2026 - 2027 Academic Year
Emergency Medicine Clerkship Syllabus
Course #: COM 771
Year: M3

Course Dates: Varies

Credits Hours: **1 credit per week**

Offered as: 4-week rotation

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Every effort will be made to adhere to the contents of this syllabus. However, this document is subject to changes in the event of unforeseen, extenuating circumstances. Students will be notified as soon as possible if changes in the syllabus become necessary.

Additionally, this syllabus provides clerkship-specific expectations and requirements. All students are also subject to the policies outlined in the M3 Clerkship General Handbook. Where differences exist, clerkship-specific requirements in this syllabus apply, provided they do not conflict with institutional policies.

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Course Description

Emergency Medicine is a fast-paced specialty focused on the evaluation and management of undifferentiated patients across the full spectrum of acute illness and injury. During this rotation, students will develop skills in rapid clinical assessment, prioritization of care, and initial stabilization of patients in the emergency department.

Students will apply knowledge and clinical skills gained in prior clerkships to formulate differential diagnoses, initiate diagnostic workups, and develop management plans under supervision. Emphasis is placed on clinical reasoning, effective communication, teamwork, and adaptability in a dynamic clinical environment.

Through direct patient care, participation in resuscitations, and collaboration with multidisciplinary teams, students will build foundational competencies in acute care that are applicable across all fields of medicine.

Course Learning Objectives (Summary)

By the end of this rotation, students will be able to:

- Apply foundational biomedical and clinical knowledge to patient care
- Gather and synthesize a complete history and physical exam
- Develop and justify differential diagnoses
- Formulate and implement diagnostic and treatment plans
- Communicate effectively with patients and healthcare teams
- Demonstrate professionalism and clinical responsibility
- Recognize system-level factors affecting patient care, including safety, cost, and care coordination
- Perform core clinical procedures safely and appropriately

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 organize and present the above findings 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
- 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 personnel, 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 regard 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 participate in system approaches to promote 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

Detailed learning objectives and assessment mapping can be reviewed below.

Educational Framework and Competency Alignment

This clerkship is aligned with nationally recognized frameworks for medical education, including the Accreditation Council for Graduate Medical Education (ACGME) Core Competencies, the institution's Educational Program Objectives (EPOs), and the Association of American Medical Colleges (AAMC) Core Entrustable Professional Activities (EPAs).

The curriculum is designed to support development across the following competency domains:

- Patient Care
- Medical Knowledge
- Communication and Interpersonal Skills
- Professionalism
- Systems-Based Practice
- Practice-Based Learning and Improvement

Course learning objectives, instructional activities, and assessment methods are intentionally aligned with these domains to ensure a comprehensive and competency-based educational experience. Detailed mapping of learning objectives to EPOs and EPAs is provided in the Appendix.

Prerequisites

Students must successfully pass all M1 and M2 courses and must successfully pass Step 1 before starting any M3 clerkships.

Rotation Information

Rotation locations, directors, preceptors and contacts are subject to change.	
Rotation locations, directors, preceptors, contacts	Please refer to the catalog M3 for rotation locations, directors, preceptors and contacts.

Schedule

- Days: Monday through Sunday (variable)
- Exceptions:
    - Friday afternoon, before the Monday start of the clerkship, from 4-5pm, is reserved for virtual orientation on Teams (occasionally subject to change)
    - Didactic sessions: Once a week, typically 2-4 hours in duration, to be specified by the clerkship director during orientation. Sessions are 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 Shelf Exam
- Attendance: mandatory except for personal emergencies or as arranged with the clerkship director and preceptor.
- Hours: Daily schedules are determined by the clinical team and supervising attending, within clerkship and institutional duty hour guidelines
- Night call? Yes, variable
- Duration of the Clerkship: 4 weeks

Detailed Shift and Duty Expectations - These expectations are designed to remain within institutional duty hour limits (not to exceed 80 hours per week, averaged over four weeks).

- The total number of hours in the ED required is: 126-140 per four-week period. The 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 students 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
- The final schedule will be generally emailed to students before the first day of the 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”.

Learning Activities

Must See Clinical Experiences and Must Do Procedures

Students are required to maintain a log of designated **"Must See" clinical experiences** and **"Must Do" procedures** using the institutional tracking system (e.g., MedHub).

- **Must See Clinical Experiences** are specialty-specific patient encounters that represent core conditions essential to the clerkship's educational objectives. Students are expected to actively seek and document these encounters during the rotation.
- **Must Do Procedures** are core clinical skills expected across clerkships and should be logged throughout the M3 year, regardless of when or where they are performed. All required procedures should be completed prior to the start of the M4 year if possible.

  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: procedures should not be performed by a student without the explicit approval of your preceptor

Students are expected to make consistent progress toward completing required experiences and procedures throughout the rotation. The Clerkship Director will monitor completion.

Failure to complete required clinical experiences or procedures may result in remediation, additional assigned work (e.g., case reports or alternative learning activities), or impact the final grade.

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 Clinical Experiences ("Must see cases")	• Surgical Emergency (Appendicitis, Acute Abdomen) • Medical Emergency (Poisoning, Cardiac, Pulmonary, Sepsis, Stroke, GI Bleed issues) • Trauma/Injury (TBI, Fractures, Dislocations, Lacerations) • Pediatric Emergency (Infection, TBI, Rash, Seizure, Injury) • OB Emergency (Delivery, Ectopic, Miscarriage, Fetal Distress, Ruptured Ovarian Cyst) • Psychiatric Emergency (Delusion, Depression, Suicidal Ideation, Mania, Anxiety)

Many procedures are integral to the practice of emergency medicine. You will be expected to either observe, assist, or perform/manage the following procedures. These procedures may be logged before, during, or after the EM clerkship as part of M3 requirements.

Required Procedures ("Must do procedures")	• Peripheral IV (optional IO insertion) • Wound care / suturing / stapling / adhesive use • Foley catheter placement • Arterial blood gas procedure and interpretation • EKG lead placement and EKG interpretation • Incision & drainage procedure • Fracture / dislocation reduction (optional) • Splint application on extremities • Lumbar puncture procedure (optional) • Nasogastric tube placement • Basic Life Support: CPR / chest compressions (optional)

	• Basic airway management • Emergency Ultrasound Procedures • Central line placement (optional) • Procedural sedation (optional) • Advanced airway management (intubation etc. optional) • Chest tube placement (optional)

Student Responsibilities & Expectations

Students are expected to actively participate in patient care and function as engaged members of the emergency department team under appropriate supervision.

Responsibilities include:

- Participating in the evaluation and management of patients, including history-taking, physical examination, and development of differential diagnoses and management plans
- Presenting patient cases clearly and concisely to supervising physicians
- Assisting with procedures when appropriate and approved by the supervising physician
- Demonstrating clinical reasoning in the assessment of undifferentiated and acutely ill patients
- Maintaining accurate and timely clinical documentation as required by the clinical site
- Communicating effectively with patients, families, and members of the healthcare team
- Demonstrating professionalism, including punctuality, accountability, and respect for patients and team members
- Seeking and incorporating feedback to improve clinical performance

Students are expected to demonstrate sound clinical judgment in managing workload, including appropriate patient selection and ensuring safe transitions of care at the end of each shift.

All clinical activities must be performed under the supervision of a licensed provider. Students must not provide medical advice or perform procedures independently.

Preceptor Responsibilities and Expectations

Preceptors are expected to:

- Provide direct supervision appropriate to the student's level of training
- Observe and provide feedback on core clinical skills, including history-taking, physical examination, and clinical reasoning
- Offer ongoing formative feedback and complete a mid-clerkship evaluation by the midpoint of the rotation
- Complete a final evaluation with both ratings and narrative comments in a timely manner
- Support student participation in clinical and didactic activities

Assignments and Requirements

Students are required to complete all assigned coursework and clinical documentation as part of the clerkship. These may include:

- Written clinical documentation (e.g., history & physicals, progress notes, or case write-ups)
- Oral or written presentations
- Participation in didactic sessions and discussions

- Completion of required clinical logs (Must See cases and procedures)

All assignments must be completed and submitted as directed. Failure to complete required assignments may result in remediation or impact the final grade.

Course Materials

Library/Learning Resources:

The CNUCOM Library and Learning Resource Center is available for students, faculty, and staff. This center includes: Library Facility and Collection, Computer resources, CNUCOM Electronic Library, and Interlibrary Loan Program. CNUCOM Resource Center maintains an Electronic Learning Resources System to provide information resources to students, faculty, and staff, and serve as an entry point for all users to meet their academic and research needs.

Required/Recommended Textbook(s), Material(s), and Equipment

Recommended

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

Additional Reading and Resources

- 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)

Assessment

Assessment Components

Student performance in the clerkship is based on multiple components, including:

- NBME Shelf Examination
- Clinical performance evaluations by preceptors
- Clerkship Director assessment
- Completion of required assignments and participation in didactic activities
- Completion of required clinical logs

Assessment of Achievement of Learning Objectives

Student achievement of the course learning objectives is evaluated through the following methods:

Skills Log	Students are required to log a set of "**Must See Clinical Experiences**" unique to each clerkship. In addition, they are required to log a set of "**Must Do Clinical Procedures**" over the course of the M3 and M4 years. Failure to complete these logs may lead to a lowering of the clerkship grade (at the discretion of clerkship director).
Clinical Evaluations	All students are required to obtain a **Mid-Clerkship Evaluation** for any rotation lasting four (4) weeks or longer. This written evaluation must be completed by a supervising preceptor, reviewed face-to-face with the student, and submitted to the clerkship director for review. This must be completed by the midpoint of the rotation. Students are responsible for ensuring completion. At the conclusion of the rotation, the site director (preceptor) is responsible for submitting a formal **Preceptor Evaluation of Student**, which includes scaled performance ratings across the ten (10) Clerkship Learning Objectives (CLOs) and a written narrative evaluation of the student's performance.
Oral Presentation	Students may be required to present oral case reports and/or clinical summaries on the wards, in clinic, and/or in didactics. These presentations will be assessed for accuracy and relevance by their preceptors, and by their clerkship director.
Shelf Exam	The **NBME Subject Shelf Examination** for all clerkships in which a shelf examination will be administered. Students must pass this exam at the 5th percentile or above to pass the clerkship.

Formative and Summative Assessments

- **Formative Assessments**
  - In person, mid-clerkship formative assessment will be provided by supervising preceptor.
  - Ongoing formative assessments will be provided throughout the rotation by the supervising preceptor and/or resident.

- **Summative Assessment**
  - A final summative assessment will be performed at the end of the rotation. Each preceptor is required to submit a completed end-of-rotation evaluation.
  - See Rotation Grading section below for additional details.

Rotation Grading

Final grades are based on a combination of NBME shelf exam performance, clinical evaluations, and clerkship director assessment. The NBME shelf exam establishes the initial grade tier, which may be adjusted based on clinical and didactic performance.		
#	**Components**	**Notes/Explanation**
	NBME shelf exam	
	Preceptor evaluation of performance	See below for Preceptor Evaluation of Student Performance Form that shows questions and assessment rubric.
	Clerkship director assessment	Including performance on required didactic activities, which may include case presentations and write-ups, completion of required assignments, completion of clinical logs

The final clerkship grade reflects both **knowledge and clinical performance**.

- The **NBME shelf exam determines the initial grade tier** (Honors, High Pass, or Pass) based on national percentile performance.
- **Clinical evaluations and clerkship director assessment** are used to adjust the final grade based on observed performance in patient care, clinical reasoning, communication, and professionalism. Professionalism is a core component of clinical performance and may directly impact the final grade.

Strong clinical performance may result in an upward adjustment of the final grade, while deficiencies in clinical performance or professionalism may result in a lower final grade, regardless of exam score.

A high exam score alone does not guarantee a final grade of Honors, and a passing, but lower exam score may be offset by strong clinical performance, at the discretion of the Clerkship Director.

Successful completion of the course is based on the following:

1. Demonstrating professional and ethical behavior
2. Passing the NBME shelf exam (≥ 5th percentile)
    - Students below this threshold may be eligible for a "Quick Retake"
    - Failure of the retake requires formal remediation
3. Demonstrating satisfactory clinical performance
4. Completing required assignments and didactic activities

Failure to meet any of these requirements may result in remediation.

Details of the grading criteria and weighting methodology are outlined in the **M3 Clerkship General Handbook**.

Course Policies

Students are expected to comply with all CNU and COM policies.

Attendance

Students are expected to attend all scheduled activities during their clinical clerkships, as full participation and punctual arrival is essential for both professional development and clinical competency. However, we recognize that life events may occasionally necessitate time away from clerkship responsibilities. Refer to 4420 Attendance and Absence Policy for additional details.

Clear, timely communication between the student and the Clerkship Director is essential in managing any episode of absence from clerkship activities.

All missed time must be addressed in accordance with the Attendance Policy. Excused absences may require make-up time, depending on the number of days missed and the clerkship's duration. Unexcused absences will always require make-up and may carry consequences related to professional conduct. Students are responsible for working collaboratively with the Clerkship Director to develop and complete a make-up plan that ensures all required clinical experiences and educational objectives are fulfilled.

Clinical Duty Hours

Clinical duty hours are designed to support student well-being, patient safety, and effective learning. Refer to 4409 Clerkship Duty Hours Policy for additional details.

Key expectations include:

- **Maximum 80 hours per week**, averaged over four weeks
- **No more than 24 consecutive hours** of clinical duties (with limited additional time for transitions of care)
- **Minimum 10 hours off** between scheduled shifts
- **No more frequent than every 3rd night call**, averaged over time
- **At least one full day off (24 hours) every 7 days**, averaged over four weeks

Students who have concerns about fatigue, safety, or duty hour violations are encouraged to report them to the Clerkship Director or the Office of Medical Education.

Use of Artificial Intelligence (AI)

Use of AI in this course must align with the California Northstate University Artificial Intelligence Use Policy. For more information, please see the CNU Artificial Intelligence (AI) Use Policy.

Remediation

Students who do not successfully pass the course (those receiving a grade of "Y" or "F") will be referred to the Student Promotion Committee (SPC) and a remediation plan will be developed.

Remediation Exam Dates

The dates will be determined by the clerkship director.

Student Evaluations of Course, Faculty, and Rotation Site

Students are required to complete evaluations of the rotation (course), preceptor, and rotation site. The goal for course evaluations is 100% student participation. Evaluations are submitted electronically.

Appendix

Detailed Learning Objectives and Assessment Mapping

The following table provides detailed alignment of course objectives with EPAs, program objectives, and assessment methods for accreditation purposes.

Clerkship Learning Outcomes (CLOs)	Educational Program Objectives (EPOs)	AAMC Core EPAs Alignment	Assessment Methods
1. Integration & Application of Foundational Knowledge: Integrate biomedical, clinical, and social science knowledge to explain disease mechanisms, guide diagnostic reasoning, and apply evidence-based principles to patient care decisions.	**MSK 2.1-2.5; PC 1.7,1.8**	EPA 7 – Form clinical questions and retrieve evidence.	Ongoing daily one-to one evaluation of the student by the preceptor. End of rotation one-to-one and written evaluation of the student by the preceptor. National standardized subject (NBME) shelf examination assessing clinical knowledge, diagnostic reasoning, and patient management.
2. History Taking, Differential Diagnoses, and Diagnosis: Elicit comprehensive, focused patient's history and perform logical, accurate physical examinations to prioritize and justify differential diagnoses through sound clinical reasoning.	**PC 1.1-1.3, PC 1.5; MSK 2.1, 2.2**	EPA 1 – Gather a history and perform a physical examination; EPA 2 – Prioritize a differential diagnosis EPA 5 – Document a clinical encounter in the patient record	Ongoing daily one-to one evaluation of the student by the preceptor. End of rotation one-to-one and written evaluation of the student by the preceptor. National standardized subject (NBME) shelf examination assessing clinical knowledge, diagnostic reasoning, and patient management.
3. Management, Treatment, and Prevention Plans: Develop and justify patient-centered management and prevention plans that include appropriate diagnostic testing, treatment selection, and timely response to urgent or emergent clinical issues.	**PC 1.6-1.8; MSK 2.2, 2.3; HC 5.1, 5.2**	EPA 3 – Recommend and interpret diagnostic and screening tests. EPA 4 – Enter and discuss orders and prescriptions. EPA 10 – Recognize a patient requiring urgent care and initiate evaluation	Ongoing daily one-to one evaluation of the student by the preceptor. End of rotation one-to-one and written evaluation of the student by the preceptor. National standardized subject (NBME) shelf examination assessing clinical knowledge, diagnostic reasoning, and patient management.
4. Use of Resources & Systems, Healthcare Delivery Systems, and Delivery Systems Improvement: Recognize patient safety risks and system-based issues, using principles of quality improvement, resource stewardship, and advocacy to enhance healthcare delivery.	**HC 5.1, 5.2; RP 6.1-6.3; PC 1.8**	EPA 13 – Identify system failures and contribute to a culture of safety and improvement	Ongoing daily one-to one evaluation of the student by the preceptor. End of rotation one-to-one and written evaluation of the student by the preceptor.

5. Communication with Medical Team and with Patients, Family Members, and Community: Communicate effectively, respectfully, and compassionately with patients, families, colleagues and interprofessional team members, demonstrating cultural sensitivity, professionalism, and clarity in both oral and written exchanges.	**C3.1, 3.2; PC 1.3, 1.4, 1.6**	EPA 6 – Provide an oral presentation; EPA 8 – Give or receive a patient handover to transition care responsibility EPA 9 – Collaborate as part of an interprofessional team EPA 11 – Obtain informed consent for tests and/or procedures	Ongoing daily one-to one evaluation of the student by the preceptor. End of rotation one-to-one and written evaluation of the student by the preceptor.
6. Professionalism: Demonstrate integrity, accountability, ethical judgment, and respect in all professional interactions while maintaining a commitment to patient welfare, diversity, and self-improvement.	**PC 1.6; P 4.1 - 4.4; RP 6.1 - 6.4**	EPA 8 – Give or receive a patient handover to transition care responsibility EPA 9 – Collaborate as part of an interprofessional team; EPA 12 – Perform safe transitions of care EPA 11 – Obtain informed consent for tests and/or procedures EPA 13 – Contribute to a culture of safety	Ongoing daily one-to one evaluation of the student by the preceptor. End of rotation one-to-one and written evaluation of the student by the preceptor.
7. Performance of Basic Clinical Procedures: Perform basic clinical procedures safely and competently, while maintaining patient comfort, adhering to infection control standards, and documenting accurately.	**PC1.2, 1.3, 1.5, 1.7 ; C3.1, 3.2**	EPA 12 – Perform general procedures of a physician EPA 5 – Document a clinical encounter in the patient record	Ongoing daily one-to one evaluation of the student by the preceptor. End of rotation one-to-one and written evaluation of the student by the preceptor.

Key: EPO = Educational Program Objective (#1=Patient Care; #2=Medical & Scientific Knowledge; #3=Communication and Interpersonal Skills; #4=Professionalism; #5=Health Care Systems; #6=Reflective Practice and Personal Development)

Preceptor Evaluation of Student Performance Grading Rubric

Preceptors are expected to complete an evaluation for each student within three weeks of the student's completion of their clinical rotation, using the evaluation questions and grading rubric provided below.

Q1. How effectively did the student gather essential details during the patient history and perform a thorough, logical physical examination?

Fail	Misses key history elements or physical exam findings; lacks a systematic approach.
Poor	Gathers basic information but omits significant details; H&P is incomplete or inconsistent.
Pass	Obtains most essential information, performs a systematic H&P, minor details may be missed.
High pass	Consistently gathers comprehensive histories and performs thorough, organized physical exams.
Honors	Demonstrates exceptional skill in obtaining H&Ps, even in complex cases.
Not applicable	Insufficient contact

Q2. How well did the student prioritize and justify potential diagnoses based on the clinical encounter?

Fail	Struggles to develop a differential diagnosis or includes irrelevant possibilities.
Poor	Lists basic differentials but has difficulty prioritizing or justifying them.
Pass	Produces reasonable differential diagnoses with some prioritization and justification.
High pass	Creates well-reasoned, prioritized differentials with strong clinical justification.
Honors	Provides nuanced, prioritized differential diagnoses with exceptional clinical reasoning.
Not applicable	Insufficient contact

Q3. How effectively did the student develop a sound management plan, including clinical reasoning, recommendation and interpretation of diagnostic tests, treatment selection, recognition of urgent/emergent issues, and justification of their decisions?

Fail	Disorganized plan; poor reasoning; inappropriate or missing diagnostics; misses urgency.
Poor	Basic plan; key gaps in reasoning or diagnostics; urgency often missed.
Pass	Sound plan; logical reasoning; appropriate diagnostics; recognizes urgency.
High pass	Clear, well-reasoned plan; effective diagnostics; manages urgency well.
Honors	Outstanding plan; sharp reasoning; precise diagnostics; expertly addresses urgency.
Not applicable	Insufficient contact

Q4. How accurately and effectively did the student document clinical encounters (including admission notes, progress notes, procedure notes, outpatient notes, etc.)?

Fail	Documentation is unclear, incomplete, or inaccurate.
Poor	Includes basic information but lacks organization or misses key elements.
Pass	Documents most relevant details accurately and concisely.
High pass	Consistently produces clear, thorough, and well-organized documentation.
Honors	Documentation is exemplary, capturing all relevant details and showing exceptional clarity.
Not applicable	Insufficient contact

Q5. How well did the student organize, tailor, and deliver oral presentations of clinical encounters?

Fail	Presentations are disorganized, incomplete, or difficult to follow.
Poor	Basic structure is present, but significant details are omitted or unclear.
Pass	Provides organized, clear presentations with minor omissions.

High pass	Consistently delivers concise, well-structured presentations.
Honors	Excels in presenting, even under pressure, with exceptional clarity and precision.
Not applicable	Insufficient contact

Q6. How effectively did the student generate clinical questions, retrieve evidence, and integrate medical and scientific knowledge into patient care?

Fail	Doesn't ask questions or use evidence; relies on flawed reasoning.
Poor	Inconsistent use of questions or evidence; limited application.
Pass	Asks relevant questions; uses and applies evidence appropriately.
High pass	Consistently uses strong evidence and reasoning in decisions.
Honors	Insightful, evidence-driven thinker; integrates knowledge expertly into care.
Not applicable	Insufficient contact

Q7. How effectively did the student communicate and collaborate with the interprofessional team, including during handoffs and transitions of care, demonstrating clarity, respect, and professionalism?

Fail	Unclear, unprofessional, or ineffective; poor teamwork.
Poor	Inconsistent or vague; limited collaboration; handoffs lack structure.
Pass	Clear, respectful, and accurate; works well with team; handoffs are adequate.
High pass	Consistently clear and collaborative; effective, well-structured handoffs.
Honors	Excellent communicator and team player; handoffs are seamless and complete.
Not applicable	Insufficient contact

Q8. How effectively did the student communicate with patients and families from diverse backgrounds, incorporate social and cultural factors into clinical care, and explain risks, benefits, and alternatives to support informed decision-making with clear language and compassion?

Fail	Ineffective or inappropriate communication; disregards cultural or social factors; fails to support informed decisions.
Poor	Basic communication; limited consideration of diversity or shared decision-making.
Pass	Clear, respectful communication; incorporates social and cultural context; explains options reasonably.
High pass	Consistently effective and culturally sensitive; supports informed, patient-centered decisions.
Honors	Exceptional communicator; deeply integrates cultural awareness and shared decision-making.

Q9. How competently and confidently did the student perform basic clinical procedures and communicate with patients during the process, while ensuring patient and healthcare team safety?

Fail	Struggles with procedural skills or patient communication.
Poor	Performs basic procedures but lacks confidence or consistency.
Pass	Safely performs procedures with minor guidance.
High pass	Performs procedures confidently and competently.
Honors	Demonstrates exceptional skill and patient-centered communication during procedures.
Not applicable	Insufficient contact

Q10. To what extent did the student identify safety risks or system issues in patient care delivery and take appropriate steps to address them? ***(e.g., Noticing frequent order entry errors, workflow inefficiencies, or recognizing inconsistent use of interpreter services and advocating for proper language support.)***

Fail	Misses safety or system issues; may contribute to harm.
Poor	Recognizes issues only when prompted; limited action.
Pass	Identifies issues and communicates appropriately; needs guidance to act.
High pass	Proactively identifies and helps address issues.
Honors	Anticipates risks, acts independently, and leads or contributes to improvements.
Not applicable	Insufficient contact

The Preceptor Evaluation of Student Performance form has been thoughtfully mapped to the specific Course Learning Objectives (CLOs) for each clerkship. The table below outlines how each evaluation question aligns with the relevant CLOs to ensure consistency between assessment and curricular goals.

Evaluation Question	CLOs	EPOs
Q1. History & PE	CLO-2, CLO-1, CLO-6	PC 1.1–1.3, 1.5–1.8; MSK 2.1–2.5; P 4.1–4.4; RP 6.1–6.4
Q2. Differential Dx	CLO-2, CLO-1	PC 1.1–1.3, 1.5, 1.7, 1.8; MSK 2.1–2.5
Q3. Management Plan	CLO-3, CLO-1, CLO-5	PC 1.3–1.8; MSK 2.1–2.5; C 3.1, 3.2; HC 5.1, 5.2
Q4. Documentation	CLO-2, CLO-5, CLO-6	PC 1.1–1.6; MSK 2.1, 2.2; C 3.1, 3.2; P 4.1–4.4; RP 6.1–6.4
Q5. Oral Presentation	CLO-5, CLO-2, CLO-6	PC 1.1–1.6; MSK 2.1, 2.2; C 3.1, 3.2; P 4.1–4.4; RP 6.1–6.4
Q6. Evidence-Based Practice	CLO-1, CLO-4, CLO-5	PC 1.3, 1.4, 1.6–1.8; MSK 2.1–2.5; C 3.1, 3.2; HC 5.1, 5.2; RP 6.1–6.3
Q7. Interprofessional Teamwork	CLO-6, CLO-5	PC 1.3, 1.4, 1.6; C 3.1, 3.2; P 4.1–4.4; RP 6.1–6.4
Q8. Patient/Family Communication	CLO-6, CLO-5	PC 1.3, 1.4, 1.6; C 3.1, 3.2; P 4.1–4.4; RP 6.1–6.4
Q9. Clinical Procedures	CLO-7, CLO-6	PC 1.2, 1.3, 1.5–1.7; C 3.1, 3.2; P 4.1–4.4; RP 6.1–6.4
Q10. Systems/Safety	CLO-4, CLO-5, CLO-6	PC 1.3, 1.4, 1.6, 1.8; C 3.1, 3.2; P 4.1–4.4; HC 5.1, 5.2; RP 6.1–6.4

Emergency Department Clinical Guide for Students

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 viscus

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 of 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 the 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 Procedures 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

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: LOA -PQRST (location, 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 – witnessed 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 physical examination is essential in the ED, frequently, that is not always possible, especially when a patient is severely ill or has altered level of consciousness (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 the patient had treatments
- 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

becomes 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 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 may 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-PQRST):
    - 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 INTANGIBLE 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 incidents 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 to 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 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 was 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 based upon 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 obstetric (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.**