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**Introduction**

I've been reflecting a bit since I finished medical school and decided to start writing about important lessons I learned, primarily from clinical rotations.

This started off as a recapitulation of my own growth process. A form of self-therapy. Then I thought maybe other people might find these lessons helpful as well. I didn't write this as an unabridged pedagogical/instructional guide for study habits or the academic side of things. The reflections here are concise and primarily character-based.

Trust that I was far from constitutionally blessed with how to excel on rotations. I found the character aspects of medicine to be the most challenging. I had hurdles along the way and am thankful for how the process unraveled. So the most I can do now is help share some of these insights. Hopefully they benefit you in some way.

**1) Nothing is more important than a positive attitude**

Keeping a positive attitude when it's most difficult is a sign of fortitude, maturity and professionalism. This is real life. We're human. Nobody is always happy and we have permission to be frustrated, annoyed and dejected at times. But to step up and be friendly, cheerful and affable in our interactions when it's most difficult benefits your colleagues and patients.

If other people are happier because you're not a sulk to be around, that contributes to a receptive atmosphere that in some way, shape or form, makes its way back to the patients, whether that be in terms of the quality of care they receive or their level of comfort in the healthcare setting.

A positive attitude is also the #1 thing people look for on any team. It's light-years more important than any knowledge you bring to the table. People want to see you're putting others first and are a positive figure. If you bring bonhomie to the team, everyone will be much better off because of it.

*When all is said and done, your attitude will make its way back to the patients.*

**2) Always keep your cool**

The ideal doctor is equanimous in temperament. He/she maintains his composure. He doesn't yell. He's not emotionally labile or reactive. He thinks before he speaks. He's friendly and affable. He listens.

In times of stress or contention, a calm and composed temperament is a hallmark of professionalism. It's also a baseline expectation.

Universally, temperament evolves with experience. When you've handled/managed a problem before, it feels like less of a crisis when you're posed with a similar situation.

If someone yells at you, would you yell back? You'd address his or her concerns in a concerned and even tone. Right? In our personal lives, this is always something we should aim to improve. In the professional setting, however, this behavior is mandatory.

I was once on-call and waiting in a handover room. There was a registrar expounding complaints in an ongoing harangue: invective here, invective there; the resident down in emergency was stupid; the radiology reg's conclusion on the CT was worthless; the timetable was causing inconvenience; patient Smith was querulous and needy.

In truth though, nobody wanted to hear her complaints, nor did they come across professionally whatsoever.

*More simply put, keeping your cool and not repining means you have the maturity and professionalism for people to rely on you.*

**3) The answer is always: why of course you do**

Do not ever demur/reject a task or offer given to you by your team.

If you're asked if you want to run a job, see a patient, accompany a member of the team to a different ward, partake in a surgery, etc. (the list goes on), the answer is always, "why of course you do."

*This is one of the most monumental maker-or-breakers in medicine.*

If you demur, in most circumstances you will never see or experience any overt/negative repercussions. As far as you're concerned, nothing has changed. But now, consciously or subconsciously, you're labeled as non-stellar and have to dig your way out. That is, you show up the next day and everything is exactly the same, but no one's counting on you for anything.

If on the other hand the individual or team is a bit more Draconian (as is the case often times on surgical rotations), you will be Xed (i.e., eliminated as a reliable/committed team member). You might notice the next time around they don't really look at you. Or they come off as if they don't have time for you. After all, you didn't have time for them. They have no business dealing with you because you obviously couldn't do your part. But yet again, if you're passionate and committed, you'd show it.

This is seen as a bare minimum expectation in medicine. It's nothing additional. It's the baseline. The top priority is helping the team. Because the team helps the patients. Everything else ceases to matter. Try putting others first and this will be a non-issue in the future.

I make several examples to follow because I cannot emphasize enough how extremely important this is. Some of these responses might seem excessive. But trust me they're not.

*This does not mean being affectedly deferential. It means being genuinely conscientious, available and interested.*

Example 1:

"You guys can go. We're just going to go see this patient now in ward 8A. Do you want to come? You don't have to."

Your answer: why of course you do.

Example 2:

"You can leave. It's 10:50pm. You've been here in theatre really late. Thanks for staying. I know the last buses are probably soon."

Your answer: "I do want to stay. I appreciate your time. Is that okay with you?"

"You can if you want but you really can leave. You're a student. You're not paid to stay this late."

Your answer: "Well I'm happy to stay as long as it's alright with you. I'm enjoying being here. I really appreciate it."

Example 3:

"Would you mind stopping by 7B and dropping these forms off? Oh actually never mind, I'll swing by there on my way down to the consultant meeting in a few minutes. Will meet you down there."

Your answer: "It's no problem, I'll do it now. Anything else you need me to do?"

Example 4:

"There's an x-ray meeting at 6:30am on Thursdays. But don't worry about it. You guys don't have to come. Just make sure you're at ward rounds at 7:30."

Your answer: "That sounds great. I'll be there Thursdays at 6:20."

I would say the only real exception to this rule (*and it's very borderline depending on what the team is asking you to do, so be careful*) is if you have a genuine scheduling conflict that will entail you needing to apologize to somebody else. In this case, you emphatically apologize to the team. And be very explicitly/doubly apologetic:

Example 5:

At the beginning of rounds, you told your team ahead of time that you had a tutorial with Dr. X at 10:00. It's now 9:57am. The current state of the team is of non-urgency.

"We're going to head to ward 9B now."

Your answer: "We're really sorry. We'd love to come. We have our tutorial with Dr. X in three minutes. Is it okay if we go? We're really sorry."

"Oh yeah, that's right. Don't be late for your tutorial."

Your response: "Thank you again. We appreciate your time. Sorry again."

That might seem a bit stretched/excessive, but it's not, insofar as you're *actually sincere*. In fact, if you extend that propriety in select circumstances such as these you'll be seen as an exceptional communicator.

If however there is an urgent matter or you are given a job to run that might make you late for Dr. X's tutorial, you still stand by the team. You'll show up at Dr. X's tutorial at 10:05. When you walk in, apologize for being late. At the end of the tutorial, address Dr. X directly and say, "Dr. X, I'm sorry to bother you. I know you're busy. I'm sorry for being late. I was with the team. I just wanted to

apologize because I know punctuality is very important and I understand my responsibility to be on time." Dr. X: "It's fine. Thanks for letting me know."

*It's normal in medicine to be given the opportunity to leave or go home/study, etc.* ***Never acquiesce/agree to that initial offer****. It's strange, but it's sort of a subconscious Litmus test. If the team/reg tells you to leave, the correct response is "why of course I don't want to leave." Ask if there are any jobs to do; say you're keen to stick around if it's okay with him/her. Then when he or she says, "No seriously, you can go,"* ***then*** *you leave.*

**4) Do not ever, by the pain of death, no matter how subtly, answer up the hierarchy or one-up anyone**

This is an absolute death sentence and possibly *the* easiest and most expeditious way to get blacklisted forever. It's also a really good way to showcase self-focus and lack of conscientiousness.

Consultant asks the resident about 6-mercaptopurine. He or she knows it's an immunosuppressant. Nothing more.

You jump in, stentorian and with confidence (because you're fresh off USMLE) and say, "It's a PRPP amidotransferase inhibitor. Activated by HGPRT. Catabolized by xanthine oxidase. Don't give if someone (e.g., a patient with ALL) is going to be on allopurinol or febuxostat (e.g., for tumour lysis syndrome). Azathioprine is a similar drug and is metabolized into 6-MP."

Holy crap. You're so amazing. Let's all now take a moment to bask in how amazing you are.

[Seriously…we're all taking a moment…]

The resident won't be displeased with you because he or she feels threatened. That's not it at all. He or she just won't like you because you clearly don't have a basic conscientiousness for how that type of professional conduct comes across. Any degree or nuance of self-focus raises questions about whether you're really the type of person who unequivocally puts others first.

Maturity is about processes that are inhibitory. Inhibition is cortical. When we're young, there's no inhibition. Children scream and hit others on the playground. Teenagers get speeding tickets. Then as you creep into your mid-20s and the frontal cortex matures, you actually start thinking before doing. You develop a sense of inhibition.

I'm not trying to come across condescending or instructional, but this is such an important facet of professional interaction that I have to be firm here:

*It's not about how amazing you are. Shut up and be humble. Stay quiet, but always be available.*

Let's say the consultant asks the resident (i.e. John) about 6-MP, he or she gives a meager answer, and then the consultant looks at you, calls you by name, and asks for your response. In this case, you're actually expected to give an answer.

But do not neglect your conscientiousness.

As long as you're calm and ***not stentorian***, it's OK. In this case, it's more about your mannerisms and communication style versus what you actually say. You don't have to play diffident. But be extremely careful with how you speak considering the circumstances:

"Well John's made a great point that it's a chemotherapeutic agent. Going off of what he said, we were thinking it's a purine synthesis inhibitor. Could be used for things like ALL and not for patients on xanthine oxidase inhibitors." Full stop.

Volume of your voice should be low and your eyes looking toward the floor. Once again, this isn't about playing diffident. It's about calibrating your communication style to this specific circumstance. And by all means, later on, look your colleagues in the eye and speak loudly and clearly.

***It's not about what you know. It's about how you convey what you know. People will respect you infinitely more for your communication style than for any knowledge you have. Don't feel you need to say everything you know. If you perfect this, you will be an invaluable asset in the medical sphere.***

Another example is if you and another medical student are asked to comment on the differences between UC and CD in IBD. The other med student starts off and gives cursory details. During this time, you're basically hypersalivating and akathisic at the thought of all of the stuff he's not mentioning – what about all of the extra-intestinal manifestations, PSC, anti-Saccaromyces cerevisiae antibodies?

As soon as he's done speaking, you basically explode with detail: "There's stuff like pyoderma gangrenosum, erythema nodosum, reactive arthritis (and the list goes on)." You were so excited. You couldn't hold it. And you did a great job of alienating your peer.

And trust me, often times the consultant (or whoever is asking you questions) will blacklist you if you come off the wrong way or try to one-up someone, even if you were knowledgeable. I once heard a story from a US resident who said a very solid student undertaking a visiting clerkship at his program lost an interview spot because of one-upping another student. Same as before, it's not about what you know. It's about how you communicate what you know.

There's nothing wrong with filling in the gaps and adding to the discussion, but it is paramount that you never neglect your conscientiousness. People want a team player at the end of the day.

**5) Evaluate your requirement for internal vs external validation, and reflect on how this manifests in your interactions with others**

I'm really not trying to become overly philosophical here. And I'm not going to go down the route of introducing all sorts of euphonious aphorisms.

*However this type of reflection is tied to a fundamental character evolution that defines how one transitions from med student to doctor.*

When we relate back to point #4 above, at the ultimate confluence of reflection and judgement, nobody truly is concluding you're not a good person just because you've rubbed someone the wrong way. The need for external validation (i.e., for someone to pat you on the shoulder and say, "you're so amazing") is probably more common in medicine than most career paths. And for some, the decision to go into medicine can be partially traced back to the subconscious need for approval.

If a child doesn't get enough praise (e.g., from one or both parents), it results in a deficiency of an internal locus of validation. In turn he or she looks for ways to get it elsewhere – externally. And needing external validation can often lead one to inadvertently focus on him or herself before others. Because when we seek the approval of others, we act in ways to acquire that approval, even if sometimes that means neglecting the thoughts and needs of those around us. This outwardly presents as hubris or arrogance.

*Insufficient development of internal validation as a child/adolescent (e.g., paucity of parental praise) → compensatory requirement for external validation → development of qualifying mindset to acquire external validation → development of self-inflating/-focused behaviors aimed at achieving qualification → development of unspecified requirement for time, resources and attention to*

*support behaviors aimed at achieving qualification → others' time/energies become personal need → development of self-entitlement → familiarity with consuming others' resources → augmented sense of self-importance → insular thinking → lesser dissemination of one's reflections to incorporate others' concerns/views → development of circular self-pride mechanisms to reinforce acquisition of praise →* ***hubris, arrogance***

**Improving one's internal locus of validation in adulthood isn't mechanistically achievable through extrinsic adulation, but instead is tied to the awareness of and comfort in one's own limitations.**

Challenges and setbacks are often the impetuses for reflection. No matter how much you learn, embrace comfort in knowing that it is infinitesimal. Get over the idea of needing to be elite or superior in some way. Get over the idea of *needing* to accomplish something that will change the world. If it happens, it will manifest because you're diligent and perseverant in the context of luck, not because you *needed* to make it happen. Because no matter what you do that's so incredible in life, it won't matter in 50 years and no one will care what you did or who you were anyway.

**My belief is one's status is determined by his or her humility. The leader is the one who stays quiet, allowing others to benefit occasionally from his or her questions and redirection. And at these moments, he or she apologizes and broaches. Not as a façade. But out of genuine appreciation that people are taking the time to listen. One who officiously and actively directs a group isn't demonstrating leadership.**

Do not be the first person to shout out answers in a group. You might know the answers, but chill. If no one in your group responds after 4-5 seconds, then consider quietly offering a possibility for discussion. It's always better to stay quiet. Allow others to speak first. If you happen to be in a group with officious, loud, and/or highly assertive students, <u>don't push to equal or surpass them. That's really important</u>. It can be difficult initially, but it's most effectual to do more listening than speaking in this setting.

**6) Don't question a superior's clinical decisions**

If you don't understand why the consultant ordered the pituitary scan or you think it was unnecessary, don't mouth that off to people.

"Honestly I don't see why it was necessary for Dr. X to get the MRI when we were going to give bromocriptine anyway. Now we know there's an adenoma but it

won't change management. Poor girl will have to be followed now and Gd knows if there will be some unnecessary intervention later on. I just disagree with it."

Reasonable thought process/concern? Sure. But never mouth it off to another colleague, or anyone, in a way that undermines professionalism or the knowledge/experience of another.

If you feel compelled to verbalize a concern, it might be more appropriate to say, "I'm not quite sure how the MRI adds value to our management here. What do you think? I might ask Dr. X about that, as well as what he or she thinks about how a positive result could relate to future interventions that might be frivolous."

There have been doctors (not just med students) who have been held back on rotations because of behavior like this. And this doesn't just apply to what you say to others. It can also be your documentation: "Plan is x, y and z, as per Dr. X. My impression is instead that x, y and w are appropriate." If you are considering a documentation that presents variation to the set plan, you would need to write (if the resident approves), "Plan is x, y and z, as per Dr. X. Might consider possibility of w, only after review with Dr. X."

**7) Don't let your guard down**

This isn't an extremely complex or difficult one to manage. It's more just a reminder that professionalism should be upheld at all times in the healthcare setting.

If one of the docs makes a joke about something or someone, don't join in and add your own joke to the mix. That doesn't mean you can't build rapport and have friendly conversations with your team, but sometimes a simple nod with a slight smile is appropriate.

Don't ever use invectives in a healthcare setting, even with people you're friends with. You don't want to get overly comfortable and forget your professionalism.

If members of your team are making jokes and you're with them at the coffee table or standing around the ward, gently quarter-smile the comments off with a closed-lip gesture. This way you avoid coming off too serious but haven't dropped your guard.

If you happen to be talking about any person, say only positive things. But in general, avoid talking about people altogether. If someone else is speaking of

another in a neutral or non-positive light, change the topic or insert something positive.

*The bottom line is: don't get overly comfortable, and especially never make jokes or non-positive comments about patients, or any individual, ever.*

**8) Begin and end every interaction with an apology**

Yeah, I know, you probably think that sounds excessive, but it's not. Once it becomes a habit you'll notice a huge difference overall in how others respond to you. I have found that even the least affable people open up if you demonstrate that you're not about yourself and are initiating a conversation by putting them first.

*You have to remember the threshold is very low in medicine for tolerating self-focused behaviors. And there's no shortage of people who think about themselves first.*

So if you meet certain staff members who seem a bit closed off, that's probably why; they're fed up with people – notably students – who don't appreciate their time.

For the following examples, let's say you're asking someone – anyone – on the ward where a chart is.

Opening –

In normal tone: "Excuse me, do you know where the chart is for bed 21?": **Rude**

In nice tone: "Excuse me, do you know where the chart is for bed 21?": **Borderline**

In nice tone: "Sorry, do you know where the chart is for bed 21?": **Acceptable**

In nice tone: "I'm sorry to bother you. Do you know where the chart is for bed 21?": **Good**

In nice tone: "I'm sorry to bother you, I know you're busy. Do you know where the chart is for bed 21?": **Excellent**

Now, let's say the nurse (or whoever is helping you) spends 8 seconds of his or her time with you: we'll now say that there's a "midpoint" to the interaction.

Midpoint (8 seconds into the interaction) –

Looking away or walking off (e.g., to continue finding the chart) while the person is helping you: **Rude**

Not saying anything/standing idle while you're being helped: **Neutral**

"Yeah, sorry to bother you.": **Great**

"Yeah, I really appreciate it.": **Great**

If you really do need to run off within a few seconds of asking for help, tell whoever is helping you, "It's okay, I'm really sorry. Thank you for helping. I really appreciate your time."

Closing –

None: **Rude**

"It's okay, I'll find it.": **Rude**

"It's okay, thanks anyway.": **Neutral**

"I really appreciate your time. Sorry to bother you.": **Great**

**So basically, here's a template interaction that takes place over 15 seconds:**

"I'm sorry to bother you. I know you're busy. Do you have any idea where the med chart is for bed 21?"

"Hm, no I'm not sure. It might be in this room over here." (he or she takes the time to help you look)

"Yeah, I'm sorry to bother you." (after 8 seconds)

"No no, you're okay. You're not bothering me."

"Oh here it is. Found it."

"You're a champion. Thanks. I really appreciate your time. Sorry to bother you."

That's it. It's really simple and shows consideration for whoever is helping you. Essentially, every interaction should have two apologies. If it extends longer than ten seconds, you need three.

Nobody is going to get angry with you or think you're affected because you're apologizing and communicating appreciation for his or her time. I was a terrible communicator at the start of third-year rotations. By the end of fourth-year, I had staff members at all levels telling me I was one of the rare few who thought about other people first. Little did they know I *struggled* with this in the beginning.

**9) Doesn't matter whom you're writing to, begin all emails with "Dear"**

It doesn't matter if you're best buds with a consultant because he or she was your advisor way back when. Outside of a professional context that's fine, but anything related to medical school, research, etc., always, always, always, start with "Dear Ms. X,"; "Dear Dr. Y,"; "Dear Mr. Z,".

You might have a student coordinator who's 28 years old and all conversations you have with him or her are always by first name. By email however, it's always "Dear Ms. X," or "Dear Mr. X,". Keep it professional.

I learned this because I've overheard a few conversations over the past couple years where staff members, even jocular ones, have complained about the casual nature of student emails. I once overheard a consultant say, "This student emailed me and said 'Hey Dr. X.' What is 'hey'? It's so rude."

*Even if someone signs off his or her emails by first name, don't bite the bait.*

Also remember that any emails sent to and from members of staff might need to be referenced at a future time (e.g., to provide evidence of communication about planned leave) by a third party. Better to be safe than unprofessional.

*When all is said and done, no one is ever going to complain that you were too professional.*

**10) Never, ever, call a doctor, junior or senior, by first name in front of staff or patients, even if he or she is super-laidback and supposedly prefers it**

I was once in an outpatient clinic sitting in with an intern, who was a friend of mine since early in med school. We had a patient in the room and I needed to step out, so I said, "Dr. X, I'm sorry to bother you. I need to run to a tutorial. Is

that okay with you?" And I recall his eyes flashing with a bit of surprise because he totally didn't see it coming. But in retrospect, it was appropriate, and I know he found it very respectful.

I've also met doctors who've outright insisted on being called by first name. This is to the point that if you'd call him or her by "Dr. X," he or she would immediately interject and say, "It's John. You don't have to call me Dr. X." In this case, I would acquiesce and refer to him or her by first name in a casual setting. But if in discussion with another staff member, at staff meetings, or in front of any patients, it's absolutely "Dr. X."

I learned this lesson in first-year medicine. I was working with a consultant who always insisted on being called John (not his real name). With every email and casual encounter, everyone under the sun called him John. At one point while I was observing a surgery, I wanted to ask a question, so I said, "John, can I ask, what is it that…" And he immediately interrupted and upbraided me, "My name's Dr. X. You're just a medical student." I was taken aback by the comment and probably blushed a little. After the surgery he politely spoke to me in the washroom and said, "Look, I didn't mean to snap at you. It's just that in a professional setting, it's always gotta be Dr. X. You see Cheryl over there; she's been working with me for 20 years. My family has spent time with hers. And she still calls me Dr. X in theatre. It's just something you gotta know to do." Happened once. Never happened again.

When I was in fourth-year, I was sitting in with a lively and friendly consultant who was addressed by another member of staff by first name in front of a patient. After the patient and staff member left the room, the consultant turned to me and said, "'John'? What the F is that? I'm a *senior consultant*. It's 'Dr. X.' Not 'John.' I barely know that staff member, and to address me in front of a patient like that. Unbelievable."

*Doesn't matter how friendly and casual things are in an informal setting, in front of staff and patients, ALWAYS be professional and never use the first name.*

### 11) Learn to perfect the morning ward round. On time = being <u>EARLY</u>

I cannot stress that enough. Generally third-year med students show up at the exact start of the ward round (or Gd forbid late) and then tail around doing nothing, hands cupped together at the waist, staring into space. Basically no one expects third-years to be very contributive because they're just starting out. But by fourth-year, people will look to see that you're adding value to the team and

can write in charts. Some consultants will even admonish a fourth-year who isn't contributing.

If your team starts rounds at 7:30 and they tell you to arrive then, *ask the intern or junior house officer (JHO) when he or she arrives and what he or she does to get ready in the morning.*

The first one or two days of starting with a new team, one of the most important things is learning the morning routine **of the intern** and then doing everything you can to help him or her out.

If the intern gets there at 6:45 to update the morning list and get the charts ready, arrive at 6:30 and start getting the charts ready yourself.

Find out how the intern takes his or her coffee during the first one or two days. Don't ask this directly, but do it passively as though you're having a casual chat about caffeine and the number of hours you guys sleep. Then on the first Thursday or Friday, have a LARGE coffee ready for when he or she arrives. Don't buy the intern coffee every day. One or two days per week is good. This isn't about being a sycophant. It's about showing consideration for making sure the intern can get his or her job done smoothly.

*Every team is different, so with some dynamics it's not even possible to help the team much in the morning, but it's always expected that you at least take active steps to try.*

Chances are you're not going to be able to update the morning list since you might not have all of the newest patient information available to you, but **getting the charts started is a baseline**.

1. Find out which patients your team sees. Pull their charts.
2. Find a trolley and put the charts on it.
3. Make sure the next 1-2 blank pages of progress notes have patient ID stickers. Never write on a page unless there's an ID sticker on it first.
4. Start writing the template your team uses for ward rounds (i.e., either SOAP, or you can look back in the chart and see what your team does).
5. Ask the nurses if there are any updates/details your team needs to know about any of the patients ("I'm sorry to bother you. I know you're busy. I'm John. I'm just one of the med students on gastro. Do you know if there are any updates for any of our patients? Sorry again.")
6. Make sure when your round starts, you chase/fetch the med (bedside) charts for the team. If you're wrapping things up with one patient (i.e., you can judge you're going to leave the bedside in <10 seconds), jump

ahead to the next and get the bedside chart. If you don't see it, run to the nurses' station to look for it there. If no luck, do a mini-improvised search. If you still can't find it, tell a nurse you're sorry to bother him/her and ask if he/she knows where it is.

7. When you get the bedside chart, let the team know the patient obs. If everything is normal, quietly whisper to the intern, "afebrile, stable, within normal limits" and then flip to the charted meds so that he or she can scan them.
8. Learn to write the SOAP format, appropriate abbreviations/symbols, and how to listen at the bedside. If you're allowed to write in the chart, the most important thing is documenting the assessment and plan. Anything the patient says (Subjective) goes at the top. Anything you see/elicit on exam (Objective) comes next. The Assessment and Plan are toward the bottom. If your rounds are fast-paced and the instant you walk up to the patient the registrar/consultant is already delineating the plan, write that down first on the bottom of the page, then fill in the subjective/objective after.
9. Learn the jobs as per the specific team you're on. If you're on endocrine, learn to do bedside blood sugars and ketones and understand how you chart insulin. If you're on surgery, learn to manage drains and fluid balance.
10. When your team is ending the ward round and they say to you, "Okay, we'll see you guys tomorrow." Say, "Are there any jobs you want us to run?" Most of the time the response is "no no, that's okay." But they're always glad you asked. And sometimes you actually can help the team out doing something worthwhile. "Hey, actually, have you done an NG tube before?"

When I was doing my orthopaedics term, our ward rounds started at 6:30. The intern and JHO arrived at 6:15. I would arrive to hospital around 6:08 and get them venti coffees from our hospital Starbucks and label the caps with "The Intern" and "JHO". I did this maybe twice/week despite them protesting (out of courtesy, not because they didn't want coffee). This didn't come across obsequious because I carried a good attitude and stayed quiet, humble, and always available. I always asked if they had jobs to run and always stayed busy on the ward rounds.

At the end of the term, *both* of them pulled me aside and said, "You're the best med student ever, seriously. You've been so helpful. Thank you so much." And I'm not saying that to be self-aggrandizing. I'm just making a point that helping out the team is so easy to do and they'll appreciate it. It just has to come from a place of genuine care on your end.

*Showing up on time for rounds means showing up on time for **pre**-rounds. Pre-rounds = helping the intern before rounds. If you show up at the start of rounds, you're late.*

Each person on the team helps the person above him or her. Don't breach that order. Not out of principle, but because the team functions best that way. If you're on a ward round and the reg and resident both have mini-jobs they need to run, always chase the resident, not the reg. And consultants will notice if you're following that order. Trust me, they stay silent, but they watch. Basically if you're doing what you're supposed to do, it's helping the intern or JHO *first*, not the reg.

*Your number one job as a med student, on any team, in any specialty, on any rotation, **is to help the intern**. Be an ace at pre-rounds.*

**12) If you're not drinking large coffees, you're not working hard enough**

When I was on my surgery term and was paired with another med student, he and I usually arrived about 45 minutes before the start of the ward round. We always had the charts ready before the intern arrived and sometimes the intern even said, "Honestly, you guys are so helpful, but you know you don't have to do this right?"

On this term I bought the intern and other med student coffee twice/week. The student used to complain that he only drank small, not large coffees, but I only buy larges and he learned to toughen up. On my tab he once ordered: "I'll have a small, skinny cappuccino please." I inserted myself and said, "He'll have a large, heavy cappuccino please."

My sentiment is if a med student isn't drinking large coffees, it's because he or she isn't working hard enough. No intern will ever repine that the coffee you got him or her was *too large*. He or she might protest the coffee, but never the size. That being said, it doesn't matter if you're a triathlete and already get perfect grades, if you're not drinking coffee you're not working hard enough and there's an issue.

*Buy large coffees once or twice a week for others; if they only drink small/medium, they'll toughen up. It's better to have atrial flutter and be sharp as a whip than to be a partial crackhead.*

**13) Dress like an intern, not a hipster, not an executive**

When I was in first-year med I had my ears pierced and grew my hair out. I went to attend a surgery and showed up with my piercings in and my little ringlets popping out from beneath the surgical head mask. The consultant gave me a look of consternation, the same look you'd expect from your curmudgeon next-door neighbor who's disgruntled at kids skateboarding outside his house. He said to me, "Those piercings you have there; that hair of yours; you don't look like a med student. I'll tell you what. If you go back to the locker room, take out those piercings, and tuck that hair into your cap, you can observe this surgery."

I acquiesced. But I hadn't learned the lesson yet.

In second-year med, I showed up to PBL/CBL discussion with the same appearance and my skateboard. This was a casual classroom setting. Our desultory conversation at one stage became about the class photo of our school's first med school cohort back in the 1930s – roughly 30-40 students who all wore grey suits. The consultant looked at me and said, "Yeah, that's how things still should be. None of this skateboard, baseball cap, bull****."

I had a good working relationship with that consultant, and he said it in good humor. But he still said it.

My sentiment during the first two years of med school was essentially:

"I can be a competent and confident doctor no matter what I look like. People shouldn't judge me superficially. If they're going to judge me based on my appearance without knowing me, that's their issue not mine."

But I came to realize that the reason there's a baseline, conservative dress code in medicine isn't because people are uptight; it's because it guarantees that zero percent of your patients will be uncomfortable around you because of your appearance.

If five-percent of your patients are less than perfectly comfortable because you don't have standard, professional dress, you need to take responsibility for that.

*You have to ask yourself: What's more important, that I get to express my individuality the way I want even if 5% of my patients might be uncomfortable and won't say anything, or that I present myself strictly in accord with the profession and 100% of my patients are comfortable.*

Medicine is a profession where we unequivocally put our patients first. It's not about you. It's not about me. Maybe individuality is important to me. But my patients are more important. And the feeling that I want to express myself

outwardly a certain way should never take precedence over the comfort of 100% of my patients.

As a career, medicine really *is* conservative. Not because it's been framed by previous generations, but because patient comfort requires it. You might be extremely competent and affable, and you might have a tiny stud in your ear. Guaranteed there's a percentage of your patients rubbed the wrong way by it who won't ever say anything.

And it's not just patients. It's also staff. People need to work together in the healthcare setting. If another staff member sees your piercing and feels you haven't learned basic conscientiousness yet, he or she might view you as questionable.

*Having any type of appearance that deviates from the conservative propriety of the profession not only rubs a percentage of patients and staff the wrong way, it also lowers the threshold for negative judgement against you if one of your decisions isn't stellar.*

There is not a single healthcare professional who isn't going to make a less-than-stellar clinical decision at some stage. Don't let others' subjectivity cloud what's objective. Don't give other people a reason to question their trust in you. If you've got a tattoo on your forearm and a labret, a bad decision suddenly becomes a catastrophic one from the patient or team perspective. It's just the nature of things.

Maybe people shouldn't base their first impressions in part off of appearances. But they do. *There's an extremely low threshold in medicine for any type of conduct or expression that presents itself as self-focused.*

I knew a guy who started med school with a clean-cut appearance. By fourth-year he had dreadlocks. I heard through the grapevine that a consultant pulled him aside and said, "Mate, if you actually want people to trust you, you have to be kidding about the hair."

*In medicine, an alternative appearance communicates that your expression of individuality takes precedence over the comfort of 100% of your patients (and staff). If you're a guy, keep your hair above the ears and lose all piercings. If you're a girl, one earring on each lobe is acceptable. If you have tattoos, cover them up.*

That being said (and yes, I'll say it), there is *also* such thing as dressing too well. If the residents and registrar on your team are wearing slacks and a button-up

shirt with no tie, and you rock up wearing a three-piece suit, you'll come off self-focused and lacking conscientiousness.

I learned this lesson in third-year medicine. By this time I lost the piercings and cut my hair, but I showed up every day to hospital sporting my collection of 800-dollar bespoke suits and silk ties. I received compliments on occasion, but I also raised some eyebrows.

I was doing a geriatrics rotation at the end of third-year working under an intern whom I had a good working relationship with. He wore slacks and a button-up shirt with no tie. His sleeves were rolled up above his elbows, as per hospital health standards.

Three moments of awkwardness transpired during the rotation:

1) We had a patient who looked at both of us and said to the intern (pointing to me), "*He* looks way more established than *you* do."

2) A nurse passed by our ward office one day and said to me, "You look great. I love the suit," then pointed to the intern and said, "You though, you look just average." He and I looked at each other and thought, "Who says that?"

3) A consultant, before starting a tutorial, said to me, "So I've just gotta ask, what's the deal with the suit?"

Toward the end of the rotation, the intern and I had a more personal convo. He said to me, "Look, do you see our reg? He wears a tie, which isn't atypical for a reg. He almost never wears a jacket, and if he does, it's because he's got a special meeting of some kind. And have you ever seen a resident wear a tie? At our intern orientation the beginning of this year, there was a guy who showed up wearing a tie and jacket, and the impression was, 'who's this wanker?'"

I said, "Wait, so are you saying the suit and tie rub people the wrong way?" [He scrunched his face and nodded] "Wait, seriously, so it rubs people the wrong way?" [He scrunched his face and nodded] I basically open-palmed my forehead thinking, "How could I have been so oblivious this whole time?"

Essentially I have no idea how I went through third-year medicine unaware that I was *dressing too nice*. It seemed ridiculous. Dress too sloppy and you're unprofessional. Dress too nice and you rub people the wrong way. Give me a break.

So I started dressing *like interns do*. Slacks. No tie. Sleeves rolled up to the elbows. This wasn't a matter of dressing down to appease those above me, as though they have insecurities, since that would be the immature perspective. It simply required **not making it about me.** This yet again falls within the spectrum of dressing in accord with the profession, and working within a team means not one-upping anyone or making people question whether you're conscientious.

*Don't out-dress anyone on your team.* ***The rule of thumb is to dress like the intern.*** *The ideal dress for a med student is therefore smart-casual. If the residents on your team wear suit + tie, then by all means it's OK to harmonize, but do not ever out-dress anyone. If you're truly* ***not making it about you,*** *then you shouldn't care about not dressing as refulgently as* ***you*** *want.*

### 14) Start thinking and presenting with a systems-based approach

When I was on paeds, a consultant during a ward round asked our small group of students, "Does anyone know anything about Kawasaki disease?" One of the girls instantly shouted, "That's the disease where you get coronary aneurysms!! Need to follow with echoes!"

The consultant rolled his eyes with annoyance.

Essentially when you're a med student and are first learning about different diseases, etc., occasionally your knowledge of seemingly strange detail that you think makes you special actually is just rudimentary and quotidian, and it's better to stay quiet.

His response was, "Why does everyone always fixate on that detail? Yes, coronary aneurysms can occur, but they also can in other vessels, such as the renal arteries. Do you have a different starting point?"

What he was looking for was for one of the students to thoughtfully proffer his or her knowledge in a systematic way: "Kawasaki disease, also known as mucocutaneous lymph node syndrome, is one of the most common paediatric large vessel vasculitides. It is most often self-limited and is characterized by…"

The same way after you go do a history and exam with a patient, you don't just start your presentation with details about family or social history. You have a system you follow: "Mr. Smith is a 48-year-old gentleman presenting with four days of x, y and z, on a background of a, b and c."

An obstetrician once asked me, “So what are the complications of placenta previa?”

My reply was along the lines of: “bleeding, fetal distress, requirement for C-section, etc.” He interrupted me and was like, “Look, don’t forget your systems. Start off by saying ‘okay, well for complications we have maternal vs fetal. Let’s start with maternal…’”

And I should have known better. Obgyn was my last rotation of med school, so I felt a bit silly that I had to be reminded this late in the game to be systematic. But that’s the learning process.

*On clinical rotations, people will look to see that you’re presenting **and thinking** systematically. This not only makes for more efficient and prioritized presentations, it also makes for more **professional** ones.*

If you’re thinking systematically, it will function as a natural chunking system. Chunking is when you memorize, let’s say, twenty-four things by remembering them as four groups of six. If you imagine your four groups as a tree-diagram with six in each bubble, it yields a visual framework that makes for greater lucidity, categorization and recall.

So if someone says to you, “Tell me about management of gestational hypertension.”

It’s a lot easier if your framework is something like, “Maternal vs fetal investigations; indications for medical therapy; drugs and dosing; inpatient vs outpatient; indications for delivery. Etc.”

Because otherwise, if someone blindly asks you that question, where do you even start from? If you have a system in place and know a few bullet points in each category, you’ve actually covered quite a bit.

Thinking in systems will make you a better doctor. We don’t just automatically have built-in systems for every novel variable that presents itself. Therefore systematic thinking should manifest as *a delay* prior to speaking/doing while you prepare yourself.

*When someone asks a question and you know the answer, there should often times be a slight **purposeful** pause because you’re rapidly organizing your information into systems for presentation/communication. The pause you make is not simply to reflect on temperament and communication style, but it reflects the assembly of a logical system.*

**15) Communicate awareness of common things vs things not to miss vs zebras**

When I was on my internal medicine rotation in third-year, a gastroenterologist asked me about causes of bloody diarrhea in any age group. Instead of starting with a system (e.g., paeds vs adults; malignancy, infectious, autoimmune, etc.), I began listing off random things coming mind, e.g., diverticular bleed, CRC, chronic granulomatous disease.

He said, "Chronic granulomatous disease?" He wasn't impressed.

I responded, "Up to 50% with NADPH oxidase deficiency can present with Crohn-like symptoms." His reply was to the effect of, "You start throwing out zebras like that before mentioning a million more common things first and you're going to get yourself into a lot of trouble down the road."

In case you don't know what a zebra is, it's something very rare. Imagine a field replete with horses and then there's a random zebra among them.

His point was that it's a med student rookie error to just start naming off anything that comes to mind, without any form of system, with disregard to how rare a condition might actually be.

If your 32-year-old female patient has sore hands/joints and you're including osteoarthropathia hypertrophicans in your initial differentials, no one will take you seriously. If she has lung cancer, that's fine, but you'd have to be careful and discuss that ***you're aware*** *it's probably still* not likely.

I've found that whenever discussing differentials, one of the best initial approaches is to say, "Well we have common things vs things not to miss." This shows you have a thoughtful and *safe system* in place.

It demonstrates that even though your assessment of two-year-old John is that he likely just has a viral URTI, you're still taking a moment to think more broadly to consider other less likely causes, which if you missed, would herald a devastating outcome.

"Common things are common, and in this case my provisional Dx is viral pharyngitis. My targeted differentials are croup and bacterial URTI. I see LRTI/pneumonia as less likely for x reasons. Things not to miss in this patient

are epiglottitis and meningitis/encephalitis, although they are less likely here for x reasons."

And if you ever mention a zebra in your differentials, **you better say you're aware it's not something you see every day**. If the kid has five days of fever, conjunctival injection, and erythematous palms, you can mention your suspicion for Kawasaki, but communicate you're not automatically rushing to conclusions.

You might be really excited that you've read about grey platelet syndrome and pseudo-grey platelet syndrome, but don't say those things. Mention your awareness for things like ITP first.

*Articulating your **awareness** for common things vs things not to miss vs zebras is vital. Not only is this systematic thinking, it shows you're both reasonable and safe.*

### 16) Attendance and punctuality are 100% compulsory. If you can't attend something, communicate effectively beforehand and get planned leave

When you're an intern it's going to be your **job**. If you just randomly show up late (or not at all) on a given day, you probably wouldn't expect to stay employed too long.

If people seem irascible over attendance, it's not because they're super-concerned that one absence or tardy is going to be irreparably detrimental to your learning. The concern is about whether you're taking things as seriously as you should be.

*Attendance and punctuality, together, are one of the most paramount indicators that you're serious about the profession and are respectful of others.*

Yes, you should be present and on time for everything, but once again I'll reiterate: **never, ever, be late to ward rounds**. We talked about earlier that being on time = being EARLY = being active on *pre*-rounds. But Gd forbid if the actual round starts and you rock up as the fifth wheel, it looks careless and juvenile.

One of my fourth-year rotations had five med students assigned to the morning rounds (yes, it was an army of us). One guy and I were active every day on pre-rounds. The other three guys were present intermittently. When they did show up, they were often late, and team was basically like, "Who are you guys?" It's like, "Hey, can I join your circle? I'm here only a third of the time and have no

idea what's going on with any of our patients, nor do I help out in any way, but sup guys."

I once worked under an intern who told me he had to upbraid the fourth-year med student he had before me.

He said, "You know what they say, if there's nothing positive to say then don't say it. But let's just say he made his own starting time. He'd come in here some days at 8:30, other days at 9. Toward the end of the rotation, I finally pulled him aside and said, 'Mate, you clearly don't have a clue do you.'"

And yes, he said that. It shows often times people will notice your conduct long before they say anything (i.e., if they say anything at all), and failure to maintain attendance and punctuality, especially, is viewed as effrontery.

If someone is holding a tutorial and you're late or don't show up, it's offensive. People don't have to spend their limited time catering to students.

*The most important thing in medicine is that you're putting others before yourself. Being present on time for everything shows you're committed to the profession and the people around you.*

If you cannot show up for something (e.g., you're sick), definitely make sure you communicate with your student coordinator letting him or her know.

"Dear Ms. X, I'm sorry to bother you. I know you're busy. I am sick today and cannot come to hospital and Dr. Y's tutorial. I am aware that attendance is 100% compulsory and that there are no excuses for missing any sessions/days of the rotation. I am sorry if this causes any inconveniences and will make up this missed day as required. I have attached a SoM sick day/leave form to this email and will send a doctor's certificate to you ASAP. Once again, I apologize for any inconveniences this may have caused."

That's it. You've started the email with "Dear"; you've shown appreciation for your coordinator's time; you've communicated that you're aware attendance is important and your full responsibility; and you've made arrangements to ensure all relevant forms/documentation are delivered expeditiously. That's pretty much all you need to do if you can't make it to something.

*People understand if something comes up and you can't attend something. What's most important is how you communicate about it. It's really just about showing respect and your seriousness for the profession.*

**17) You can't divide 100 by two and get 100**

This might sound self-explanatory, but it can be a really hard lesson to learn. Chances are you're extremely ambitious and eager to take on many projects at once, but bear consideration as to whether you're truly optimizing or are simply harming yourself.

Eight hours you spend pipetting in a lab is eight hours you spend not studying medicine.

Four hours you spend on the court improving your serve is four hours you spend losing your golf game.

A x B x C, etc. = a Constant. If you focus on one thing, you have to accept compromise in another. That's just life. It's inconvenient. We move on.

When I was full-time in third-year medicine, I was also doing my PhD full-time at the same time, working as an author for *First Aid*, tutoring ten hours a week to support myself, and trying to prep for USMLE Step 2. It was a complete disaster.

Needless to say, I began to resent everything in my life. Med was getting in the way of the lab; the lab was getting in the way of med; I wanted to excel more with *First Aid* but couldn't; I had to turn down many clients; and I wasn't doing as many QBank questions as I wanted to.

I then began to resent biological requirements. Suddenly going to the gym, eating meals, and sleeping meant I was trapped by my biology.

As fast-spinning as life may be, I had to come to terms with the fact that I wasn't an electron and couldn't be in multiple places at the same time.

*In an absolute sense, when multi-tasking, the magnitude of your productivity can be objectively acceptable for each individual project. But in a relative sense, dissemination of your time toward multiple projects necessitates* ***working below your potential in everything****.*

I reluctantly began cutting down on the number of things I was doing and found I became a lot better at the ones I stuck with.

An important part of consolidating the number of activities you're engaged in is questioning your reason for doing things.

I began to loathe working in my lab. Why was I still doing it? I felt all of those hours I could be learning med instead, and that that was a better use of my time. But I didn't want to make any impetuous decisions.

Looking back, I probably stayed in the PhD four or five months too long. My dad gave me some good insights: "everyone's supposed to hate his or her PhD"; "it's about delayed gratification, not instant gratification"; "you don't see your advisor in the lab; once you finish that part of the process, you don't ever have to set foot in the lab again; that's just how academia works."

But I grew increasingly menaced as time moved on, so I humbled myself, converted the PhD to a Masters, and then diverted much more of my time to medicine. It felt great. Not only was I not as encumbered, but now I was actually achieving greater efficacy doing what I truly enjoyed.

So my point being: multi-tasking for the sake of ambition is *not* necessarily a good thing. **Focusing on one thing and doing it really well is often times better than spreading yourself thin and accepting mediocrity in everything.** Other people might not think you're doing a bad job and might even give you praise, but you know yourself and will be cognizant of how far you could excel in any one direction if you just focused strictly on that.

*If you want to really excel on clinical rotations and get the most out of your learning, focus the bulk of your time on them rather than on many things at once. It's okay to have hobbies, but focus primarily on rotations, not side-projects x, y and z.*

### 18) If you're going to ask a question at a time that isn't completely opportune, acknowledge that you're stupid

I might as well have at least one point that's a bit ridiculous for the sake of levity. But I've found people respond well to this.

Sometimes a consultant may say to you (e.g., after a clinic), "Do you have any questions?" Naturally, these times are appropriate to ask whatever you need to.

Other times you'll want to ask a question when it isn't completely opportune. You might be moving from one patient to the next on a ward round, or catching a consultant between thoughts during a tutorial.

To be honest, I can't quite pinpoint when or where I started asking questions this way, but the approach probably developed abreast the broader conscientiousness I acquired during clinical years.

By the end of fourth-year, during tutorials especially, I always apologized when asking questions. Not in a disingenuous way, but out of awareness and habit. And for about a third of the time, I'd preface with acknowledgement that my question was stupid.

"I'm sorry (volume of voice low, eyes flashing at the person I'm speaking to then down toward the table), I have a bit of a stupid question. I was wondering…"

About half the time, whomever you're speaking to will say, "There's no such thing as a stupid question." But regardless, embedded within your preface is the tacit communication that you're appreciative of his or her time and are acknowledging that you're approaching him or her from a humbled position.

It's hard to explain, but people seem quite comfortable with this approach, perhaps because it takes any pressure off of them and eliminates any intimidation an interrogative scenario might present.

In general, people like humble people who make them feel comfortable.

When I was on my endocrine term, I began to notice none of our diabetic patients were ever on α-glucosidase inhibitors. I asked the consultant between patients on a ward round, "I'm sorry to bother you. I just have a bit of a stupid question. Do we ever use acarbose or miglitol for the type-IIs. Or is that just textbook stuff." Her reply was to the effect of, "There's never a stupid question. The research shows x, y and z. And our patients generally hate them because they cause them to poo all the time." Nevertheless, I could gauge that the way I asked the question made her much more receptive.

When I was on my surgery rotation, I was lost with another med student in the labyrinth of the hospital operating theatres, and we couldn't find our way out. I saw two members of theatre staff in conversation. I said, "I'm sorry to bother you. " They looked over. I said, "We're med students. And we're stupid. And we lost our way. Do you know how we get out of here?"

*I noticed after I said we were stupid they quickly smiled and became very receptive. In retrospect, it's possible it was at this moment that I recognized this form of communication as very effective.*

This doesn't mean you should walk around all day saying you're stupid. But in various and select circumstances this is a very good way to convey humility.

### 19) If you're going to ask a superior something in which there is *any* possibility he or she doesn't know the answer, preface or follow up accordingly

If a speaker/doctor is giving a talk/tutorial on skin cancer and you feel the need to ask about vemurafenib, it's not going to be a fun situation if he or she has no idea what that even is. Don't say, "What's your opinion on vemurafenib?" Then you've put the doctor in an uncomfortable position if he or she doesn't know.

Consider prefacing with, "Sorry, I had been reading about this drug vemurafenib, which supposedly targets BRAF kinase in some melanomas. In your experience, do you guys ever use that drug, or do you just use other things?"

This way, if he/she literally has never heard of it, your question has enough wiggle room for him/her to answer broadly, "We actually don't use that drug in our practice; we tend to use x, y and z."

If on the other hand you've asked something the doctor doesn't know and you didn't preface, follow up quickly and diffuse the tension.

"Sorry, how effective is fidaxomicin for *C. difficile*?"

"I'm not quite sure. Haven't heard of that one before. Oral metro, and sometimes vanc, is typically the go-to."

"Oh okay, sorry about that. I may have been mistaken."

*Prefacing some questions is a good idea. If you forget to and the doctor doesn't know the answer, follow up with something humble.*

### 20) Learn theatre etiquette, and be particularly excessive showing your ID upon entering theatre

Wearing your ID badge while in hospital is mandatory just about anywhere. In surgical theatres this is no different. You might have the ID attached to your scrubs, but sometimes scrub nurses will get angry if you don't make yourself explicitly known. Then you'll get a speech about how you need to introduce yourself better next time and to stay away from everything sterile.

You can basically turn it into a little activity to see how quickly you can get the scrub nurse to be receptive.

I've walked into theatre before where almost instantaneously I'm being intensely stared down by the senior scrub nurse.

*Whenever walking into a surgical theatre, hold up your badge with an outstretched arm and say to whomever you see, loudly and clearly, as though he or she is the police, "Hi, I'm John Smith. I'm just one of the med students under Dr. X. I wanted to introduce myself. Would you like me to write my name on the whiteboard and sign into the computer?"*

In zero-percent of circumstances will you get a response that isn't overwhelmingly positive. Most often it's just because not enough people introduce themselves, so it's a huge relief that 1) you're doing it period, and 2) you're doing it in such an overly explicit way that it demonstrates you're preter-aware of the importance of doing so.

Usually they'll tell you, "Yes, thank you, write your name on the board and I'll type it into the computer."

If the current atmosphere of the theatre is calm/non-chaotic, and the scrub nurse seems to be in a neutral or positive mood, I've found introducing a quiet line of humor in this situation is OK:

"Now I'm sure the next thing you want me to do is stand in your way and hover over everything that's sterile." And she'll smile and say, "Yes, that's exactly what I want you to do." This demonstrates that, in addition, you know you're aware of how the sterile process works. Because the last thing she needs is to assume you know theatre rules and then you brush up against a clean surface.

Another good thing to do, even if you're not going to be gowning for a procedure, is to wash your hands beforehand and put on a facemask. Otherwise sometimes you'll be told to grab a mask. And also be ready to grab a pair of non-sterile gloves to help the theatre staff assemble equipment/prepare the patient if necessary. If you see people getting the bed ready or transferring the patient between beds, this is a good time to be useful.

### 21) Follow the intern/JHO after morning rounds instead of outright retreating to the hospital library

Definitely spend time in the hospital library on breaks here and there. But if your rotation timetable, for instance, shows that you have the morning or afternoon free, try tailing the intern/JHO on the ward instead of going to the library.

It will sometimes reap *massive* rewards.

I know there's a lot of reading/studying you'll need to do for your rotation and you'll probably feel as though you never have the time to do it, so going to the hospital library is frequently a default setting. But just bear in mind the type of learning you get on wards is completely different from anything you get from books.

I did have some rotations (e.g., ortho, obgyn) that required a disproportionately large amount of time reading in the library. But in retrospect, it's pellucid to me that rotations such as geriatrics and endocrine, where I spent all day, every day, on the wards (and I'm literal about that), ***I learned tons in terms of how the job of the resident is performed. And when I left med school, it was this skill that made me feel like I had moved beyond med student level.***

It really is the case that as you spend more time on wards and approach the end of med school, you'll look back at how you once functioned during third-year and notice a big difference with respect to your usefulness to the team and understanding of what the resident does.

When I was on geriatrics in third-year, I worked 8-6 every day under the intern doing admissions with full Hx/PE, discharge summaries, ward work/jobs, chart documentation, prepping for rounds, etc. I used to annoy him a lot in the beginning because there was so much he had to teach me.

He said to me one day, "You honestly can know jack **** knowledge-wise. But if you know how to do the *job* of an intern – the paperwork, discharge summaries, presenting to the reg/consultant, phone calls here and there – you will be viewed as a *fantastic* intern."

I am very thankful to that intern for having spent so much of his time guiding me, because once I got to fourth-year, I found myself taking on a similar role helping the third-years gain footing.

So definitely spend time on wards if you can. *Tell* the intern/JHO at the end of your morning rounds that you're keen to learn his or her job. Remember, these guys were in your position just 1-2 years ago. They know the team structure and are aware that, even if they're busy, it's their responsibility to the profession to

teach you a thing or two. Never act entitled to an intern/JHO's teaching/time, but at the minimum, take active strides to tell him or her you're keen to learn.

Say, "I'm keen to learn; is there anything I can do to help out; is there anything you want me to learn; are there any jobs I can run?" If he or she says, "Oh no, it's okay. You can go study if you want." Say, "Okay, well I'm just letting you know I'm keen to learn your job and if there's any stuff you want to show me, I'm open to that." And then they usually take you on board.

*It's normal for doctors to be focused on their ward/patient work instead of enthusiastically catering to students. This can come off as though they're not keen to teach.* ***But show you're interested and they'll gradually open up and teach you a lot. Some residents who aren't didactic at first will teach you a lot if you show you're keen.***

**22) Even if the consultant seems disinterested in your presence, he or she is observing your commitment to the team**

When I was on my endocrine term near the end of fourth-year, I worked 8am-7pm almost every day. We had 30 patients and were always busy. My team didn't have an intern, only a JHO, so there was a lot I was able to do to help the team. I basically played 'acting-intern.'

I arrived early every day, helped the JHO during pre-rounds, was active on ward rounds, and always asked about jobs. I learned how to do blood sugars/ketones and chart insulin second-nature. I learned the team dynamic well enough that I was able to predict ahead what we needed to do, and then I would sometimes break away from the team, complete those things, and report back. I wrote in charts, using proper headings and documentation formats.

*And most importantly, I stayed super-humble, quiet, and was always available. I kept my attitude positive.*

The consultant on this team was very slow to open up to me, and she never looked at nor spoke to me. I felt uncomfortable at first, but I tried not to take it personally or make it about me. I began to realize after about two weeks that she acted this way because she was most likely accustomed to years of dealing with unhelpful, self-entitled med students.

Regardless, I kept my focus on strictly helping the JHO. Because truthfully it didn't matter how affable the consultant seemed. My job was to help the team run smoothly and make the JHO's day less beleaguering.

Occasionally I asked questions and always apologized when I did, because after all, the consultant was super-busy, and I wasn't entitled to her time. I believe she noticed that I was helping the JHO considerably. And the JHO would sometimes mention to the team that I helped out with x, y and z.

Over the entire course of the rotation, the number of times that my knowledge came into play where I was put on the spot, was maybe two or three. That's it. The point being: no matter how much you know as a student, it's infinitely more important that you're helping the team and carrying a good attitude.

At one point the reg asked the JHO a question and she didn't know the answer. I wanted to answer but kept my cool. The reg then asked me. My answer was, "Well you know I'm not allowed to answer up the hierarchy." And they both were like, "Hah, what do you mean?" And I said, "You know, I'm not supposed to do that." And this was done in such a way where it came off as conscientious, rather than supercilious, because it was in concord with the rest of my behavior. I know that both the reg and JHO saw it as a good move.

*At no point during this rotation did the consultant ever overtly open up to me or come across affable whatsoever, but she began to make occasional comments acknowledging she was aware I was doing my part.*

On the last day, the consultant filled out my clinical participation form and said to me:

"I'm a really tough grader and have failed students and residents before. Everything you've been doing, just keep doing exactly that. Having you on board was like having an extra member of *faculty.* If you ever want to work here as an intern I will write you a top evaluation."

I'm not mentioning this to self-aggrandize or promulgate how incredible I am. I mention this because when I started off rotations in third-year I rubbed many people the wrong way and had bare minimal conscientiousness. I had to learn these lessons from the occasional admonishment and observation of people's behavior toward me.

This document was literally a *self-reflection*. The only reason I know these things now is because I had made these mistakes myself.

**Recapitulation**

I hope this document has been even minimally helpful to you. There are quite a few additional points to make / things to talk about, such as effective study habits and ways to get the most out of your learning, but I felt I should keep the focus primarily to character-based stuff, because my original purpose for writing this PDF was for self-reflection, not as an instructional tool. Once again, thanks for reading. Here's a review of the points we've covered here:

i. **Carrying a positive attitude will always be most important**
ii. **Always keep your cool**
iii. **The answer is always: why of course you do**
iv. **Do not ever, by the pain of death, no matter how subtly, answer up the hierarchy or one-up anyone**
v. **Evaluate your requirement for internal vs external validation, and reflect on how this manifests in your interactions with others**
vi. **Don't question a superior's clinical decisions**
vii. **Don't let your guard down**
viii. **Begin and end every interaction with an apology**
ix. **Doesn't matter whom you're writing to, begin all emails with "Dear"**
x. **Never, ever, call a doctor, junior or senior, by first name in front of staff or patients, even if he or she is super-laidback and supposedly prefers it**
xi. **Learn to perfect the morning ward round. On time = being EARLY**
xii. **If you're not drinking large coffees, you're not working hard enough**
xiii. **Dress like an intern, not a hipster, not an executive**
xiv. **Start thinking and presenting with a systems-based approach**
xv. **Communicate awareness of common things vs things not to miss vs zebras**
xvi. **Attendance and punctuality are 100% compulsory. If you can't attend something, communicate effectively beforehand and get planned leave**
xvii. **You can't divide 100 by two and get 100**
xviii. **If you're going to ask a question at a time that isn't completely opportune, acknowledge that you're stupid**
xix. **If you're going to ask a superior something in which there is *any* possibility he or she doesn't know the answer, preface or follow up accordingly**
xx. **Learn theatre etiquette, and be particularly excessive showing your ID upon entering theatre**
xxi. **Follow the intern/JHO after morning rounds instead of outright retreating to the hospital library**
xxii. **Even if the consultant seems disinterested in your presence, he or she is observing your commitment to the team**