Emergency Medicine Clerkship Handbook 2025-2026

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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.

Clerkship Goals and Learning Objectives

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 interpersonal 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 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.

Learning Objectives for Emergency Medicine Clerkship

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 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 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

Educational Program Objectives (EPOs) & Course Learning Objectives (CLOs)

The clerkship curriculum is structured around the six ACGME Core Competencies, ensuring alignment with nationally recognized standards for medical education. These competencies are mapped to the **Educational Program Objectives (EPOs)**, as illustrated in the table below. Student performance in each competency area is assessed through the students' final evaluation. Additionally, the **Course Learning Objectives (CLOs)** are aligned with the EPOs, providing a framework for instructional goals and evaluation criteria, as shown 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.	**MSK1-5 PC7**	NBME EM Shelf Examination, Preceptor, and CD evaluations
CLO-2	Demonstrate knowledge of scientifically established standards for developing diagnoses and differential diagnoses of acute and chronic system-based conditions encountered in family medicine and apply their knowledge while reflecting sensitivity to differing cultures and personal backgrounds.	**PC 1-7 C 1-2 HC 1**	Preceptor, and CD evaluations
CLO-3	Demonstrate knowledge of evidence-based management of acute and chronic diseases encountered in Family Medicine and apply this knowledge reflecting sensitivity to differing cultures and personal backgrounds.	**PC 1,2,5,7; MSK 1-3**	NBME EM Shelf, and Preceptor evaluations
CLO-4	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 5,7,8 MSK 1-4**	NBME EM Shelf and Preceptor, and CD evaluations
CLO-5	Foundational knowledge of the structure and function of the major organ systems, including the molecular, biochemical and cellular mechanisms for maintaining homeostasis, as well as understanding of the pathogenesis of disease, interventions and effective treatment.	**PC 1,2,5,7 RP 2**	NBME EM Shelf and Preceptor, and CD evaluations
CLO-6	The student will demonstrate professionalism through dedication to the standards of the medical profession, upholding the ethical principles of honesty, integrity, compassion and dedication to excellence while continuing to self-reflect and engage in independent learning as a means to self-improvement.	**P 1-4, 5, 7 HC 1,2 RP 1,3,4**	Preceptor, and CD evaluations

The Preceptor Evaluation of Student Performance form, detailed in the M3 General Handbook including all 10 questions and grading rubrics, 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	Primary CLO(s)	Secondary CLO(s)
Q1. History & PE	CLO-2	CLO-3, CLO-6
Q2. Differential Dx	CLO-3	CLO-1
Q3. Management Plan	CLO-5	CLO-4, CLO-1
Q4. Documentation	CLO-2	CLO-6
Q5. Oral Presentation	CLO-2	CLO-6
Q6. Evidence-Based Practice	CLO-1, CLO-4	CLO-5
Q7. Interprofessional Teamwork	CLO-6	CLO-2
Q8. Patient/Family Communication	CLO-6	CLO-5
Q9. Clinical Procedures	CLO-5	CLO-6
Q10. Systems/Safety	CLO-6	CLO-4, CLO-5

Clerkship Educational Activities

Rotation 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: at discretion of attending
- Night call? Yes, variable
- Duration of the Clerkship: 4 weeks

Hours and Shifts and Didactics

- 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".

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 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 patient who needs 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. The 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

Mid-clerkship evaluation by a preceptor

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

- 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

Required Clinical Experiences ("Must See" Cases and Procedures)

Must See Cases: Students must maintain a log of specific diagnoses encountered during the clerkship and should be documented via MedHub. 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 all be logged before the M4 year.

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.

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")

Experience	Level of Participation
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

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: procedures should not 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: 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 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-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 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 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.**

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 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

Recommended Resources

- 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)

Summary of Core Clerkship Policies and Expectations

All third-year medical students are expected to follow the policies outlined in the **M3 Clerkship General Handbook**. This guide establishes consistent standards across all core clerkships, supporting a professional, equitable, and safe learning environment. Below is a high-level summary of key policies. Students are responsible for reviewing the full handbook for details. For full policy details, grading rubrics, and institutional resources, please refer to the M3 Clerkship General Handbook.

Professionalism Expectations

Students must demonstrate integrity, accountability, respect, and ethical behavior at all times. Professional lapses—such as tardiness, dishonesty, or unprofessional conduct—may result in grade penalties, formal remediation, or referral to the Student Promotions Committee.

Patient Confidentiality & HIPAA Compliance

Students must strictly protect patient privacy. This includes not accessing unauthorized records, avoiding discussions in public areas, and never storing PHI on personal devices. Violations may result in disciplinary action or dismissal from clinical duties.

Preceptor Responsibilities

Preceptors are responsible for daily supervision, direct observation, clinical teaching, and timely feedback. They must complete mid-clerkship and final evaluations (including narrative comments on strengths and areas for growth) within three weeks of the rotation's end. Narrative comments may support grade adjustments in borderline cases. Preceptors may not medically treat students under their supervision. Best practices include encouraging independent patient encounters, assigning focused tasks, and using brief debriefings and readings to enhance learning.

Clerkship Clinical Supervision

All patient care activities must occur under the supervision of licensed professionals. Students are expected to work within their level of training and seek guidance when needed. Preceptors are responsible for real-time oversight and feedback.

Formative Feedback and Mid-Clerkship Evaluations

Students are expected to seek and respond to regular feedback throughout the rotation. Preceptors will provide ongoing feedback on clinical skills, professionalism, and communication. A formal mid-clerkship evaluation is required to assess progress and set goals for improvement. Feedback plays a critical role in student development and contributes to the final evaluation.

Attendance and Absences

Full attendance and punctual arrival is expected. Excused absences may be granted for illness, emergencies, or approved events, with advance notice and documentation. Excessive or unexcused absences must be made up and may impact your professionalism evaluation.

Clinical Rotation Duty Hours

Students must not exceed **80 hours per week** of clinical duties (averaged over four weeks). Students must have **10 hours off between shifts**, **1 full day off per 7-day week**, and are limited in the frequency of overnight call. These guidelines protect wellness and patient safety.

Immunization and Screening Requirements

Students must maintain up-to-date immunizations, including annual TB testing and a tetanus-diphtheria booster every 10 years. Site-specific immunizations may also be required. All documentation must be complete at least one month before third- and fourth-year clinical coursework. Incomplete records may delay rotations or graduation. A background check and drug screening are required before clinical work; random or for-cause screenings may occur throughout enrollment.

Workplace Injuries & Needlestick Protocols

Students must report all workplace exposures immediately, follow proper first-aid procedures, and seek medical care at designated facilities. CNUCOM students are covered under **Workers' Compensation** for clinical-related injuries.

Mistreatment and Harassment

Any behavior that undermines student dignity or creates a hostile learning environment is strictly prohibited. This includes verbal abuse, discrimination, or exclusion. Concerns can be reported confidentially to the Clerkship Director, Clinical Education, or Student Affairs.

Clerkship Grading

Final clerkship grades are based on a combination of:

- **NBME Shelf Exam performance** (nationally standardized exam)
- **Clinical evaluations** by preceptors and Clerkship Directors
- **Didactic participation and assignments** Grades may be adjusted based on clinical performance and professionalism. A "Y" grade may be issued for incomplete or remediated components.

Preceptor Evaluation of Student Performance Form

Preceptors must complete student evaluations within three weeks post-rotation using a standardized rubric across ten domains (e.g., history-taking, clinical reasoning, communication, professionalism). Ratings range from "Fail" to "Honors," with "Insufficient Contact" as an option when applicable. Be sure to review the actual questions in the **M3 Clerkship General Handbook**.

Student Evaluation of Clinical Experiences

At the end of each clerkship, students must complete evaluations of their preceptor, clinical site, and overall rotation. These evaluations are submitted through a secure online system and are reviewed only after a threshold is met to ensure anonymity. Honest, constructive feedback is essential for improving the quality of clinical education.

For full policy details, grading rubrics, and access to institutional support, please consult the M3 Clerkship General Handbook.