

WHEN AND WHERE TO DO AN EMERGENCY MEDICINE ROTATION (Adrienne Birnbaum, MD; Wallace Carter, MD)

Choosing an institution

Students may choose to perform a rotation at their home institution, visit another institution, or both. Potential reasons for choosing an "away" rotation include targeting a program or geographic area that the student has potential interest in as a residency training site.

In general, the performance of multiple EM rotations, especially more than two, at different institutions that simply duplicate experiences is probably best discouraged. The fourth year of medical school provides the student with a unique last opportunity to experience various areas of medicine with education as the primary goal. A student might consider supplementing core rotations at the home or other institution with an additional subspecialty elective in an area such as EMS, Toxicology, or Pediatric EM.

Students are encouraged to collect information on available rotations. Rotations may, for example, differ considerably in the level of responsibility for patient care afforded. The true sub-internship experience often allows the student to function, under faculty supervision, at the level of care-giver, while a more observational role is the norm in other institutions. Many programs offer a lecture series specially designed for students as well as conferences provided for EM residents. Experiences unique to certain institutions include a level one trauma experience, EMS experience in ambulance and/or helicopter transport, hyperbaric medicine, toxicology, pediatric EM fellowship program, etc. A good source of information on programs offering student electives in EM can be found by visiting the SAEM web page. The Undergraduate Rotations Directory can be found in the table of contents on the home page. This directory includes a variety of information such as: type of hospital(s); patient volume and variety; EMS opportunities; conference information; requirements of the rotation and unique opportunities afforded by the institution. Details about scheduling and availability are also provided.

While the student may be attracted to an institution because of the presence of a particular feature, such as a helicopter program, hyperbaric medicine, toxicology or pediatric EM, the assumption should not be made that students will automatically be exposed to that particular aspect during the standard student rotation. Specialized interests should be directed to the rotation preceptor in advance to design an individualized rotation that includes the specific request.

Begin planning early

Proper supervision of medical students requires faculty supervision, a resource that is limited. As a result, many institutions have a maximum quota of students that they are willing to accept for each rotation block. Students that are interested in EM residency training should plan to perform the student rotation early in the academic year (by October or latest, November) in order to confirm their interest in EM as a specialty and so that evaluations and letters of recommendation from these rotations will be available in time for residency application. Heavily subscribed student electives may fill their quota of students accepted into the rotation by spring of the academic year preceding the planned elective. To avoid being closed out of such rotations, start investigating options early. A student who has special interest in performing an elective at a particular institution that has filled its quota should speak directly to the preceptor of the rotation to express their specific interest in the program.

Advice to Students Beginning a Medical Student Rotation in Emergency Medicine (Adrienne Birnbaum, MD; Wallace Carter, MD)

Strategy

EM is largely fast-paced and hands-on. Students that show enthusiasm, initiative, and interest during the rotation will undoubtedly have the best experience and make the best impression on evaluators. Knowing one's limitations and asking for help when needed must, of course, temper this strategy. Demeanor is all-important in how the student will be perceived. Over-confidence at the student level will be perceived negatively, as will the sense that a student is working overly hard to make a favorable impression. Focus on learning, providing good care to patients and getting the most that you can from the provided experiences. Whenever possible, follow cases through to completion of the pertinent ED work-up and beyond. Ask to observe interesting cases and or procedures that you are not directly involved in.

Be prepared to think like an EM physician

The fast pace of the ED requires EM physicians to focus rapidly on the chief complaint and to efficiently tease out relevant information from the history and physical exam to generate a differential diagnosis and to make prompt decisions about necessary diagnostic tests, disposition and treatment. Depending on the acuity and nature of the problem, treatment may need to be instituted simultaneously with the performance of the history and physical exam. The EM approach to a sick patient is relatively unique in its focus on ruling out diseases in the differential diagnosis that are potentially life-threatening, i.e. the diagnoses that "one cannot afford to miss", even if such diagnoses are not the most likely possibility. Be prepared to rapidly and efficiently work up patients with undifferentiated complaints with this approach in mind.

Professionalism

Dress and act professionally. While ED attire is often casual, check out the policy on clothing such as scrubs and jeans before you start, to avoid appearing unprofessional. Be prepared to treat patients of diverse ethnic backgrounds, socioeconomic status, and variable levels of acuity of illness. Keep in mind that the ED serves as the only access to medical care for some patients and that what constitutes an emergency is often in the eyes of the beholder. Be prepared to encounter patients with various overlays of psychosocial issues as well as both organic and functional impediments to history taking and physical exam. Make an effort to be non-judgmental and persevere to do the best job possible under sometimes difficult circumstances. Consider volunteering to work one or more evening, overnight or weekend shifts, if not required. EM is a 24 hour per day operation. The "off-hours" experience may be significantly different in volume, patient mix, physician coverage and cadence than that of daytime.

Personal Safety

Be cognizant of personal safety. The hectic, fast pace of the ED, combined with the large number of procedures performed on ED patients, can be a recipe for disaster if the proper universal precautions are not adhered to. Students rotating through the ED are particularly prone to injuries such as needle-stick or other exposure to body fluids. Glove, gown, mask when appropriate. Never, never, never recap needles. Report any such exposures immediately. Seek help with potentially combative or violent patients.

Ask Around – The Informal Survey

Do, by all means, use the rotation as an opportunity to talk to as many residents and faculty as possible about EM and/or about their institution. Keep in mind that residents, and even attendings, may not be in a position to compare programs to one another or to give accurate

information about programs other than their own and that word of mouth information may be prone to inaccuracies. Finally, remember that no one program is right for everyone.

Reading list

General textbooks of the specialty, such as Rosen, et al. *Emergency Medicine: Concepts and Clinical Practice*. Mosby, can serve as valuable references but are too voluminous for even the most avid reader to master during a one month rotation in EM. Hamilton, et al. *Emergency Medicine: An Approach to Clinical Problem-Solving*. W.B. Saunders, is somewhat more manageable for this purpose and is written at the student/resident level. It is organized by chief-complaint, an approach that is particularly useful for students developing an approach to ED patients with undifferentiated problems. Tintinalli, et al. *Companion Handbook to Emergency Medicine: A comprehensive Study Guide*. ACEP, is an example of a handbook that can provide a portable source of basic information.

A final word...

A little planning and a lot of enthusiasm, initiative and positive attitude will maximize the likelihood of a positive experience on the EM rotation. Make the best of each clinical and didactic experience. Keep in mind that EM is a hands-on specialty, the art of which is often best learned at the bedside. Make an effort to take care of as many sick patients as possible and to discuss the cases with EM faculty. Enjoy the diversity, excitement, and privilege of being involved in saving lives or at least making a difference in the lives of the patients that you come into contact with in the ED.

EMERGENCY MEDICINE PATIENT PRESENTATIONS: A "How-To" Guide For Medical Students (Kerry B Broderick, MD; David E Manthey, MD; Wendy Coates, MD)

Patient presentation is an art. This art form is taught from the day the student does his or her first patient history and physical and presents to the physician preceptor. It continues to be molded and re-formatted throughout medical school and residency. Each medical specialty has different nuances of patient presentations. For instance, within the OB/GYN specialty, there is a more detailed and structured presentation of the patients OB/GYN history. In pediatrics, the gestational and birth history, immunization status, as well as height and weight statistics take on more importance when presenting that patient. Surgical patient histories focus on the perioperative period, while medical patient histories are typically detailed and complex. Emergency medicine (EM) has its own nuances for patient presentations that manifest themselves in several ways. First, different types of patients (e.g., trauma, pediatric, cardiac, and psychiatric) all have particular information that should be offered earlier in the presentation. This is similar to the data and pattern requested by the specific specialties. Second, there are dynamic nuances that depend on the overall activity level of department. For instance, when the emergency department is not exceedingly busy, a more detailed history on patients may be possible. When the department is busy, the student needs to include only the most important parts of the history including the pertinent negatives, having extraneous data available if requested. Third, the severity of the medical condition of the patient will dictate the type of presentation. A stable patient may allow for a complete presentation, while a patient who becomes unstable may require that the student answer specific and directed questions. Finally, the patient's presentation may occur in two or more parts. The first includes the presentation of symptoms and exam findings with development of an evaluation plan. This may be followed by the formulation of a disposition plan that takes into account all information derived from the initial evaluation.

GENERAL

There are several general principles to remember when presenting a history and physical to the EM attending (faculty).

1. **Acuity Level** - Convey how sick the patient is to the preceptor immediately. If you feel the patient is seriously ill, mention this at the start so that the presentation can occur in conjunction with patient management. If you feel certain aspects need immediate treatment (hypoxia, hypotension), present this first. For example, "Dr. Preceptor, as I present Mr. Blue to you, I believe we should immediately treat his hypoxia and wheezing. Mr. Blue is a 63 year old COPD patient who..." This is guaranteed to get their attention and moving toward the care of the patient. Although students often get the most stable patients, it is not unusual for a patient's status to change.

2. **Relevance** - Present only the pertinent data. Try to decide whether or not the data you are about to present will make a difference in the differential diagnosis, evaluation or treatment of a patient. For example, a patient's history of high cholesterol is not important in treating a trauma patient, but their tetanus status is. Remember that negative data such as no history of medication allergies or no history of bleeding disorders are also important. You may collect much more data than you eventually present. This information may or may not be requested as your attending reviews your presentation. A reasonable way to discern what information is important for a given presenting complaint is to ask yourself if you needed the data in your

clinical reasoning process. As you gain more experience with clinical reasoning for various presenting complaints, your presentations will improve.

3. Differential Diagnosis - Prepare and present a differential diagnosis. You may present this either based on the most emergent or the most likely. Make sure all emergent conditions that would fit with the disease process are included. You may rule them out by the history and physical without further tests, but they should still be mentioned (and then summarily excluded). Include diseases that are common even though they are not emergent. While emergency physicians are viewed as the experts in the evaluation and management of critically ill patients, they often act as primary care physicians. Do not present zebra diagnoses unless you think they are realistic possibilities.

4. Assessment and Plan - Many students make the mistake of omitting their own assessment and plan and wait to be asked. Prepare and present your approach to the evaluation and treatment of the patient. As a medical student, you may have many questions about what to do. However, by presenting what your thought process is, the attending will be able to gauge your level of knowledge and experience as well as tailor their teaching to your level. In addition, by taking a "chance" to give your ideas, you will better understand what to do that next time you see a similar patient.

5. Interpretation of Data - During the second presentation to the preceptor, you will have gathered all or a portion of the information gathered after the first presentation. At this time, you should do several things. Interpret the laboratory, radiographic, and additional history and exam findings. In many cases, this involves the consultation of a textbook or on-line reference. Learning the basics prior to your presentation enables the attending to teach you at a more sophisticated level. When presenting your thoughts, use causal reasoning to explain the patient's symptom complex and laboratory findings into a cohesive diagnosis. This will require a refinement of the previous list of differential diagnosis based on the results of studies ordered.

6. Disposition - Prepare a plan for the patient's disposition, which includes reasons for admission and/or discharge as well as treatment and follow-up. Include this with your final presentation. When completing the chart, be sure to include discharge instructions to the patient advising them of reasons to return to the ED and outline your plan for their follow-up.

7. Questions - Feel free to ask questions. Many procedural questions can be answered by residents, nurses, or other students. Management or evidence based questions can be asked to the attending at any time during the patient work-up, but should generally be reserved for a time when the patient is stable. One author suggests keeping them until the end. At that time, you can present and ask about those areas that you were unsure of whether or how to present or evaluate. Another author suggests asking questions as they arise. That way, you can use your new information to complete the work-up of the patient. By asking questions, the attending can evaluate your level of understanding and teach you what you need to know at that moment. By doing this, you increase your knowledge of the condition so that you can begin at a higher level the next time you have a patient with similar complaints. This can help mold your next presentation.

8. Evaluation - Recall that the purpose of the patient presentation is three fold. One is to impart data to the attending for the purpose of caring for the patient. The second is to allow the attending to evaluate you. Most evaluations include your ability to perform a directed history and physical, interpret that data, develop a differential diagnosis list, design an evaluation and

treatment plan, present a patient, as well as your overall knowledge level on different presenting complaints and specific disease processes. Third, it is often during the presentation that the attending physician addresses critical teaching points.

SPECIALTY AREAS

Remember that each medical specialty has developed its own particular issues and information that are important based on their relevance to the patients with these complaints. Learning what these are helps you to make an appropriately focused presentation to your preceptor and consultant.

1. **Trauma** - The majority of trauma patients seen by the student will be minor trauma. All trauma patient history and physical examinations require specific information. The history of the traumatic event includes information such as when it occurred, mechanism of injury, time since injury, as well what treatment has been done so far. A quick assessment of allergies, medications, past medical history, and time since the last meal are important for determining management. Pertinent examples may include: the patient is a hemophiliac or on an anti-coagulant drug, patient is a diabetic, or pregnant, or on prednisone. Even with minor trauma, it is important to ask briefly about medical history to prevent missing an important factor that may impact treatment or follow-up care.

a. **MVA** - For motor vehicular trauma, restraint device use, impact of vehicle or patient, vehicular damage (i.e. amount of passenger space intrusion, steering wheel or windshield damage), ejection of patients or other occupants, as well as other occupant death are all important issues used to calculate a pre-test probability for injury. Extrication issues such as, prolonged extrication with a depressed level of consciousness versus self-extrication and ambulatory at the scene allow for evaluation of risk. Time from accident to treatment, documented loss of consciousness at the scene or en route to the hospital also help in deciding severity of illness.

2. **OB/Gyn** - A female with abdominal pain needs to have a brief ob/gyn history obtained and presented. The conciseness and cohesiveness of the presentation can be very different as illustrated by the following examples; Example 1: A 17 year old female presents with 2 days of abdominal pain; without vaginal bleeding, no fever, chills, slight nausea, no diarrhea, no urinary symptoms, no trauma. Her vital signs are.... Example 2: A 17 year old female G1P0 with LMP 6 weeks ago, history of GC and chlamydia one year ago, presents today with lower abdominal pain, worse on the left, non-radiating, without vaginal bleeding or discharge, with no associated urinary symptoms, no fever, chills, nausea, vomiting or trauma. The pain is constant and increasing, worse with movement. Her vital signs are..... A more detailed ob/gyn history up front helps the preceptor to organize the patient's risk stratification up front.

3. **Pediatric** - The younger the child the more unique the history will be, such as, prenatal, birth, and neonatal history. These may all be very relevant to the child's presentation to the ED. As the child gets older and further away from their birth, these factors become less important. Immunizations, developmental and family history are always important factors in assessing and presenting a child. Adolescents should be assessed for risky behaviors and depression as part of their evaluation.

4. **Medical** - Adults frequently present to the ED with an exacerbation of a chronic problem (some of these can be critical) or with a completely unrelated complaint.

- a. For young, healthy adults with a focused problem, a pertinent history that addresses their chief complaint is usually enough. A simple query such as, "Do you have any medical conditions or take any medications?" is often sufficient.
- b. A person with a chronic condition with a simple problem should be asked first about their presenting complaint. Then, an inventory of their medical history can be assessed. In some cases (e.g., a dirty foot laceration with a foreign body in a diabetic), the underlying condition will figure prominently in their treatment and should be discussed as a major part of the presentation. In other cases (e.g., the same laceration in a patient who has asthma), the underlying condition may be superfluous. It may be mentioned as part of the past medical history during your presentation.
- c. The patient with an underlying condition who presents with an exacerbation should have a full history of the problem explored (e.g., A patient with known coronary artery disease who presents with accelerating chest pain). Information about their disease may include prior events, diagnostic studies (e.g., catheterization), medical management, etc.

SUMMARY

Patient presentations are an art and as EM encompasses such a wide variety of medical specialties and patients, this 'art' is especially fun to learn and develop in the ED.

- * Convey the patient's medical urgency immediately to the preceptor.
- * Present only the pertinent data; Be concise and thoughtful.
- * Be sensitive to the department's activity status overall and be tolerant of modifications that you may need to make in your presentations accordingly.
- * Prepare and present your own differential diagnosis and an approach to the evaluation of the patient.
- * Present the patient's completed evaluation and an updated differential diagnosis.
- * Organize a disposition plan for your patient to discuss with your attending.
- * Ask intelligent questions.
- * Have fun!

Presenting Your Patient: A Guide for Medical Students Rotating in the Emergency Department (Tamara Howard, MD; Kerry B Broderick, MD)

Introduction

Welcome to the emergency department (ED)! The purpose of this guide is to assist medical students who are rotating through the emergency department with the development of presentation skills. The attending will want you to be able to present information on each patient that you see in a coherent, systematic, and time-efficient manner. Many patients are in the ED for a single, discrete issue or problem. However, a number of patients will be complex. They will probably have several chronic conditions, which may be the reason for the ED visit, or will impact the treatment plan and ED management.

As you see each patient, keep in mind that your goal is to identify and address the acute problem(s). The emergency department visit differs from a routine office visit, in which the physician may be addressing a number of issues. It is often unrealistic to attempt to address each health issue of the patient in the ED. ED treatment is confined to addressing only those issues that led to this ED presentation or which directly affect the type(s) of treatment the patient will require in the ED. What you do for the ED patient is also different from what you are expected to do when working up an admitted patient on the floor. When you are seeing floor patients, it is not unusual to spend 30 min or more with the pt each time you visit them. On the floor, you are assessing the efficacy of interventions made since admission. However, you can't spend this much time with each patient in the ED, and you are making the first set of interventions that will affect the remainder of the patient's course in the hospital.

Now, let's say you have seen your patient! Before you head off to find the attending or senior resident to present your patient, make sure you have checked the patient's chart and noted certain key pieces of information. Don't forget to read the nurse's notes and the triage sheet. Ideally you will do this before you see the patient, but sometimes in the ED you have to see the patient before the chart is available. Both of these documents will offer some sort of comment with regards to why the patient is here. If the chief complaint given by the patient to you differs from what is written on the triage sheet or the nurse's note, be sure to resolve the differences with the patient and remember to comment on them during your presentation. If you are at an institution with computerized patient records, you may want to check recent discharge summaries as well as determine date of last ED visit. Don't spend too much time on this task prior to seeing the patient; if this information isn't quickly available, see the patient, get a treatment plan going, and then check with the desk clerk to see what info can be obtained.

Anatomy of the Presentation

When you see the patient, you will gather a lot of data. Only some of it will be important enough to include in your presentation. Key questions to consider (and which will be in the mind of the listener): Why is the patient here? Can they be treated here and referred elsewhere for follow-up, or do they require admission? If they require admission, what level of care is appropriate (floor, step-down, ICU, isolation, etc.)?

ID patient, location in the department, and why the patient is here. Begin your presentation by identifying the patient. Use a name and a limited amount of demographic information (e.g. Ms. Rodriguez is a 38 year old female in bed 3). Don't call patients "the woman in room 2" or "the man with right arm pain". There are a lot of reasons to avoid doing this. The first reason is that each patient is a human with one or more immediate health care needs. They should be identified by their name, and not by their disease process(es). The second reason is that patients get moved around quite a bit by various individuals, for a lot of different reasons. The person who is moving the patients around may or may not notify you that your patient is being moved to another room. The man who was in room 2 when you examined them can easily get moved to room 6 by the time you present the patient. Imagine the confusion that can result if the attending / senior resident goes without you to room 2 to see the patient there, but now room 2 (without your knowledge) now has a different man who will of course report something different to the attending /senior resident compared to what you have reported. State the chief complaint, and give a limited amount of history of present illness. Provide relevant details. How long has the symptom or problem been present? Has the patient had previous episodes? Is this an exacerbation of a previously diagnosed chronic condition such as asthma, GERD, or hypertension? What makes the symptom get worse? Better? Has the patient sought care regarding the problem in the past? If so, what was done? If the symptom is a pain, describe things such as the character of the pain (e.g. sharp, dull, pulsating, constant, etc.); whether it radiates versus staying in one place; and any accompanying or associated symptoms (e.g. the person says they become nauseated or diaphoretic when the pain comes on). Briefly state how long symptoms have been present, exacerbating/relieving factors, whether the patient has had similar problems in the past, and if the patient has tried treatments prior to coming to ED. If this appears to be complication or exacerbation of a previously diagnosed problem, say so.

PMH

In preferably two sentences or less, indicate PMH. You can report it as a single sentence, such as "Ms. Foster has a 10 year history of hypertension, has end stage renal disease and has been on dialysis for 3 years. In limited cases, it is also appropriate to indicate that the patient does not have a history of such-and-such disease. For example, if the patient is a 60 year old male with a chief complaint of crushing chest pain associated with exertion and he says that he has no known medical problems, it is appropriate to state that the patient denies any history of angina or myocardial infarction. Keep in mind that the purpose of reporting the PMH is so that you and your listener can consider what aspects of the patient's PMH (e.g. previous fractures, migraine headaches, etc.) may directly or indirectly affect how you will manage the patient. For example, the patient's chief complaint may be cold like symptoms, which they define as a runny nose, nasal congestion, moderately decreased energy level, and sneezing. Such a patient probably has a URI. If they tell you that they have a PMH of hypertension, then remember not to give this patient Sudafed or any other sympathomimetic to treat the nasal congestion because such drugs will only aggravate hypertension. Special Note: if you are presenting a neonate, infant, or toddler, consider presenting information about presence/absence of prenatal care, birth history (spontaneous, induced, vaginal delivery C section, complications during or after delivery, days in hospital prior to discharge after birth).

PSH

Past Surgical History. This issue doesn't necessarily need to be reported for all patients. It becomes important if the patient's chief complaint may be suggestive of a surgical problem. For example, if the patient is a 40 year old female with abdominal pain, nausea, and vomiting, and she tells you that she had an appendectomy at age 25, it is appropriate to state in your presentation what the patient has told you. If she denies any history of surgery but has abdominal pain as her chief complaint, it is useful to indicate that she has no history of surgical procedures. Either way, the listener needs to hear about the presence or absence of previous surgeries in a patient with abdominal pain because the physical exam findings will give information in regards to whether the patient might be developing a surgical issue, or may be experiencing delayed complications (e.g. small bowel obstruction) of prior surgical procedures. Don't forget to ask about previous eye surgeries if the chief complaint involves the eye. Sometimes patients forget to tell you about aspects of their PMH or PSH. After you have asked the patient "do you have any medical problems?" and "have you ever had surgery?", a backup way to elicit problems they might have forgotten to mention is to ask "have you ever stayed in the hospital overnight?" If they say yes, then ask when and why.

Medications

Ask what medications the patient is taking, and report them. Sometimes the patient will tell you they are taking a medication after they deny having any medical problems. They don't do this to mislead you. What happens is that in their mind, they don't have a medical problem because the medication is keeping whatever it is treating under control. By inquiring about current medications when you see the patient, you may also learn about chronic conditions that the patient has. In this way, when you are doing your presentation you can simply report in one or two sentences what medications the patient takes, and if there are questions about additional details from the attending /senior resident, you can fill in the details later on. Along the same lines, the patient may say they are taking no medications at all. Ask if they are supposed to be on any. You may find that they are supposed to be taking several different medications but, for whatever reason, they are not. This information is useful to include in the presentation because it may help explain the reason for the chief complaint.

Allergies

Always, always, always report whether the patient has any known allergies to medicines. If they state that they do, ask what happens when they take the medication. It would be quite dangerous to give to a patient something to which they are allergic. On the other hand, it may be that the person has identified an intolerance as an allergy. Report what the patient states, and then discuss with your listeners how you have interpreted the information.

Social History

Report whether the patient smokes, drinks, and uses any recreational or street drugs. In certain specific situations, other aspects of the social history should also be reported. For example, it is important to inform the listener of the patient's living (e.g. patient lives alone, is a group home resident, lives in a dormitory, is a prisoner, etc.) if, in light of the chief complaint, the living situation affects disposition or may suggest that other people are at significant risk for similar

illnesses. For example, a patient who presents secondary to a head injury may need to be admitted for observation if they live alone and don't have anyone who can monitor them for possible deterioration. It is important to report whether a patient who appears to have contracted a potentially serious infectious illness such as meningitis lives with others versus lives with others or has come from an institutionalized setting, because it may become important to contact and treat others who live with the patient. Asking about the source of heating, or the presence of smokers in the place where the patient lives, is important if the complaint is a respiratory one (e.g. asthma exacerbation). Mentioning during your presentation that a patient has been a victim of domestic or other interpersonal violence is very important. In general, allow the chief complaint to guide you in regards to how much social history to elicit from your patient, and then decide whether or not it is something that needs to be included in the information that you present to the attending or other listeners. Other aspects of the social history to consider including in your presentation: * if the patient has emigrated here from another country, and if so, when * if the patient has been outside of the country within the past year * information about the patient's occupation if it is relevant to the chief complaint or would affect disposition or treatment

Immunization Status

This question is important in most pediatric patients, but is sometimes also relevant for adult patients. If the patient is a child, ask the parents if the child's immunizations are up to date. Most parents will say yes. The next question is to ask the parents how they have determined that the child's immunizations are up to date. If they say that the child has received all the immunizations each time that they were recommended by the PMD, then they are probably correct. If they look at you blankly and say, "Well, I guess they're up to date – they've gotten a lot of shots" then find out who the PMD is and at some point during the visit, attempt to contact this person to verify that the immunizations are indeed current. If the person is a child or adult who has emigrated from another country, don't assume that the immunization status is current. You can ask the patient or caretakers what immunizations have been given. They may or may not know. Just keep in the back of your mind whether their chief complaint should lead you to consider certain diseases that most people in the US don't contract if they have not had the opportunity to receive immunizations that are standard for US citizens.

Most people assume that if the child is enrolled in public school, that their immunizations are up to date. This is usually true but not always. There was a recent major problem in our nation's capitol in which thousands of schoolchildren were attending public school for months (or years) without proof of immunization. At some point, their parents were sent letters from school officials, but it took several months to either vaccinate or disenroll the children.

You don't need to comment on immunization status for most adult patients, unless the chief complaint involves burns, eye injury, or skin abrasions/lacerations. In these cases, remember to ask about tetanus status. If an injury like this has occurred and the patient has not had a booster in the past five years, they will need a booster during this visit. When you report immunization status, a simple statement will suffice. Sample statements that you may find helpful are as follows: "Immunization status for this recent emigrant from El Salvador is unknown." "Child's

father says he thinks the child's immunization status is up to date but he isn't sure." "Child's mother has the child's immunization card with her which shows that the immunizations are current." "Mr. Brown says he doesn't know when he received his most recent tetanus booster." "Mr. Suarez says he last received a tetanus booster two years ago secondary to a forearm laceration."

GYN History

While information such as last menstrual period (LMP), previous pregnancies, and gynecologic diagnoses will be written somewhere on the chart of each female, it is usually not necessary to include all of this information in the oral presentation of each female patient. Include the information in the oral presentation when the chief complaint or likely treatment plan will be affected by this information. For example if the patient is a 25 year old female with a chief complaint of a finger laceration secondary to injuring it on broken glass, the only aspect of her GYN history that may need to be presented orally is the LMP. In such a patient, an x-ray will probably be obtained prior to laceration repair in an effort to search for retained glass fragments. Knowledge of the LMP is not absolutely essential because most attending will check a pregnancy test anyway (regardless of the LMP) prior to ordering the x-ray. If the patient is a 25 year old female complaining of abdominal pain, vaginal bleeding, or has symptoms that suggest any type of endocrine or gynecologic problem, then more detailed information about the GYN history is important and should be presented.

Vitals

If all the vital signs are normal, you can say this. But make sure to read the triage sheet carefully, and inform your listeners of any vitals that are not normal. For example suppose that the patient has a fever but all other vitals are normal. You can say that "vitals remarkable for a temperature of 101.3 degrees, with remaining vitals within normal limits." It is helpful to report a pulse ox and fingerstick in the vitals if these numbers are important to the patient's disease process.

Physical Findings

Look at the physical examination (PE) as a screening tool to show the cause of the chief complaint. It's not meant to be a comprehensive physical that one would do as part of routine well-baby or well-adult care. You don't have to state every single detail that you found during the exam. Start with the patient's general appearance, then give the findings from the physical exam that are relevant to the chief complaint and any findings that help to either rule in or rule out disease. Findings are pertinent if they: * help rule in or rule out disease * are related to the chief complaint * are a grossly abnormal finding, requiring either immediate attention in the ED, or at least a suggestion to the patient that they see a PMD about the issue

Problem List, Assessment, and Plan

Before you make your assessment, make a problem list. Do not skip making a problem list. At the very least, make it in your head because it tells you what should be in your assessment. The

problem list is typically going to consist of abnormalities identified either through the chief complaint or on physical exam such as "elevated blood glucose" or "fever" or "right lower quadrant pain". Once you make the problem list, prioritize the items. If the person has numerous items on this list, choose the ones that have to be addressed immediately and decide which ones can be handled on an outpatient basis by PMD or clinic referral. Prioritizing the patient's issues is also important with regards to deciding which tests or labs should be done.

Next, make your assessment. This is what you will report to the attending / senior resident. When you make your assessment, give consideration to a differential diagnosis (or diagnoses) that will tie together the elements of the problem list. Some patient's have an obvious problem (e.g. a lacerated forearm). For the rest of the patients, carefully consider 2-4 things that could be causing the chief complaint, and include them in your differential. After reporting your assessment, your listeners will want to hear your plan – that is, how you want to address the abnormalities you have identified. Your plan will lead you to which item in the differential is most likely. Therefore, the plan should be supported by the chief complaint and the data in your physical exam. When you give the plan, have in the back of your mind an idea of what you are looking for with each test that you order – because some attendings /senior residents will ask you why you want to order a given test.

Disposition

Disposition refers to what you want to do with the patient. There are, in general, two things you can do here: discharge or admit. Here is a simple strategy that may help you report your proposed disposition. Decide whether you think the patient can be safely discharged, whether you think more information is required before making a decision, or whether it is obvious the patient needs to be admitted and the only question is the level of care required. Don't worry about whether or not your initial thoughts end up being "correct"; all that matters at this point in the presentation is that you have given some sort of thought as to what needs to be done to allow the patient to either get admitted or go home. Report the disposition that you feel is appropriate; examples of this are listed below.

Situation #1: You think the patient can be safely discharged. State that: After completing the actions mentioned in your plan to address the patient's issue, you plan to discharge the patient and refer them to their PMD or a clinic for follow-up, or After obtaining and evaluating the labs/x-rays discussed in the plan, you will make an intervention if necessary, then discharge the patient and refer them to their PMD or a clinic for follow-up

Situation #2: You think you need more information before deciding that it is safe to discharge the patient. State that: After obtaining the results of the diagnostic studies discussed in the plan, you will make an intervention, then re-evaluate for possible discharge

Situation #3: You think the patient needs to be admitted. You can report that you want to do one of the following options:

- * admit to the floor
- * explore options for a stepdown or monitored bed
- * send the patient to an intensive care setting

Your disposition will need to be periodically re-evaluated by you. You will do this by checking up on the results of x-rays/labs/test, and re-examining the patient to see if interventions you have done have helped the patient. If you notice any abnormal labs or x-rays, consider what they mean and how they should be addressed. When you report back to your attending/senior resident with this data, remind them of who the patient is, then give a revised plan and disposition. Hopefully this guide will help you to synthesize information that you gather as you interact with your patient in the emergency department. Enjoy your stay and learn as much as you can!