TRANSITIONING TO CLERKSHIPS:
2 Seniors share their strategy

Because the shift from lab work to being a Med Student again can prove challenging for students, a Clerkship Transition Committee was recently created. Their purpose is to answer questions, provide guidance. We decided to ask them a few pertinent questions when it comes to MSTPs and the return to the third and fourth year of medical school. What emerged from this "email interview" are suggestions and practical advice that I hope will give MD/PhD students some helpful ideas during their transition back to the wards.

What time of the year is optimal for an MD/PhD to transition to the wards?

Mark: The earlier you return, the better, in the sense that an early return allows for more time for electives. Electives help you figure out what clinical path suits you best and serve as good opportunities to acquire letters of recommendation for residency applications. With that in mind, anytime of the year would be an acceptable return time, up until September or October. Returning later than that severely reduces elective time and would not be advisable unless you are certain of what clinical discipline you want prior to your return.

> If I had to do it all over again, I would start with Surgery. This is the one rotation where you will learn to be efficient and learn how everything in the entire hospital works....
>
> *-Kori Wallace*

Kori: Going back really depends on if the person knows what they want to do or not. Make sure you have enough time as we're only funded for 4 semesters then med school is out of pocket. You want to have enough time to finish the required clerkships (peds, surgery, obgyn, medicine, family) by the end of 3rd year or the following summer. Neurology is not required to do away rotations or to take Step 2 but it is helpful. Acute care/geriatrics is not necessary and should be kept until the end since it is not required for anything besides graduation and doesn't really help with transitioning back to clerkships. I wish I would have done it last. The surgery selectives can be saved for the end as they again are only required for graduation, unless of course you want to go into urology, ortho, ent, optho. Then I would get them done during 3rd year.

What clerkship would be ideal to start back on as you transition from your PhD to third year of medical school and why?

Mark: Many people seem to start back on the Acute Care/Geriatrics block. Those two clerkships do not have shelf exams at the conclusion and are good opportunities to relearn the system of how the hospital operates. Alternatively, I returned on Family Medicine, and while it is a shelf-tested clerkship, I found it very beneficial to have the one-on-one preceptorship that Family Med offers when I first returned. I would recommend avoiding either Medicine or Surgery if possible. They are the two hardest clerkships, both in terms of clinical knowledge and shelf exam difficulty.

Kori: If I had to do it all over again, I would start with surgery. This is the one rotation where you will learn to be efficient and learn how everything in the entire hospital works; plus everything else will seem easier. Unless of course you want to go into surgery then hold off until the middle and get medicine under your belt. If you are cramped for time, do not do the acute care clerkship until the end. As much as student affairs will try and convince you otherwise, it's not helpful at all

Should you do any preparation for reentering medical school? And if so, how should you prepare?

Mark: Truthfully, there isn't much you can do that will make a difference. You can get a review book specific to your first clerkship and read up on topics ahead of time if you want, but the reality is that you will spend your first few clerkships trying to plug holes in your knowledge base. Unfortunately, there's no good way to know what you've forgotten until you're asked to utilize the information on rounds, while talking with your resident before rounds, etc. That being said, you will relearn things very quickly, in part because graduate school has taught us to be literature search and fact-finding buffs. Don't be afraid to let your attendings/residents know that you are a newly returning MD/PhD. They know and understand, and it will buy you some leniency early on. Obviously realize, however, that this should not be used as a crutch, and that you will be expected to show improvement just like any other student.

Kori: You can't prepare for going back to clerkships. The only helpful thing to know before hand is how to print rounds reports and set up a

soap note. Everything else you will learn from your residents/attendings/ reading.

What's the best strategy for getting high marks (grades) in third and fourth year?

Mark: You'll make your money on your clinical evaluations. On most clerkships, these count for anywhere from 25-50% of your grade. You can maximize your evals by not being a self-serving jerk. That sounds flip-pant, but I mean it. Always act professionally and always take your responsibilities seriously and put your patients first. Always offer to help out with team activities. If you can save your resident a few minutes by collecting vital signs for them, or by calling consult services, or by retrieving records from outside hospitals, they will remember that and will be more likely to evaluate you highly, or take time to teach you, or allow you to do small procedures at the bed-side. Always appear interested and willing to work and learn, even if you're not terribly interested in the particular problem at hand.

ALWAYS be a team player. It is your job to make your resident look good, and it is their job in turn to make you look good. It is NOT your job to make yourself look good at others' expenses. It always amazes me that some medical students forget to be an enthusiastic team player, and they end up looking self-serving and annoying the people who are evaluating them. Obviously, a good performance on the shelf exam is required for that high "A", but a top notch clinical evaluation can give you more wiggle room when it comes to the exam.

Kori: Don't be a jerk, be helpful. When your resident tells you to go home or that they don't need anything, they really mean it.

How should I go about deciding which specialty I'd like to match in?

Mark: The answer to this question is very individualistic, and it depends as much on your personality style as it does your interests. I chose pediatrics this way. I enjoyed the rotation when I did it in January/February of this year, but it wasn't until I returned to adult medicine that I found that I truly missed working with kids. In fact, I found myself being more interested in interacting with the children of my adult patients I was in interacting with my adult patients themselves. I did not initially attempt to match my clinical interests with my PhD research, but as turned out, the two were more in line than I had expected. My advice: keep an open mind, and choose something that you would miss if you couldn't do it on a regular basis.

Kori: Whatever works best for the individual.

> Always act professionally and always take your responsibilities seriously and put your patients first. Always offer to help out with team activities.
>
> *-Mark Fitzgerald*

Are there certain rotations I should think about doing away instead of at UVA?

Mark: This depends on what you're going into. For some of the more competitive clinical disciplines, an away rotation using your elective time at your top choice programs could be beneficial, and may even be recommended. For the less competitive disciplines, it won't make much difference. When it comes to 3rd year rotations, I don't think it's particularly important whether you are at UVA or away. I spent as much time away as I did at UVA. Others spend all their 3rd year time at UVA. We all do well. The number of away rotations that you get is determined by some undecipherable process that may be related to what time of year you return to clerkships, but that may also be related solely to the whims of the student affairs folks when you meet with Dr. Innes for the first time.

Kori: Not in particular. In Roanoke you act more like an intern. Salem surgery is rough but you get to do a lot.

When should you take Step 2 CS & Step 2 CK?

Mark: Medical students must take both by December 31 of the academic year in which they plan to graduate. As MD/PhDs we have no such restriction because we typically do not return at the beginning of an academic year in April/May. Supposedly you cannot sit for Step 2 until you complete the required core clerk-ships of 3rd year. Whether "required core clerkships" includes Acute Care/Geriatrics is a matter of debate when it comes to Step 2. Regardless, I would recommend taking them as soon as you can after completing your 3rd year clerkships. Be sure to schedule as early as possible however, as CS spots fill fast and there are limited testing sites (five nationwide).

TRANSITIONING TO CLERKSHIPS:
2 Seniors share their strategy

Kori: Depends what you're going into and how well you did on step 1. Surgery/derm/rad-onc, etc you better have done well on Step 1 and have done well on Step 2. Medicine/peds not as important. the average step 1 score for peds is 215 so it's not that competitive and if you did well on Step 1 there is no need to rush out and take Step 2 (you might do worse). You have to complete Step 2 CK by December and Step 2 CS can be pushed back for Mud-Phuds until March.

8. *Any last tips/advice for students about to re-enter medical school?*

Mark: You will feel nervous, confused, and unprepared when you start back. But don't despair. Clinical medicine is a lot of fun, and you already have the analytical and personality skills needed to succeed. You just need to learn the system. That takes a bit of time, but it is easily accomplished.

Kori: Be helpful to your resident, be prepared to be ignored.

Thanks to Kori and Mark for sharing their experiences! We wish you the best as you interview and go through the match!

Contributed by Jarish Cohen , Grad 3