your patients. Especially while on clinic duty at the VA, you’ll get to have some autonomy with both interviewing, developing a plan for, and physically treating your patients.

A colleague who honored this rotation glowed: “Dermatology was an awesome rotation – it had great hours and a straight-forward test if you use the online modules to study from.”

Exam: Easy to ace if you use the online material provided. Don’t bother using the book; people score near 100% without it. The curve is very high for this exam.

EKG/Lab Medicine
Length: 2 weeks
Time Commitment: 4 hrs/day; 5 days/week (weekends off)
Lecture component: That’s all it is!
This rotation is a flashback to those golden hours spent in FCP IV getting lectured by Don Brown, MD. In the morning, you’ll have an hour or two analyzing EKGs that were pre-assigned from a paper packet ten or twenty at a time. Then you’ll have a couple hours’ break, in which you can complete the EKGs for the next day. Following this, you’ll have a couple hours of lectures on laboratory and pathology lab topics, such as blood bank basics. This rotation is great because you get to wear jeans, the hours are sick, you get to work with Dr. Brown again, there’s no call… basically, it’s highly reminiscent of the M2 year and you realize just how carefree you used to be back before clinical duties called.

Exam: In two parts for EKG; a QRS analysis and an ST analysis. Everyone told me to study hardest for the QRS, which I ended up acing, and not bother too much with the ‘easy’ ST analysis, which I did poorly on. So balance your efforts despite what you might hear! The test gives you a packet of EKGs and then a list of terms; a matching test.

The test for the Laboratory Medicine component of the course is simpler; it’s a computerized test based on the lecture materials. Also, you’ll get together with several classmates and be required to do a research presentation on a relevant topic of your choice (from a list).

**A Reflection on Community Health**

By: TJ Clark

Over the course of my first year of medical school, I have spent the lunch-hour of each Wednesday learning the meaning of Community Health Outreach. Through discussions with community leaders, passionate physicians dedicated to improving the health of the indigent, representatives from various social service agencies such as Shelter House, the Iowa City Free Medical Clinic, and the Domestic Violence Intervention Program, as well as through my own weekly service work at the Pheasant Ridge Community Center, I have been made aware of the varying needs of the diverse and vibrant community cradled by the bends of the Iowa River.

Throughout the course, we had speakers ranging from: a Johnson County Supervisor, physicians who dedicate their precious few unused hours to the Iowa City Free Medical Clinic, a community member battling drug and alcohol addictions, a representative from Proteus (an organization dedicated to providing healthcare to migrant workers in Iowa), a community member who has struggled with illiteracy for the majority of his life, and representatives from the Emma Goldman Women’s Clinic and Shelter House. Some weeks I left class feeling defeated and overwhelmed at the great need that I felt so inadequately able to meet. At other times, I felt rejuvenated and inspired to work harder in my courses in order to gain medical knowledge (and the accompanying financial resources) so that I might be more able to give the assistance that was so blatantly needed.

As part of the service component of the course, I spent an hour and a half each Monday afternoon teaching elementary school children the importance of proper nutrition, adequate physical exercise, and proper health hygiene at the Pheasant Ridge Community Center. Through this experience, I was able to interact with children from varying cultural and ethnic backgrounds and make a real difference in health awareness in these young children and their families.

In summary, I entered the course a foreigner to Iowa City with some vague feeling of desire and obligation to “help thy neighbor”. Throughout the year, I was able to see who my neighbors actually were and what “helping” them might actually mean. My thinking was stimulated and I was forced to wrestle with the questions “Is healthcare a basic human right, or a commodity to be accessed by those with the means to purchase it?”, “As physicians, what is our role in regards to advocacy for the poor?”, and “As a student, what can I realistically do right now?” With the conclusion of my first year rapidly approaching, I can say that while I have not answered all of these questions completely, and while other questions continue to arise, my perspective on the Iowa City community and my place within it has taken firm shape, and I feel a connection and a pull to aid my community in whatever way I am able.

**Step 1: An Action Plan**

Who wrote this article? A fair question, but I won’t say. I want to make this article about you and your board score, not me and mine. I want to share, however, that I did well on the boards. I scored above a 240. So, the advice I’m about to share at least worked for me. We all study differently, but I feel that anyone at a top school like the University of Iowa can get an excellent board score by following a few general principles. But first, what is
a good board score? The answer isn't as straightforward as with the MCAT and other standardized tests. A good Step 1 score is the score that will get you where you want to go. An average score is around 222. Plastic surgery and dermatology are notoriously competitive, with averages around 243 and 240, respectively. Orthopedics (a popular specialty at Iowa), radiology, radiation oncology, and ENT have averages in the 230s. Neurology, anesthesiology, emergency medicine, internal medicine, pediatrics, surgery, and pathology tend to have specialties around the national average of 222. PM&R, psychiatry, family medicine, and ob-gyn have averages between 208 and 213. Passing is a score of 188. About 95% of MD student pass Step 1 on their first attempt.

However, you don't actually have to get the average board score in order to match into the specialty of your choice. It is an average, so about half of the matched residents scored below the average. Your grades, letters of recommendation, research, service, Step 2 scores, and interviews are all important. That being said, your Step 1 score is a factor you can choose to do something about, and it is one of the most important parts of any residency application. So my advice is this: chose to work hard to achieve a high Step 1 score. It is a challenge, but it is a worthwhile one. It will help you no matter what specialty you want to join. It will keep your options open if you are unsure about specialties. It will help you understand the basic science of medicine and principles of research. Most importantly, you will learn about mechanisms of disease and illness and methods to alleviate them in order to improve the lives of our patients.

So, let's focus on specific advice. Starting on day one of medical school, I recommend that you try your best in your classes. This doesn't mean that you can't hang out with friends on the weekends, go on trips, etc. It just means that you have to be mindful of your responsibility to study when it is time to study. Don't "sacrifice" classes. Some people, when they realize they may not get Honors in a class, adjust their expectations downward and decide to just try to pass.

A better idea is just to try to get the best score you can on each test you take. Most of the material could show up on your Step 1 exam, and you may very well surprise yourself and get Honors or Near Honors after all. In sum, schoolwork should be your primary focus the first three semesters of medical school. Rest assured that your efforts in class will help you on your boards.

After your third semester, during winter break, I recommend buying your Step 1 study material. Specifically, buy the newest edition of First Aid for USMLE Step 1, Rapid Review Pathology, and consider subscribing to USMLE World for Step 1 practice questions. Starting around winter break and continuing until the end of M2, you should try to have read through First Aid at least once. This should be active reading, meaning that you should look up words you don't know and clarify concepts you are unfamiliar with. This is what the Rapid Review book is for. You should not study this book, but use it as a reference in order to annotate First Aid with clarifying details. You can also annotate details from class into First Aid. Many people try to coordinate their FCP IV schedule with what they are reading in First Aid. By the end of M2, you should have read and understood all of First Aid. You need not have memorized it; just have understood the material as you read it.

During spring break of M2, many people go on vacation. If you feel you must go on vacation, then go. Alternatively, you could get your first week of real Step 1 studying done during this time. An approach I recommend is to try to really learn the most difficult chapters in First Aid: biochemistry and microbiology. You will undoubtedly have to go over these subjects many times in your studying, so it is good to go through them as early as possible. At the end of the week, consider taking your first practice exam to set your baseline score. Realize that no matter what the score is, you can still attain any score on the real deal.

At the end of M2, I recommend taking as much time as possible to study before taking Step 1. This may be different for different people. Keep in mind that some schools allow their students eight or more weeks to study for Step 1 before the start of M3 and plan accordingly. During this time, your goals should be three-fold: try to get through all the practice questions on USMLE World at least once, try to memorize First Aid, and take a couple official NBME practice tests in order to gauge your progress. Importantly: you will not be able to memorize all of First Aid. Regardless, this should be your goal because this is the type of learning necessary to score well. Most people get through First Aid about twice more in the weeks following M2. Try to hit your weak areas a third and fourth time if possible.

On the day before your exam, try not to study very much. Breeze through stuff while lounging on the couch for example. In the early afternoon, stop studying altogether and do something you enjoy to take your mind off boards. Try to get a good night of sleep. At this point, it is important to remind yourself that your happiness is not predicated on a board score and that you worked hard and learned a lot and that is what matters most. Medical school is very goal oriented and I understand that this article is a manifestation of that. I believe you should take a mature, healthy attitude toward the boards: realize that while a good score is desirable, there is more to life and any board score can lead to a satisfying career. Keep this in mind during the three weeks it takes to get your score back. Better yet, don't think about the boards at all during this time.

I sincerely wish you the best of luck.
Promoting Lifelong Health

By: Rachel Sandler

As a student of Western medicine, I have learned a particular approach to examining patients and caring for their needs. When a patient comes to me, he or she likely already has a problem. Be it high blood pressure, a cold, or something more obscure, there is something about his/her health that isn’t quite the same as before. My job is to figure out what the problem is based upon interviews, physical examination, and laboratory tests and then, more importantly, do something to make the problem better. Thus this system is largely reactive and responds to a patient’s current health concerns. Recently, I had the opportunity to spend 2 weeks with the Deendayal Research Institute in the Chitrakoot region of India. There I learned that health care can be just that—caring for health, not treating disease. Through lectures and fieldtrips, I learned how medical plants and yoga can be used to promote overall wellbeing through daily and seasonal ritual. I practiced yoga myself and felt a sense of balance that I rarely do at home. Moreover, the Deendayal Research Institute is working to promote education and entrepreneurship so that every member of society can be a valued and integral part of the communal whole. An organic, plant-based diet forms the basic alimentation of the people as well, a practice that has been shown to prevent many diseases.

In years of studying Western medicine, I have learned that we practice reactionary, specialized medicine that values profit and quick fixes. In just two weeks at the Deendayal Research Institute, I saw how prevention and lifestyle are not just buzz words used for marketing campaigns, but can be truly embraced as a part of living. When a person becomes sick, he or she can be shown how to live a better lifestyle and can be encouraged to use meditation and introspection to change his/her ways. In Western medicine, we seek to cure quickly with pills when many diseases can be prevented or their symptoms lessened with changes in diet and exercise. We have seen that in the United States the way we live is killing us and our healthcare system isn’t helping us much either. I think we could all stand to learn a few things from the ways of India. Eat from the Earth, continue to be active, meditate, and learn to relax. If we do these things, we can be healthy and keep it that way.

Vital Signs Staff
Editor
Mattie Oelschlaeger
Editor-in-Chief
Denny Porto

Submit Your Writing, Photography, and Art to Vital Signs!

Submission Details and Legal Fine Print
Any member of the College of Medicine is welcome to join the staff of Vital Signs. Contact one of the staff for more information. Being an open forum publication, we provide space for letters to the editor and encourage our readers to write. All submissions should be identified by author in order to be considered for publication. Articles, announcements, comments, ideas, or drawings can be turned in anytime to the editors who reserve the right to reject or edit any submissions for clarity and space considerations as we deem appropriate. Please limit articles to less than 1,250 words. The opinions expressed within these pages are those of the respective writers and do not necessarily represent those of the editors, the staff of Vital Signs, or The University of Iowa College of Medicine.

Designed by: Denny Porto
Write for Vital Signs!

“What can I submit to Vital Signs?”
Photography, poetry, fiction, nonfiction, art, rants—anything you use to express yourself!

“Okay, but how do I submit these for publication?”
Email one of our friendly editors:
Mattie Oelschlaeger [martha-oelschlaeger@uiowa.edu]
Denny Porto [dennis-porto@uiowa.edu]

“But what should I write about?”
Write about your vacation, service trip, research—or anything else! Include pictures if you can!

“I want to be an editor just like you!”
Email an editor; we are always looking for new talent.

“I want to advertise in Vital Signs!”
Email an editor! Discounts available for student groups!