Emergency Medicine Clerkship Handbook 2024-2025

EMERGENCY MEDICINE CLERKSHIP FOR THIRD-YEAR AND FOURTH-YEAR MEDICAL STUDENTS

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Duration of the Clerkship: 4 weeks

Reference source for students:

1. **Emergency Medicine Med Student: 1200 Questions and Explanations. Garrison, Shoff, and Cornelius: 2017 Edition. StatPearls Publishing**
2. **Case Files Emergency Medicine (LANGE Case Files) by Eugene Toy (Author), Barry Simon (Author), Kay Takenaka (Author), Terrence Liu (Author), Adam Rosh (Author)**
3. **Tintinalli's Emergency Medicine: A Comprehensive Study Guide, Eight Edition**
4. **Pre-Test Emergency Medicine: Adam Rosh, Clara Barclay-Bichanan**

INTRODUCTION

HISTORY OF EMERGENCY MEDICINE

Emergency medicine started to develop into a specialty in 1968 with a group of four physicians who decided to leave private practice and work in emergency rooms full-time. The first effort to organize a professional association named the American College of Emergency Physicians commenced in 1968. In 1970, the first emergency medicine residency program began at the University of Cincinnati. By 1979, emergency medicine was accepted as the 23rd medical specialty by the American Board of Medical Specialties. This eventually led to the development of the certification examination by the American Board of Emergency Medicine. Emergency medicine has since evolved into an important specialty, including several sub-specialties such as pediatric emergency medicine, ultrasound in emergency medicine and toxicology, just a to name a few. After internal medicine, family medicine, and pediatrics, emergency medicine is the fourth most sought specialty by graduating medical students.

Emergency departments serve as one of the main gateways for hospital admissions and is an integral part of undergraduate medical education. Medical students gain invaluable exposure and experience during their clinical rotations in emergency medicine. Compared to primary care and other specialties, medical students learn a different approach to evaluate and care for patients in an emergency

department. They are taught to be problem specific, and use a logical approach in formulating a differential diagnosis to prioritize the life- and limb-threatening problems first. It also includes appropriate pain control as early as possible during patient evaluation.

INTRODUCTION TO THE EM CLERKSHIP

It is important to realize that emergency medicine requires a sufficient level of cognitive and clinical skills before one can make decisions to care for patients in an emergency department. This cannot be comprehensively taught in a four-week period as is done in a standard medical school curriculum. Therefore, the main objective is to learn fundamentals of knowledge and clinical skills of managing patients in the emergency department setting. This requires, not only applying what you learn in the emergency department, but also incorporating knowledge and skills you have gained in other clerkships, such as internal medicine, pediatrics, surgery, etc.

Emergency department staff work together as a cohesive team and this level of teamwork requires well developed inter-personal skills. In addition, emergency physicians consult with specialists, and this also requires excellent rapport with all physicians and specialty departments in the hospital.

In order to learn fundamentals of emergency medicine, it is necessary to comply with the General Competencies as set forth for medical students by the Accreditation Council for Graduate Medical Education. Part of the learning process is also to incorporate feedback, evaluation, and remediation to assess strengths and weaknesses, errors in making clinical evaluations and decisions to mold students ' future personalities as effective clinicians.

EDUCATIONAL PROGRAM OBJECTIVES (EPOs) AND COURSE LEARNING OBJECTIVES (CLOs)

The Curriculum follows the 6 ACGME Curriculum General Competencies. These are mapped to the Educational Program Objectives (EPOs) as indicated on the table below. The Final Evaluation of the students in MedHub assesses the student's performance in each area. The Clerkship Learning Objectives (CLOs) are mapped to the EPOs in the second table.

General Competency	Educational Program Objectives
PC1: Patient Care	PC1: Clinical History Taking PC2: Patient Examination PC3: Medical Notes PC4: Oral Presentations PC5: Medical Skills PC6: Patient Care Teams PC7: Patient Management PC8: Cost Effective Comparison in Treatment
MSK2: Medical and Scientific Knowledge	MSK1: Knowledge of Medical Practices MSK2: Problem Solving & Diagnosis MSK3: Medical Treatment MSK4: Life-Long Learning MSK5: Research or Knowledge Expansion
C3: Communication and Interpersonal Skills	C1: Communication Medical Team C2: Communication with Patient, Family and Community
P4: Professionalism	P1: Ethical Behavior P2: Ethical Responsibility P3: Ethical Principles and Boundaries P4: Professional Relationships
HC5: Health Care Systems	HC1: Healthcare Delivery Systems HC2: Delivery Systems Improvement
RP6: Reflective Practice and Personal Development	RP1: Personal Assessment RP2: Time Management RP3: Stress/Wellness Management RP4: Conflict Resolution

Clerkship Learning Objectives (CLO)	**Narrative**	**EPO**	**Assessment**
CLO-1	Demonstrate an adequate fund of foundational knowledge in the application of relevant basic science principles and concepts to the surgical and medical problems encountered in Emergency Medicine.	**MSK 1-5, PC-7**	NBME EM Shelf Examination, Preceptor, and CD evaluations
CLO-2	Demonstrate skill in obtaining a focused and complaint-directed medical history and physical examination in the emergency setting and communicate both orally and in writing clear and concise presentations. Demonstrate the ability to interact with Emergency Department staff and consultants as a team member.	**PC 1-7,** **C 1&2,** **HC 1**	Preceptor, and CD evaluations
CLO-3	Identify relevant clinical historical and physical findings, understand the appropriate use of diagnostic studies and formulate reasonable and a logical differential diagnoses for common complaints encountered in the emergency department setting.	**PC 1,2,5,7** **MSK 1-3**	NBME EM Shelf, and Preceptor evaluations
CLO-4	Demonstrate an understanding of the use of medical resources and ability to interpret commonly ordered diagnostic studies, such as EKG's, imaging studies and laboratory tests effectively use available information technology and educational resources to manage patients efficiently in the surveillance and prevention of disease.	**PC 5,7,8** **MSK 1-4**	NBME EM Shelf and Preceptor, and CD evaluations
CLO-5	Demonstrate understanding of the principles of the treatment of disease, including treatment to stabilize unstable patients, and the rationale to assess and reassess in the monitoring of patients' progress.	**PC 1,2,5,7** **RP 2**	NBME EM Shelf and Preceptor, and CD evaluations
CLO-6	Demonstrate professionalism during interactions with ED staff and consultants, and as an active team member, participate in all aspects of patient care, and demonstrate professional, respectful, and effective patient centered communication with patients.	**P 1-4, 5, 7** **HC 1,2** **RP 1,3,4**	Preceptor, and CD evaluations

CLERKSHIP REQUIREMENTS

RESPONSIBILITIES IN THE ED

- Adhere to a professional dress code: scrubs, optional white lab coat, clearly visible name badges (both CNUCOM and that of the facility you are assigned to)
- Report to your attending physician
- Pick up patient charts at a comfortable and safe pace
- Report immediately to your attending physician and nursing staff if you see a patient who is seriously ill.
- Perform a focused history and a physical examination
- Present each patient to your attending physician and complete all tasks necessary for that patient
- Communicate with the nurses and other ancillary staff members. Do not hesitate to ask for their help
- Perform all basic procedures on your patients, with permission from your attending physician (IV insertion, NG tube placement, Foley catheter placement, LP, suturing etc.)
- Participate in management of critical patients and resuscitations
- Avoid picking up charts to see patients during the last hour of your shift, except an unstable patients who need to be seen immediately
- Utilize available online and printed resources to learn about the cases you see in the ED

DUTY HOURS

- Not to exceed 80 hours per week
- Overnight call not to exceed 1 in 4, averaged over 1 month
- Continuous duty not to exceed 24 hrs. plus 4 hours for transitions of care
- Will have 10 hrs. break between shifts
- Will have 1 out of seven days off, averaged over 1 month
- **Total number of hours of EM clerkship required**: 150-160 hours per four week period. Number of actual shifts per four-week period may vary depending on the length of each shift at the ED you are assigned to. Of these, must include at least one night shift and one weekend shift.
    - Included in this total are:
        - Didactics 4 hours x 4 = 16 hours
        - Shelf prep and exam time = 8 hours
        - **Actual Target hours in ED = 126-140**
- No more than five consecutive shifts per week
- Mandatory initial orientation and weekly didactic sessions at CNUCOM
- Mandatory orientation at each ED you are assigned to

Excused vs. Unexcused Absences

Event	Excused?	Make Up Time Needed?	
		6 week clerkship	**4 week clerkship**
Student illnesses, including infections that could put patients or other staff at risk	Yes	If > 2 days missed	If > 1 day missed
Illness or death of an immediate family member	Yes	If > 3 days missed	If > 1 day missed
Presentation at a medical conference	Yes, if notification >2 months ahead	If > 2 days missed	If > 1 day missed
Religious holidays (not national holidays)	Yes	If > 1 day missed	If > 1 day missed
Wedding (student is getting married)	Yes, if notification >2 months ahead	If > 2 days missed	If > 1 day missed
Residency interview or orientation	Yes	If > 2 days missed	If > 1 day missed
NBME exam – Skills exam in Year 4	Yes	If > 2 days missed	If > 1 day missed
All other	No	Yes – for all days missed	Yes – for all days missed

CASE AND PROCEDURE LOGS

- Students can access both required patient encounters (must see cases)
- And required procedures (must do procedures)

All this can be done in MedHub, even from the cell phone MedHub app. The "must see" cases are specialty specific and are required to be completed during the course of each clerkship. The "must do" procedures are not specialty specific and can be logged and accessed at any time during the M3 year. They should be all logged before the M4 year.

EMERGENCY MEDICINE REQUIRED PATIENT ENCOUNTERS (MUST SEE CASES)

In 2007 Nawar et al, reported that more than 25% of emergency department patients had seven common chief complaints. They are as follows: abdominal pain, chest pain, fever, back pain, headache, shortness of breath, and vomiting. You will see many patients with these complaints that are included in the "must see" case list for this clerkship. The required encounters ("must see") cases and that are central to the educational experience in the ED:

REQUIRED CLINICAL EXPERIENCES (MUST SEE CASES)

EXPERIENCE	LEVEL OF PARTICPATION
Surgical Emergency (Appendicitis, Acute Abdomen)	Evaluate or Assist
Medical Emergency (Poisoning, Cardiac, Pulmonary, Sepsis, Stroke, GI Bleed issues)	Evaluate or Assist
Trauma/Injury (CBI, Fractures, Dislocations, Lacerations)	Evaluate or Assist
Pediatric Emergency (Infection, CBI, Rash, Seizure, Injury)	Evaluate or Assist
OB Emergency (Delivery, Ectopic, Miscarriage, Fetal Distress, Ruptured Ovarian Cyst)	Evaluate or Assist
Psychiatric Emergency (Delusion, Depression, Suicidal Ideation, Mania, Anxiety)	Evaluate or Assist

Make every effort to complete all patient encounters listed during the first three weeks of your EM rotation. Contact your CNUCOM Clerkship Director prior to the last day of your EM clerkship if you have not completed any of the above. Your completion of this list will be monitored by the Clerkship Director, and failure to complete your list can result in either a lowered final grade, or potentially the requirement to repeat the clerkship, or your Clerkship Director may assign you additional case reports or virtual encounter experiences to complete.

REQUIRED PROCEDURES (MUST DO PROCEDURES) FOR EMERGENCY MEDICINE CLERKSHIP

Many procedures are integral to the practice of emergency medicine. You will be expected to either observe, assist, or perform/manage the following procedures. The logging of these procedures, however, can happen before or after as well as during your EM Clerkship.

REQUIRED PROCEDURES (MUST DO PROCEDURES)

PROCEDURE	LEVEL OF PARTICPATION
Peripheral IV (optional IO insertion)	Participate or Perform
Wound care / suturing / stapling / adhesive use	Participate or Perform
Foley catheter placement	Participate or Perform
Arterial blood gas procedure and interpretation	Participate or Perform
EKG lead placement and EKG interpretation	Participate or Perform
Incision & drainage procedure	Participate or Perform
Fracture / dislocation reduction (optional)	Manage / participate
Splint application on extremities	Participate or Perform
Lumbar puncture procedure (optional)	Observe / Participate or Perform
Nasogastric tube placement	Participate or Perform
Basic Life Support (CPR / chest compressions optional)	Participate or Perform
Basic airway management	Participate or Perform
Emergency Ultrasound Procedures	Observe / Participate or Perform
Central line placement (optional)	Observe / Participate
Procedural sedation (optional)	Observe / Participate
Advanced airway management (intubation etc. optional))	Observe / Participate or Perform
Chest tube placement (optional)	Observe / Participate

Your participation goal varies from procedure to procedure. You may either:

- **Observe** (watch your preceptor perform and learn)
- **Participate** ("scrub-in" or hands on helping involvement)
- **Perform/Manage** (actually perform the procedure, but with Preceptor monitoring your performance)

Note: no procedure should be performed by a student, without the explicit approval of your preceptor

THE ED PATIENT: FROM DOOR TO DISPOSITION

Patients in the emergency department are approached somewhat differently than those who go to primary care or other specialties. In the ED, patient evaluation commences with a problem-oriented approach using the chief complaint as the starting point. The concept of triage is employed and "life or limb" patients as well as patients with moderate to severe pain are seen first.
It is important to treat patients and their family members with kindness and empathy. This is not different from what you would expect from any ED staff if you or one of your family members were being treated.

APPROACH TO THE ED PATIENT

- Identify severely ill patients. Observe nursing staff and your resident or your attending physician
- Learn to identify abnormal vital signs and how to manage them
- Learn resuscitation of severely ill patients - ABCDE
    - Airway
    - Breathing
    - Circulation
    - Disability (neurological deficits)
    - Environment /Exposure
- Assess and treat acute pain – pain scale. Pain documentation: L**OA -PQRST** (onset, associated symptoms, provocative/palliative, quality, region/radiation, severity, timing, temporal relationships/therapeutics)
- Manage stable patients
- Have an open mind – avoid "anchoring" (pre-determination/bias of a diagnosis)
- Consider unique problems of elderly patients
- Consider differences of pediatric patients. They are not "small adults"
- Assess unique needs of psychiatric patients
- Identify patients with chronic medical problems

ED HISTORY AND PHYSICAL EXAMINATION

- Review vital signs. Address abnormal vital signs
- Conduct a brief focused and complaint-directed H & P in the ED – withnessed by your preceptor
- Incorporate additional associated relevant physical findings
- Make a rapid differential diagnosis with the most life and limb-threatening problems considered first
- Initiate treatment within the first few minutes following the initial brief focused H & P to save a life or a limb
- Do a problem / complaint-oriented Review of Systems (ROS)
- Anticipate obstacles to obtain a thorough H & P in pediatric patient and patients who are severely ill with ALOC or are unable to give a history or appropriate responses during the PE

GATHERING RELEVANT DATA IN THE ED

Although a thorough PE is essential in the ED, frequently, that is not always possible, especially when a patient is severely ill or has ALOC. Pediatric patients are also included in this category as it is sometimes difficult to get a detailed H & P except from parents or by observing the ill child. In addition there may be patients who do not speak English making patient-management more challenging. To assist with these situations, information may be available from the following sources:

- Nursing staff – review the triage notes and talk to the nurse assigned to the patient
- EMS Personnel can provide extremely valuable information
- Previous medical records from within the hospital or from previous medical institutions where patient had treatments at
- Patient's primary care physician
- Family members or accompanying friends

Incorporate appropriate laboratory and imaging studies and EKG tracings as needed to support your differential diagnosis. It is important to be selective to obtain studies that are clinically indicated.

THERAPEUTIC INTERVENTION

Often there is insufficient time to wait for the results of laboratory and or imaging studies to be available before beginning treatment for an ED patient. Frequently, treatment is initiated almost simultaneously with a focused H & P, and modifications or therapeutic interventions are adjusted as and when more data become available.

This is not an issue for stable patients who can be managed in a more step by step approach.

ED DIAGNOSIS

Although both the patients and ED physicians expect to arrive at a definitive diagnosis after the evaluation, frequently this is not possible with the available limited time and resources. Of paramount importance is making the best attempt to arrive at a definitive diagnosis, and to identify and treat life- and limb threatening medical conditions. Once a patient is stabilized in the ED, he / she may be admitted to the hospital as indicated by the admitting physicians in other specialties who will continue to hunt for a definitive diagnosis. If the patient is sufficiently stable to be discharged to home, appropriate follow-up arrangements should be made for further evaluation and treatment, which may be with the patient's primary care provider or by a provider of an appropriate specialty. In addition, all patients should be offered the opportunity to return to the ED if his / her condition does not improve or becomes worse. This is also true in situations when they are unable to get a needed follow-up appointment.

CONTINUITY OF CARE/DISPOSITION FROM THE ED:

Patients are either admitted to the hospital or discharged from the ED. This decision is to be made with your resident and the attending physician. Often, ED physicians make that decision early in the course of their evaluation and treatment of a patient.

If you feel a patient needs to be admitted for his / her medical condition, but the specialist consulted does not agree, it is necessary to discuss this issue with your resident and your attending physician.

DISCHARGE INSTRUCTIONS:

Approximately 75% of ED patients are discharged after their visits. Patients who are discharged from the ED should be given both verbal and written explanations of results of diagnostic tests, treatments given, and an opportunity to ask questions. Appropriate follow-up arrangements need to be made. If any prescriptions are given to the patient, it is necessary to advise the proper use and possible common side effects of those medications.

Fortunately, there are many sources of pre-prepared written discharge instructions now available in most EDs. These discharge instructions are problem-specific, such as vomiting, abdominal pain, asthma etc. However, it is the responsibility of the treating physician to make sure that particular discharge instructions given to a patient must be individualized as necessary. Each of those needs to have a statement to follow-up with the patient's primary care provider and / or a specialist as necessary for the specific problem, and a statement offering to return to the ED if no improvement or if the problem becomes worse within a specified time period.

DOCUMENTATION OF THE ED CHART

An essential part of working in the ED is providing thorough and accurate documentation of H & P, findings of diagnostic studies, treatment rendered and response to such treatment, and plans for admission or discharge. Failure to document any of the areas noted above will always be assumed that the ED physician did not address the omitted area. This problem comes up frequently in medical legal cases which becomes defenseless for a physician facing a trial as a defendant.

In order to facilitate documentation, today there is access either to electronic medical record (EMR) systems or pre-prepared printed templates. If such resources are not available, and you have to handwrite your chart, it is absolutely necessary that your handwriting is legible. If not, you may want to consider typing your ED chart.

Thorough and complete documentation must not be considered just as a reason to reduce medical-legal potential, but must primarily be an integral part of our profession.

Each ED chart must include the following:

- Time the patient was seen
- Patient's name and identifying information on the chart; confirm with the patient on initial contact
- Nursing triage notes and vital signs
- Focused history (CC, HPI, PMFSH, ROS) and physical exam
- The HPI should include the following information (LOA-OPQRST):

    - L: location of pain, O: onset of pain, A – associated symptoms
    - P – palliative and provocative factors
    - Q – quality
    - R – radiation
    - S – severity (10 point scale)
    - T – temporal (duration)

- Document the ten systems of ROS reviewed and specific findings
- Document the differential diagnoses and medical decision making (MDM)
- Document the plan
- Document all results of all laboratory and imaging studies
- Document treatments given in the ED and response to each treatment
- Document time of re-assessment
- Document all your communications with other specialists
- Document your diagnoses / impressions
- Document all instructions given to the patient and their family members
- Co-sign your charts by your attending physician

MASTERING INTANGIBILE ED SKILLS

There will be ample opportunity to develop skills that are mandatory for practice as an effective and efficient emergency medicine physician. These include:

- Effective communication
- Teamwork
- Multitasking
- Time management
- Conflict-resolution

COMMUNICATION

Effective communication is of prime importance. Patients and family members need to be spoken to in lay terms that they can understand. Use of medical terms should be explained in simple language. Communicate with your residents, attending physicians, and nursing staff clearly and succinctly. Since time is precious in the ED, facts must be present in the best summarized manner. To facilitate effective communication, it is helpful to write your notes when you speak to the patient.

Often the care of the ED patient requires input or consultation by a specialist or arrangement of follow-up appointment with a specialist. It is imperative to develop excellent and diplomatic communication skills, and learn to present cases in a concise, but thorough manner. There are occasions when a consultant may not come across friendly. Even when such situations occur, continue to be professional and polite, and bring such incidences to the attention of the attending ED physician.

COMMUNICATING WITH SPECIALISTS IN OTHER DEPARTMENTS

A common need in the ED is to work with specialists from other departments, which may be a telephone consult to arrange a follow-up appointment or to request a specialist to see the patient in the ED for possible admission to the hospital. Therefore, it is imperative to develop excellent and diplomatic communication skills, and learn to present cases you need to discuss in a concise, but thorough manner. There are occasions when a consultant may not come across friendly to you. If and when such situations occur, we have to continue be professional and polite, and bring such incidences to your attending ED physician.

TEAMWORK

Working in any ED requires teamwork. It is essential that you work as a member of the team of your residents, attending physician, nursing, and other ancillary staff. In fact, there are many occasions that you will need assistance from the janitorial staff for certain tasks. Although not be directly related to patient care, they are nevertheless vital to work in the ED.

LIMITATIONS

As a medical student ("student doctor"), it is important to recognize and accept your limitations. **Do not perform any tasks without first discussing and getting approval from your resident physician or the attending physician.** If a patient needs any examination that is personal, such as a pelvic exam, do not perform these examinations without the presence of your resident or the attending physician, especially not without a female chaperone ED staff member if the patient is female.

If a patient needs any procedure, you must involve your resident or the attending physician to get their input and approval to do such tasks.

END OF SHIFT

The end of any ED shift can be stressful. Most ED physicians do not like to leave loose ends before they leave, but this is sometimes unavoidable. It is important to do your best to complete your patient care as much as possible before the end of your shift, but when it is not possible, it is necessary to make sure the remaining tasks are well-organized and in place before you leave the department, and a full report is given to the incoming physician. All such plans need to be discussed with your resident or the attending physician who were with you on that shift. You must always give your end of shift report to the incoming resident and to your attending physician. In addition, you may give that report to any incoming medical student as well.

ED AS A SAFETY NET and EMTALA

It is important to accept that EDs often are the safety nets for thousands of patients who do not have a primary care physician or are unable to get an appointment with a primary care physician in a timely manner. In addition, EDs cannot refuse any patient who comes to the door regardless of their age, ethnicity, economic status, religion, cultural background, or language they speak. Every patient must have a medical screening examination by a designated medical provider to determine if the patient does not have a medical or an obstetrics (OB) emergency.

ADDITIONAL CONSIDERATIONS

- You may be the first provider the patient encounters. Your professionalism, attitude, and empathy will be the first impression the patient experiences. In essence, in those situations, you will be the first person to represent that institution. Therefore, a kind and caring attitude will be a lasting experience for that patient
- Patients who smoke, abuse drugs or alcohol should be offered a brief professional counseling followed by an offer of additional available resources for help
- Assess patient's home / living conditions before he / she is discharged and offer any available assistance by a social worker, etc.
- If you suspect any possible child, elder, or spousal abuse, you have a moral and a legal obligation to bring those to the attention of your attending physician

TIPS ON PRESENTING THE CASE TO THE ATTENDING AND CONSULTANTS

Do not give a lengthy presentation. Make it short and simple, yet complete.

- **START:** you have a patient with / with possible diagnosis #1, diagnosis # 2, diagnosis # 3 etc. Mention the most likely diagnosis, followed by other possible reasonable diagnoses.

- **CC:** Mention the CC on the chart and what the patient may have told you

- **HPI:** Do a thorough but pertinent HPI. Characterize the pain as mentioned in your documentation. Mention pertinent information on previous evaluations, including from other hospitals.

- **Pertinent PMH / Meds / Allergies / FH / SH**
- **Pertinent ROS**

- **Vital signs:** triage and subsequent VS

- **PE:** mention pertinent positive and negative findings. If you did not perform a particular part of the exam, be honest about it and go back and complete those parts of the exam

- **Differential diagnoses:** start with most likely and go down to least likely; justify your reasoning

- **Plan:** Discuss your next steps depending on your differential diagnoses. State tests you feel are necessary to rule out or rule in

- **Discuss what you think is the expected disposition: admit, observe, discharge etc.**

STUDENT POLICIES AND GUIDELINES

HOURS AND SHIFTS AND DIDACTICS

- Total number of hours in the ED required is: 126-140 per four-week period. Number of actual shifts per four-week period may vary depending on the length of each shift at the ED you are assigned. Beyond this the student will participate in approximately 16 hours of didactics, and 4 hours of Shelf Exam.
- At least one night shift and one weekend shift. Other shifts may be distributed equally among the different shifts available or as advised by your clerkship director / coordinator at each facility
- No more than five shifts in a row per week
- Final schedule will be generally emailed to student before first day of clerkship. Any trades or changes, including makeups for sick days, that occur after the schedule is released must be approved by the clerkship director/coordinator at the facility AND by the CNUCOM clerkship director prior to the day of the shift trade. NO ‘‘DAY OF” SWAPS for convenience or non-urgent causes.

If you have an unexpected illness or an emergency, you must call the CNUCOM and the facility clerkship coordinator or the clerkship director. If you do not call to inform of such late changes, you will be marked as ‘‘absent without an excuse”.

STUDENT HEALTH SERVICES -- IMMUNIZATION REQUIREMENTS

Third and fourth-year students on clinical service are required to update their immunizations as follows:

1. TB clearance must be updated each year. If you have had a negative PPD previously, you must get another one done annually. Reactors must complete a CXR or Tuberculosis blood (IGRA) test preferred).

2. Td or Tdap (diphtheria tetanus booster) must be renewed every 10 years.

3. Certain clinical sites will have added immunization requirements. Please check with the Office of Student Affairs and Admissions if you have any questions.

4. Students must undergo a urine drug screening at CNUCOM's expense prior to starting clinical coursework, and may be subject to further screening at random or for cause at any time during enrollment at CNUCOM.

Medical Requirements for Away Clerkships

All medical forms for away clerkships are to be sent to the Director of Student Affairs and Admissions (do not send them to the Medical Director of Student Health Services). Each Hospital or school has different requirements, some of which are more stringent than CNUCOM requirements. If anything is missing, the student will be informed and it is his or her responsibility to update. In order to expedite the process, we strongly recommend that students keep their immunizations complete and up-to-date.

Incomplete Immunizations

If immunizations are not up-to-date at any time, students may be withdrawn from clinical coursework. Immunizations must be up-to-date at least one month prior to the start of the third and fourth years. If a student's immunizations are not up-to-date, he or she will be notified and may be unable to start the academic year on time. This start may be delayed one month or more, until these immunizations are brought up-to-date. <u>This could potentially delay graduation for those students who have not maintained current immunizations.</u>

NEEDLE STICK POLICY

Student Responsibilities

1. Attend office/department orientation regarding infection control policy and post exposure management procedures.
2. Utilize appropriate barrier precautions during the administration of care to all individuals.
3. Utilize appropriate safety devices for the handling/disposing of contaminated sharp instruments or other equipment.
4. Report needle sticks and exposure to blood or body fluids.
5. Initiate immediate intervention for the management of accidental exposure to blood or body fluids. (See section below)
6. Provide health education to individuals and groups regarding the prevention, transmission

and treatment of HIV.

Accidental/Occupational Exposure Procedure

In the event of an occupational exposure to blood or body fluids and/or needle sticks, the student should:

1. Immediately wash the area of exposure with soap and water.
2. Immediately report the incident to instructor, preceptor or supervisory personnel.
3. Initiate referral to the nearest Emergency Department, Clinic, or Private Physician for post exposure management.
4. Decisions regarding post exposure management, prophylaxis and follow-up will be at the discretion of the individual and his/her care provider. CNUCOM recommends a minimum of:
    a. Baseline screening for: HIV, Hepatitis panel (to include antibodies);
    b. Update any needed immunizations.
5. Students are financially responsible for the emergency treatment, prophylaxis and all follow-up care resulting from the incident. The Office of Student Affairs and Admissions will be available to guide the student as to further follow-up based on current CDC guidelines in conjunction with the treating physician.
6. Appropriate documentation of the incident will be completed at the time the incident occurs. This is to include information on the patient's medical history, past and current. Any possibility of infectious disease process is to be documented. This would include: All types of hepatitis, HIV/AIDS, TB and any other communicable disease process.

CNU Worker's Compensation

As students of CNU you are covered under the University's worker's compensation insurance in the unfortunate event that you are injured while "on the job", including while working at one of our clinical sites. This includes things like slips and twisted ankles, back injuries while lifting, and needle stick injuries. Please contact us immediately if an injury occurs:

M3s – Dr. Ted, Wesly Tse, Dr. Lee, and the clerkship director for the rotation you are on (Theodore.Hoehn@cnsu.edu, Wesly.Tse@cnsu.edu, Edward.Lee@cnsu.edu)

M4s – Dr. Ranasinghe, Wesly Tse, and Dr. Lee (Leonard.Ranasinghe@cnsu.edu, Wesly.Tse@cnsu.edu, Edward.Lee@cnsu.edu)

If you need to get treatment for a non-emergent condition:

You can call the Nurse Triage Hotline: 855-469-6877

You can find a provider through this website:

https://search.harborsys.com/ICWGroupMPN#Search

If there's an emergency and/or if immediate care is needed, please go to the nearest emergency department.

Finally, if a workers 'compensation claim needs to be started, please call 800-877-1111. Here is our policy information:

Company's Policy Information

California Northstate University LLC
WSA-5056542-04
Insurance Company of the West - ICW
08/01/2024 - 08/01/2025

But please be safe, and take care!

CONFLICT

- Conflicts with fellow medical students - Inform the CNUCOM clerkship director
- Conflicts with ED staff - Inform the ED attending physician and CNUCOM clerkship director
- Conflicts with patients - Inform the ED attending physician and CNUCOM clerkship director

ANTI-HARASSMENT AND ANTI-MISTREATMENT

California Northstate University is committed to providing a work environment free of harassment, disrespectful or other unprofessional conduct. University policy prohibits conduct that is disrespectful or unprofessional, as well as harassment based on:

1. Sex (including pregnancy, childbirth, breastfeeding or related medical conditions),
2. Race
3. Religion (including religious dress and grooming practices)
4. Color
5. Gender (including gender identity and gender expression)
6. National origin
7. Ancestry
8. Physical or mental disability
9. Medical condition
10. Genetic information
11. Subordinate position (“power mistreatment”)
12. Marital status or registered domestic partner status
13. Age
14. Sexual orientation
15. Military and veteran status
16. Any other basis protected by federal, state or local law or ordinance or regulation.

It also prohibits harassment, disrespectful or other unprofessional conduct based on the perception that anyone has any of those characteristics, or is associated with a person who has or is perceived as having any of those characteristics. **All such conducts violate University policy**.

The University's anti-harassment policy applies to all persons involved in the operation of the University and prohibits harassment, disrespectful or other unprofessional conduct by any employee of the University, including supervisors and managers, as well as vendors, students, independent contractors and any other persons. Applicants, employees, unpaid interns, volunteers and independent contractors are all protected from harassment.

Prohibited harassment, disrespectful or other unprofessional conduct include, but is not limited to, the following behavior:

1. Verbal conduct such as public humiliation, epithets, derogatory jokes, disparaging or deprecating comments, slurs or unwanted sexual advances, invitations or comments.

2. Visual displays such as derogatory and/or sexually-oriented posters, photography, cartoons, drawings or gestures.

3. Physical conduct including intimidation, assault, unwanted touching, intentionally blocking normal movement or interfering with work because of sex, race or any other protected basis;

4. Threats and demands to submit to sexual requests as a condition of continued employment, appropriate evaluations or to avoid some other loss, and offers of employment benefits in return for sexual favors.

5. Retaliation for reporting or threatening to report harassment.

6. Communication via electronic media of any type that includes any conduct that is prohibited by state and/or federal law, or by University policy.

Sexual harassment does not need to be motivated by sexual desire to be unlawful or to violate this policy. For example, perceived or actual hostile acts toward an employee because of his/her gender can amount to sexual harassment, regardless of whether the treatment is motivated by any sexual desire.

If you believe that you have been the subject of harassment or other prohibited conduct, bring your complaint to the attention to one of the following: your supervisor, Clerkship Director, Clinical Sciences Senior Chairperson, Assistant Dean of Student Affairs and/or Human Resources of the University as soon as possible after the incident. You will be asked to provide details of the incident or incidents, names of individuals involved and names of any witnesses. It would be best to communicate your complaint in writing, but this is not mandatory. Supervisors will refer all complaints involving harassment or other prohibited conduct to Human Resources. The University will immediately undertake an effective, thorough and objective investigation of the allegations.

If the University determines that harassment or other prohibited conduct has occurred, effective remedial action will be taken in accordance with the circumstances involved. Any employee determined by the University to be responsible for harassment or other prohibited conduct will be subject to appropriate disciplinary action, up to, and including termination. A University representative will advise all parties concerned of the results of the investigation. The University will not retaliate against you for filing a complaint and will not tolerate or permit retaliation by management, employees or co-workers.

The University encourages all individuals to report any incidents of harassment or other prohibited conduct forbidden by this policy **immediately** so that complaints can be quickly and fairly resolved. You also should be aware that the Federal Equal Employment Opportunity Commission and the California Department of Fair Employment and Housing investigate and prosecute complaints of prohibited harassment in employment. If you think you have been harassed or that you have been retaliated against for resisting or complaining, you may file a complaint with the appropriate agency. The nearest office can be found by visiting the agency websites at *www.dfeh.ca.gov* and *www.eeoc.gov*.

INFORMATION FOR ATTENDING AND PRECEPTORS

Rotation schedule:

Days: Monday through Sunday (variable)

Exceptions:

- Friday afternoon, before the Monday start of clerkship, from 4-5pm, is reserved for virtual orientation on Teams (occasionally subject to change)
- Wednesday afternoons, from 1-5pm are reserved for didactic sessions, live and in person at College of Medicine (clerkships from Zone 3 or greater may join virtually as hybrid didactics)
- The last Friday of the rotation is reserved for NBME Subject Exam.

Attendance: mandatory except for personal emergencies or as arranged with the clerkship director and preceptor.

Hours: at discretion of attending

Night call? Yes, variable

Maximum work hours per week: per ACGME duty hours 'policy (see above)

CNU COM Clerkship Grading Policy

A student's final clerkship grade will be based on the following three components:

- Academic NBME Shelf Exam Results.
- Clinical Evaluation of Student by Preceptor in rotations.
- Clinical Evaluation of Student by Clerkship Director in didactics.

The NBME Shelf exam score is an empirical measurement of student knowledge in the particular specialty field. Students are scored against a large national cohort of similar third year medical students. CNSU-COM's policy is that students Shelf score will be graded based upon the following percentile results on Shelf:

- ≥ 5 = Pass
- ≥ 30 = High-Pass
- ≥ 75 = Honors

This NBME Shelf "grade" will be the starting point of the student's final grade.

But this Shelf grade will then be compared against a composite Clinical grade, generated from the combination of Clinical Evaluation by Preceptor, and Clinical Evaluation by Clerkship Director.

The **Final Grade** will then be determined as follows:

- The NBME Shelf exam grade will generally* be the starting point
- But the final grade can be moved up, or down, based upon student performance in the clinical segments (Preceptor and Didactic)*

Example Grading Scenario #1

- NBME score of "pass" but is in the upper half* of the "pass" range
- Combination of Preceptor and Didactics Score is "honors"
- Students final grade can be elevated (at discretion of CD) from pass to high-pass based upon superlative clinical performance.

Example Grading Scenario #2

- NBME score of "honors" but in the lower half* of the "honors" range
- Combination of Preceptor and Didactics Score is only "pass"
- Students final grade can be reduced (at discretion of CD) from honors to high-pass based upon less than stellar clinical performance.

An academic grade of pass, will not be lifted all the way to honors by even stellar clinical performance, but it can move the final grade up (or down) to the next adjacent grade level above (or below) their academic grade.

*** Flexibility in the Grading System**

Clerkship Directors may and can opt to tighten up the parameters, for example only allowing movement up or down…if Shelf is in upper or lower quarter of grade range (rather than the upper or lower half of the grade range). Doing so would give the Shelf move weight, as compared to clinical and didactics components.

Details of Preceptor Grade Component (Attending preceptors please note)

Numeric "5 Point Likert Scale" Scoring

Completion of the MedHub Educational Program Objectives (EPO) scores are important to help us assign student grades. Preceptors are asked to rank students on 15 areas of performance. These 15 topics are grouped and follow the COM General Competencies System:

- GC1 are questions about Patient Care (PC)
- GC2 cover Medical Skills and Knowledge (MSK)
- GC3 addressed Communication Skills (C)
- GC4 deals with Professionalism (P)
- GC5 deals with EMR and Healthcare Systems (HC)
- GC6 deals with Reflective Practice and Personal Development. (RP)

In each area of student performance, preceptors are asked to evaluate the student on a 1 to 5 Likert scale, with the 1 to 5 scale representing:

1. Fail – you believe the student should flunk the clerkship (and repeat)
2. Needs Improvement – performance not so low as to fail student, but in this area student should obtain remediation before passing
3. Pass – good performance sufficient (at this level of training and without remediation) to proceed forward with training
4. High-Pass – exemplary performance above average
5. Honors - outstanding performance

On average, a student performing at or above 3.0 on average will be considered to have Passed their preceptor evaluation. A student performing from 3.5-4.4 will be considered for the "High-Pass" grade. A student who averages 4.5 or above will be a candidate for an "Honors" grade. A student scoring below 3.0 will be seriously evaluated for necessary remediation. This could include additional course assignments, repeat of some or all of the clinical time in the clerkship, or might contribute to a failing grade in the clerkship. Any of the 15 topics ranked or graded as 1 (fail) will require full review by CD and possibly Student Evaluation & Promotions Committee (SPC), even in the case of of the overall score reaching a passing average of 3.0 or above.

Narrative comments are critical to thorough student evaluation.
Preceptors provide narrative comments on each student, commenting on both strengths and weaknesses. All narrative comments by preceptors will be reviewed by the Clerkship Director, along with the checklist scores when determining final grades for the clerkship rotation. Student's numeric preceptor grade component for the clerkship rotation component may be raised or lowered based on exceptionally persuasive narrative comments from an attending preceptor. This is entirely at the discretion of the CD, and their own judgement of the narrative comments.

Details of Didactics Grade Component

The bulk of the Final Grade is based upon the above two components:

- The Academic NBME Grade
- The Clinical Preceptor Grade

But there is one final component, that similar to the Clinical Preceptor Grade, can bump the Final Grade up, or down. That final component is the Grade conferred during Didactics by the individual Clerkship Director. The specific structure used in the production of this component will not be specified here, as it can and does vary from clerkship specialty, to clerkship specialty, and may even vary somewhat from block to block, as the availability of resources (guest lecturers, lab availability, in-person vs virtual didactics, etc) is changing and active. At times, even the Clerkship Director themselves may change, and the new CD may recommend different grading ideas and rubrics from the former. But the sum-components of the Didactics experience that may be brought to play in the production of this Didactics component may include:

- Attendance
- Timely submission of assignments
  - Assignments may include
    - case reports
    - quizes
    - mid-clerkship evaluations
    - clinical topical write-ups or presentations
    - other at discretion of CD
- Successful logging of “Must-See Cases”
- Ongoing logging of “Must-Do Procedures”
- Participation in Discussions
- Participation in Lab (if any)
- Grading of any of the above (vs pass/fail)

To be clear, the Didactics grade is entirely at the discretion of the Clerkship Director, and to reiterate cannot by subject to strict simplification or restriction in this document.

Professionalism and Remediation

Lapses of professionalism or low preceptor ratings. Professional behavior (discussed elsewhere) is the sine qua non of being a physician. Any allegation of a lapse in professionalism in the clerkship will be investigated by the clerkship director. Such lapses may include, but are not limited to, cheating; plagiarism; or failure to fulfill patient care responsibilities. Likewise, any score of "below expectations" or less by any preceptor will be investigated by the clerkship director. If the allegation of a lapse in professionalism is substantiated, or if the rating of "below expectations" or less is found to be accurate, either of these criteria alone (regardless of NBME exam scores and other preceptor evaluations) may be grounds to receive a failing grade in the clerkship. The student will also be referred to the Student Evaluation and Promotions Committee for further consideration. Y "incomplete" grade may be assigned, and remediation may be required. Further details are discussed in the next section.

Details of remediation of borderline performance; Y grade options.
Scenario: Low NBME score, acceptable preceptor evaluations
A student who receives ratings from preceptors at or above the "meets expectations" level, but who scores less than 5% on the NBME Subject Examination in emergency medicine can me managed along one or both of the following pathways:

1. "Bad Test Day" – if the student feels he are she was prepared for the test, but suffered from some unforeseen problem such as illness, family or other stress, or other un-avoidable distraction that prevented them from performing up to par, that student may request a "quick re-take" of the Shelf exam. This must be explained to the Clerkship Director and the CD must agree that a quick re-take is justified. Quick means ideally that the students sits for the re-take in general within a week of the original exam date, or at most two weeks of original exam date. Note that this quick re-take is not intended to allow the student to study more. This presumes that they already did study enough, but just suffered from unforeseeable stresses on the test day.

2. If the student does require a quick retake test, and fails this second attempt...OR if the reason the student did not pass the first attempt was actually lack of study and preparation for the first test, then the student will be given a Y grade for the course. Student and CD then need to sit down and discuss the situation, and come up with a remediation plan. A remediation plan could involve:

    1. Identification of flex or other time where student can study more for a re-take test

    2. Deferral of an upcoming clerkship to create time for study

    3. Referral to student affairs for test preparation counseling

3. This plan must be documented in a SPC referral, signed by student and CD and the Chief of Clinical Education, and submitted to SPC for review and either approval, or other remediation recommendation.

The student may remediate the Y grade by taking the examination a final second, or third time (third if a "quick retake test" was allowed), the time frame to be determined in consultation with the clerkship director.

If the student passes the retake NBME exam (after the administration of a Y grade), their Y will then be upgraded to a Y/P grade, which is a passing grade, but the Y will remain along with the Pass. The maximum grade achievable upon remediation shall be that of "Y/Pass".

CLERKSHIP GOALS

The overarching goals of the clerkship are to

a. refine the taking of a history
b. refine the physical examination
c. develop a reasonable differential diagnosis; and
d. outline an initial diagnostic and treatment plan.

We want students to meet these goals by examining patients with internal Medicine conditions in both inpatient and outpatient settings.

Preceptor Responsibilities:

All attending physicians and residents are expected to provide:

- Daily supervision.
- Direct observation of basic skills.
- Teaching and guidance.
- Constructive feedback.
- Written and verbal assessment of student performance must be performed at mid-clerkship and upon completion of the rotation.
- Preceptors are prohibited from medically treating the medical students that they are supervising.

Specific responsibilities.

These goals can be met in different ways in different venues. At minimum, we request the following of attending preceptors:

- Allow each student to perform one complete focused history and examination and present that patient to the preceptor, on average once per day. Students will write/type up each evaluation and submit it to the preceptor for comments.
- Students must also submit one write up per week to the clerkship director.
- Assign additional patient experiences that may include focused exams on follow-up patients.
- On inpatient services, allow students to follow 5-6 patients (depending on complexity).
- Exposure to critical care setting is highly desirable.
- Ensure student experiences are hands-on, with oral patient presentations to preceptors.
- Provide constructive feedback on physical exam, differential diagnosis, and treatment.
- Fill out two evaluation forms per student:
    - the **"Mid-Clerkship Evaluation"** will be provided by student to the preceptor on paper, for the preceptor to complete, sign, and review with the student. The student will be responsible for submitting this formative evaluation to the Clerkship Director
    - the **"Preceptor Evaluation of Student"** is managed on MedHub. This evaluation form will be forwarded to the preceptor's MedHub Inbox during the final week of the clerkship. It can be completed at any time after arrival, but needs to be completed no later than 3 weeks after the end of the clerkship.
- Preceptor will participate in a Preceptor Orientation provided by the COM before precepting CNU students, and then an update or re-Orientation course every 2 years thereafter.
- Assign brief readings (preferably from recent primary literature) on interesting patient topics as you see fit.

Giving Student Feedback

Ongoing formative feedback during the clerkship is essential to allow students to improve skills during the rotation. At minimum, the following categories should be evaluated:

Cognitive skills
- History taking
- Physical examination
- Understanding of ancillary testing & data
- Formulation, differential diagnosis, and treatment plan

Personal skills
- Professionalism
- Dress
- Demeanor
- Any other concerns

Preceptors should communicate any concerns to the clerkship director for monitoring or remediation as appropriate.

Frequency and Mechanism of Formative Feedback

Frequency	Mechanism
Daily	Verbal feedback from attending physician preceptor
	One-on-one interaction with preceptors & residents
	"teachable moments" at the bedside and during clinical care
Weekly	Formative quizzes in didactic sessions
	Case discussions in didactic setting
	Checklist submitted by preceptor (since students rotate weekly)
Mid-clerkship	Formative feedback summarized & discussed in meeting with clerkship director
	Formal review of patient log, adjustment of assignments as needed
End of Clerkship	Final Shelf examination
	Preceptor Evaluation of Student

Documenting student performance: <u>Attending preceptors please note</u>

While completion of the MedHub set of Likert Scale (rating 1 thru 5) questions about student performance (15 or so questions there) is useful for assigning student grades, the preceptor's narrative comments *are critical* to thorough student evaluation. <u>PLEASE</u> provide narrative comments on each student, commenting on both strengths and weaknesses. Your narrative comments may boost a student's clerkship score if their final clerkship grade is on the borderline between two letter grades. Likewise, choosing the higher rankings in a category on rating scales may provide evidence of superior performance in borderline cases.

LETTERS OF RECOMMENDATION (LOR)

1. Students may request a LOR from any of the ED attending physicians you worked with at any facility

2. You may request a LOR from your CNUCOM clerkship director
3. Please submit the following with your request for a LOR:
   a. Current CV
   b. A personal statement
   c. Copy of your EROS cover letter

ADDITIONAL READING AND RESOURCES

Emergency Medicine, A Comprehensive Study Guide. Tintinalli, Ruiz, Krome. McGraw Hill

Emergency Medicine Concepts and Clinical Practice. Rosen, Barkin. Mosby

The Clinical Practice of Emergency Medicine. Harwood-Nuss. Lippincott-Raven

Clinical Procedures in Emergency Medicine. Roberts, Hedges

https://cdemcurriculum.com/m3-curriculum-revisions/

REFERENCES

Emergency Medicine Clerkship Primer by CDEM

University of California, Davis, Department of Emergency Medicine Patient & Procedure Logbook. Emergency Medicine Clerkship (EMR 440)

EM CLERKSHIP CURRICULUM

DATA SUPPLEMENT 1: SPECIFIC DISEASE ENTITIES LIST BY ORGAN SYSTEM

1) Cardiovascular

a. Abdominal aortic aneurysm

b. Acute coronary syndrome

c. Acute heart failure

d. Aortic dissection

e. DVT / pulmonary embolism

2) Endocrine / Electrolyte

a. Hyperglycemia

b. Hyperkalemia

c. Hypoglycemia

d. Thyroid storm

3) Environmental

a. Burns / smoke inhalation

b. Envenomation

c. Heat illness

d. Hypothermia

e. Near drowning

4) Gastrointestinal

a. Appendicitis

b. Biliary disease

c. Bowel obstruction

d. Massive GI bleed

e. Mesenteric ischemia

f. Perforated viscous

5) Genito-urinary

a. Ectopic pregnancy

b. PID / TOA

c. Testicular / ovarian torsion

6) Neurologic

a. Acute stroke

b. Intracranial hemorrhage

c. Meningitis

d. Status epilepticus

7) Pulmonary

a. Asthma

b. COPD

c. Pneumonia

d. Pneumothorax

8) Psychiatric

a. Agitated patient

b. Suicidal thought/ideation

9) Sepsis

Specific objectives based on specific emergent disease presentation

1) Abdominal pain

a. Demonstrate the ability to identify a surgical abdomen
b. Discuss/explain the role of analgesia in patient management

2) Altered Mental Status

a. Recognize the breadth of the differential for altered mental status
b. List emergent causes for altered mental status (hypoglycemia, hypoxia)

3) Cardiac arrest

a. Identify Asystole, ventricular tachycardia and ventricular fibrillation on ECG/monitor
b. Describe the initial treatment of asystole, pulseless ventricular tachycardia / ventricular fibrillation, pulseless electrical activity
c. List the most common causes of pulseless electrical activity and their treatments
d. Discuss the role of adequate chest compressions and early defibrillation in the management of pulseless patients.

4) Chest pain

a. Interpret classic acute coronary syndrome findings on electrocardiogram
b. List important initial management options (aspirin, nitroglycerin, oxygen, pain relief)

5) GI Bleeding

a. Recognize hemodynamic instability
b. Identify probable source of bleeding and recognize how this influences initial management (gastroenterology vs. surgery)

6) Headache

a. Recognize emergent causes and identify diagnostic modalities and management

7) Poisoning

a. Describe common toxidromes
b. List commonly available antidotes or treatments (for acetaminophen, aspirin, tricyclic antidepressants, carbon monoxide, toxic alcohols, narcotics)

8) Respiratory distress

a. Describe clinical manifestations of respiratory distress
b. List life threatening causes or respiratory distress
c. Describe role of arterial blood gas in assessing respiratory status

9) Shock

a. Describe the clinical manifestations that indicate shock
b. List potential causes (classifications) of shock
c. Recognize importance of fluid resuscitation in maintaining perfusion

10) Trauma

a. Describe the initial evaluation of a trauma patient (primary and secondary survey)
b. Promote injury control and prevention
c. Describe the screening for intimate partner violence

DATA SUPPLEMENT 2: EM CLERKSHIP PROCEDURAL CURRICULUM

1. **Access**

a. Peripheral Access

i. Demonstrate placement of an intravenous line
ii. Demonstrate basic phlebotomy technique

b. Intraosseous Access

i. List the indications for an intraosseous line
ii. Describe intraosseous insertion technique

c. Central Venous Access

i. List the indications and complications of a central line
ii. List the steps for the Seldinger technique

iii. Describe relative advantages and disadvantages of different kinds of lines

2. Airway Management

a. List the indications for emergent airway management

b. Bag-Valve-Mask

i. Demonstrate effective ventilation

ii. List the factors that can make BVM difficult or impossible

c. Airway Adjuncts

i. Describe the roles and indications for various airway adjuncts

ii. Demonstrate correct placement of a nasal and oral pharyngeal airway

d. Intubation

i. List the indications for endotracheal intubation

ii. List the steps in orotracheal intubation

iii. Describe possible complications of intubation

iv. Describe situations when rescue techniques may be used in a failed airway

3. Arrhythmia Management

a. Cardiac Monitoring

i. Correctly place patient on a cardiac monitor

ii. Demonstrate the ability to apply leads and obtain a 12-lead electrocardiogram

b. AED

i. Demonstrate appropriate use of an AED

c. Defibrillation

i. Recognize ventricular fibrillation and pulseless ventricular tachycardia

ii. Demonstrate appropriate use of a defibrillator.

d. CPR

i. Demonstrate effective chest compressions

4. Gastroenterology

a. Nasogastric intubation

i. List the indications for placement of nasogastric tube

ii. Describe proper technique for insertion of a nasogastric tube

iii. Describe complications of nasogastric tube placement

5. Genitourinary

a. GU Catheterization

i. Demonstrate the correct placement of a Foley (male and female)

6. Orthopedic

a. Joint reduction

i. List the indications for emergent joint reduction

ii. Describe initial assessment of suspected dislocated joint

b. Splinting

i. List several types of extremity splints and their indications

ii. Demonstrate correct application of a splint

iii. Describe complications associated with splints

7. Infection

a. Incision and Drainage

i. List the indications for an incision and drainage

ii. Discuss the technique for an incision and drainage

iii. List the indications for antibiotic therapy for an abscess/cellulitis

iv. Describe complications of incision and drainage

8. Trauma Management

a. Initial trauma management

i. List the steps of a primary survey

b. Cervical Spine precautions

i. Demonstrate maintenance of c-spine stabilization

c. Basics of Fast Examination

i. List the components of a FAST ultrasound examination

ii. Recognize an abnormal FAST ultrasound examination

9. Wound Care

a. Preparation

i. List factors that go into the decision to close a wound primarily

ii. Describe the difference between a clean and dirty wound

b. Anesthesia

i. Explain local and regional (digital) anesthetic techniques

ii. Describe the maximum doses of lidocaine

iii. Demonstrate application of local anesthesia

c. Irrigation

i. Describe the role or sterility in wound irrigation and repair
ii. Explain proper irrigation technique
iii. Describe how to detect a retained foreign body

d. Closure

i. Describe different closure techniques (Steri-strips, Dermabond, suturing)
ii. List the various suture materials and their appropriate uses
iii. Demonstrate proper closure of a wound (simple interrupted technique)

e. Follow-up care

i. Describe the number of days for suture removal
ii. List the indications for tetanus prophylaxis

LEARNING OBJECTIVES FOR EMERGENCY MEDICINE CLERKSHIP (NARRATIVE REDUX OF TABLE ABOVE)

Patient Care

- Demonstrate the ability to collect an appropriate history, physical examination and data collection to common medical and surgical emergencies
- Demonstrate the ability to complete a comprehensive neurologic physical exam finding all abnormalities present
- Demonstrate the ability to organize and present the above finding in: a comprehensive note, SOAP note, or oral presentation in a concise manner noting pertinent positives and negatives in the history or physical examination
- Demonstrate the ability to communicate with the patients and family in a respectful and compassionate fashion

Medical Knowledge

- Correctly evaluate laboratory data, imaging results and EKG interpretation
- Describe a list of additional tests that may be needed to confirm the diagnosis and assist in the selection of the appropriate treatment
- Interpret the most common diagnostic tests and procedures that are ordered to evaluate patient with the medical problems listed below
- Identify and provide the rationale for the region of the nervous system that is affected given specific symptoms and clinical findings from the neurologic exam
- Provide early stabilizing management for common medical and surgical emergencies
- Use medications appropriately
- Discuss on clinical rounds the study design, data analysis and scientific findings of journal articles relevant to their patient's medical condition

Communication

- Effectively communicate with patients and family members in the acute care setting
- Effectively communicate (written and oral) with peers, medical team personal, and faculty involved in the care of their patient
- Demonstrate the ability to communicate with "the community" at large

Professionalism

- Understand and practice ethical medical behavior in all patient and medical team interactions especially in regards to patient privacy and patient consent
- Demonstrate their role as a patient advocate for clinical care using integrity, honesty and authenticity in all interactions with patients, faculty and the medical community at large

Health Care Systems

- Use the multiple forms of health information technologies found in their clerkship rotation
- Recognize, and possibly has participated in, system approaches to quality improvement
- Become familiar with patient care delivered in in-patient, out-patient, or if used, telehealth modalities

Personal Development

- Demonstrate the ability to take constructive suggestions and incorporate them into his/her clinical practice
- Use self-assessment for continual improvement and shows improvement in time management
- Has identified effective approaches to both articulating opinions as well as in personal stress management

Learning Structure

Evaluation

- Logs all clinical conditions/skills they participated in (see reverse of card)
- Inpatient rotations: Weekly faculty/resident assessment & feedback
- Outpatient rotations: Daily faculty/resident assessment & feedback
- Telehealth rotations: Daily faculty/resident assessment & feedback

Work Load

- Work Hours: Maximum of 80 hrs/week; max 30 hrs consecutively
- Inpatient Work Load: 1 admission on call and 2-3 patients carried at a time
- Outpatient Work Load: see 2-4 patients per half-day of clinic; notes and oral presentations
- Inpatient and Outpatient: case-based reading daily
- Time Off: 24 hour free of duties over a 4 week period

Mid-clerkship evaluation by a preceptor

LCME requires us to include a mid-clerkship evaluation. This is not an option

- The responsibility of getting this form completed by a preceptor is on each student
- This must be completed on or prior to second Friday of EM clerkship
- It is a paper form which a student will give to a preceptor during an ED shift. It does not require logging on to a computer etc.
- Only one preceptor needs to complete this form during the clerkship
- Request verbal feedback from the preceptor after completion of the form, if he / she has time
- This form may be completed by any preceptor who has already worked with the student Therefore, it does not have to be completed by EM clerkship site directors, unless the EM clerkship director already had the student for an ED shift with him / her
- Students will upload the completed forms to CANVAS on or prior to third Monday of the EM clerkship
- EM clerkship director will review those completed forms and will address any concerns, red flags, or commendations offered by the preceptor who completed the form

CLERKSHIP COMMENDATION FORM

California Northstate University
College of Medicine

Emergency Medicine Clerkship Commendation Form

Please complete and submit this card to the clerkship director when you wish to compliment a student for his/her performance. This information will be conveyed to the student and noted in the student's file.

Name of Student _____ Date _____

Clerkship: _____

My commendation about the performance of this student is based upon his/her demonstration of exceptional ability/quality in the following areas (check all that apply):

Clinical skills	Teaching
Communication skills	Professionalism
Medical knowledge	Team work
Clinical judgement	Leadership

Please include any additional comments:

_____

_____

_____

_____

Faculty name: _____ Faculty Signature_____

Title: _____

CLERKSHIP EARLY WARNING FORM

California Northstate University
College of Medicine

Emergency Medicine Clerkship Early Warning Form

Please complete and submit this form to the clerkship director or coordinator when you have any concerns about the performance of a student. This information will be used constructively to help the student.

Name of Student_____ Date _____

Clerkship: _____

My concerns with the performance of this student include (please check all that apply):

- Professionalism
- Clinical practice
- Medical knowledge
- Team work
- Interpersonal relation and/or communication skills
- Other

Please include additional comments:

_____

_____

_____

Faculty Name: _____ Faculty Signature: _____

Title: _____