



Surgery Core Clerkship

OM7134

Rotation Syllabus

CLASS OF	2027
DATES	2025-2026
CREDIT HOURS	8.0
CONTACT HOURS	320
ASSESSMENT TOOLS	Clinical Performance - Preceptor Evaluation(s) Professionalism Cognitive Performance - COMAT
TRANSCRIPT CATEGORIES	Honors/Pass/Fail
LOCATION	Rotation Site
CLERKSHIP DIRECTOR	Sergey Shimunov, DO
COURSE COORDINATOR	Whitney Cano

Course Description

The Surgery core clerkship is an eight (8) week experience served in both ambulatory and inpatient settings. The clerkship is divided into two, four-week rotations. One four-week experience will be served in a general surgical practice. The second four-week rotation will offer the opportunity to select one or two subspecialty experiences. This will be determined by the RAC site in which the experience is served but may include cardiothoracic surgery, otorhinolaryngology, ophthalmology, orthopedics, vascular surgery, neurosurgery, bariatric surgery, and others. Students will have the opportunity to participate in the care of patients presenting with acute or chronic conditions commonly seen in surgical practice. Experience will be gained in diagnosis and case management including participation in surgical procedures. Each practice may have a unique profile of patients that will offer greater insight into a particular entity.

Course Goals

The general goals of the Surgery Clerkship are to:

1. Promote the student's attainment of a fundamental surgical knowledge base.
2. Introduce the student to basic surgical procedures, including suturing techniques, wound management, nasogastric tube placement, central line access, urethral catheterization, and IV catheter insertion.
3. Facilitate understanding of a surgical approach to clinical problem solving.
4. Promote acquisition of basic surgical diagnosis and management capabilities.
5. Promote the continued development of the student's professional and ethical behavior.
6. Develop an understanding for appropriate timing of referral for surgical evaluation.

By the end of the Surgery clerkship, the student is expected to have achieved, at a minimum, the following objectives through reading, conference attendance, observation, discussion, and hands-on clinical experience.

Patient Care

Medical Students should:

- 1) Create and sustain therapeutic and ethically sound relationships with patients and their families.
- 2) Be able to obtain appropriate histories and perform skillful and comprehensive physical examinations by developing effective listening skills and the ability to elicit and provide information.
- 3) Develop appropriate differential diagnoses and patient care management plans.
- 4) Recognize and understand the principles for managing life-threatening situations.
- 5) Perform and accurately interpret results such as labs and diagnostics tests in patient care management.
- 6) Develop effective methods of encouraging patient health and wellness through patient education.

Medical Knowledge

Medical Students should:

- 1) Demonstrate their knowledge in basic science and clinical medicine.
- 2) Normal structure and function of the body.
- 3) The molecular, cellular and biochemical mechanisms in understanding homeostasis.

Professionalism

Students are expected to conduct themselves at all times in a professional manner and to exhibit characteristics of a professional student. Measured by the following behaviors:

- Altruism
- Commitment to competence and excellence
- Dependability and punctuality
- Honesty and integrity
- Respect for others
- Responsibility and reliability

- Self-assessment and self-improvement
- Accountability

In addition to these behaviors there are expectations for attendance, appropriate attire, and general professional maturity. You will be observed in the clinical setting, small group learning sessions, and at lectures.

Course Objectives

<u>Objective:</u>	AOA Core Competencies	<u>Programmatic Level Educational Objectives</u>
1. Provide teamwork training during the clerkship as an active patient-based learning by solving problems in a real clinical setting.	3, 4, 7	1,4,6
2. Formulate a prioritized list of the 8-10 most common differential diagnoses for each of the problems/diseases specified by combining clinical information and outside resources effectively (literature search, readings, etc.)	3	1,3,5,6
3. Formulate a cost-effective diagnostic approach consistent with the prioritized differential diagnoses	3	5,7
4. Define therapies for common disease processes encountered in Surgery	2	1
5. List common risks vs. benefits to be considered when selecting treatments and management therapies	3	1,4,5
6. Perform a thorough history and physical exam.	3	1,3,4
7. Present cases concisely, emphasizing the pertinent elements of the historical and physical findings, labs, treatments, and the biopsychosocial explanations for each problem	3	1,4
8. Recognize urgent/emergent situations and alert appropriate healthcare providers	3	1,4
9. Demonstrate professionalism, compassion, and empathy when communicating with patients and healthcare team members	5	3,4
10. Demonstrate effective communication in the patient's chart by creating a comprehensive and pertinent legal document	3	3,4
11. Demonstrate a desire to learn by asking questions of faculty, fellow students, and team members	3	1,4,6
12. Exhibit a capable and professional demeanor by concern for patients and in interactions with team members	5	1,6
13. Exhibits the ability to recognize the patient as a whole person and promote and integrate OMT into the clerkship	1	2

Required Resources and Equipment

Textbooks:

- *Essentials of Surgery and Surgical Specialties* by Lawrence, 7th Edition

Recommended Textbooks:

- *Suture like a Surgeon: A Doctor's Guide to Surgical Knots and Suturing Techniques used in the Departments of Surgery, Emergency Medicine, and Family Medicine* by Mastenbjork, MD and Meloni, MD

Readings:

Required reading will be assigned during the clerkship.

Your required text is *Essentials of General Surgery and Surgical Specialties 6th Ed.* by Peter F. Lawrence. This e-book is available on the library Clerkship Site. Reading this textbook will better prepare you for the Surgery Clerkship Shelf Examination.

Student Responsibilities Regarding Patient Supervision

All medical activities involving medical students must be supervised by a licensed physician responsible for the care of the patient. The supervising physician has the responsibility for determining the level of supervision needed.

Equipment

Students are required to bring their stethoscope to each rotation. Additional equipment will be recommended at the discretion of your site attending.

Surgical Progress (SOAP) Note:

Date/time:

Subjective: Include any acute events overnight, pt's complaints. ROS pertaining to cc/dx/post-op ie pain, bowel function, food tolerance, SOB/cp, etc. Include pertinent vitals, labs, imaging, change in drain color/volume for ICU/SICU pts ie hyper/hypothermic episodes, wbc, newly developed irregular rhythms, uop etc.

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PE: - present pertinent systems (tailor to cc /working dx/post-op)

Vitals: always start w/ vitals including uop, ngt output

GEN

CV - if pertinent or change

Resp - if pertinent; include chest tube (CT) output/function

Abd - ?BS ?TTP and location ?distention. ?Incisions clean/dry/intact (c/d/i). JP drain output and color.

Skin - if wounds present -describe location/size, tissue color/consistency, signs of infection (drainage, erythema, induration, fluctuance, edema, etc)

Labs: Document all available **but present pertinent systems (tailor to cc/dx/postop or if preop to PMH/PSH if it will influence surgical approach/exposure or risks pertaining to the surgery)** For example wbc, electrolytes/Cr - unless emergent, electrolytes like K+/Phos must be corrected if severely depleted or elevated. If pt is cirrhotic or is on anticoagulation – must check and correct INR. Check H&H and transfuse prior to surgery if needed. (Address type and cross order for any transfused blood products including PRC, FFP, cryo, platlets, etc. in your A/P below). **Include new labs (with recent lab –to show trend – if it will influence surgical approach/exposure or risks pertaining to the surgical management even if not planning surgery ie pts with sepsis, bleeding, immunocompromised/suppressed or pts with hormonal imbalances effecting electrolyte levels like K+, Ca2+)**

Imaging: Document all available imaging **but present pertinent systems (tailor to cc and PMH/PSH if it will influence surgical approach/exposure or risks pertaining to the surgery) -include prior imaging results/findings for comparison.**

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A/P: Everyone likes it done differently.

There are essentially 2 ways of approaching this:

1. You can organize this by problem addressing each assessment and plan **separately**

For example:

A1

A2

A3

P1 (addressing A1)

P2 (addressing A2)

P3 (addressing A3)

2. You can organize this by problem addressing each assessment and plan **together**

For example:

A1-P1

A2-P2

A3-P3

Either way, start with a quick sentence summarizing admission/consult as such:

1. If treating pt conservatively or planning on surgery, then start with:

This is a age/gender presenting with cc/o found to have so and so and go into you're A/P.

-if further work-up needed include it in plan with your rational

-include consultation order here

-include follow up orders here

-if you're planning surgery make sure to address all issues that will affect or hinder surgical complications/outcomes (ei transfuse blood products with needed for low H/H, platelets for pt with thrombocytopenia/on antiplatelet therapy – clopidogrel/ticagrelor [plavix/brilinta], FFP with elevated INR if urgent/emergent or Vit K otherwise, glucose/K+ correction in DKA prior to OR if possible, dialysis, CHF exacerbation, etc)

2. If post-op then start with:

This is a age/sex POD (post-op day)# s/p surgery/procedure with so and so go into you're A/P discussing improvement/worsening of any issues.

-state any post-op complications and include management

-include post-op management (ie ambulation, IS use, case management for home care, wound care)

-address any abnormalities and plan to correct

-include consultation order here

-include follow up orders here

-include GI prophylaxis

-include DVT prophylaxis

-address other diagnosis plans here

Procedure/Surgery Note:

Date of procedure/surgery:

Procedure performed:

Preoperative diagnosis:

Postoperative diagnosis:

Surgeon:

Assistant:

Anesthesia: General, MAC, local

Estimated blood loss (EBL):

UOP –mainly for critically ill pt or major vascular surgery

Fluids: Albumin, PRBC, FFPs, etc - mainly for critically ill pt or major vascular surgery

Drains: JP drain, chest tube, nephrostomy tube, etc

Implants: Essential any foreign body inserted or left intentionally ie any drains, implant devices, etc.

Findings –some surgeons and hospitals like to include this section –refers to pertinent intra-op findings

Indication for procedure:

Description of procedure:

Specimen:

Complications:

Condition: Stable, unstable, Guarded, Critical, etc

Recommendations –some surgeons/hospitals like to include this –refers to follow up orders pertaining to surgery ie chest xray after central line placement to r/o pneumothorax.

Sections highlight in bold are common to all notes of this type.

Surgical Admission/Consult Note:

Date/time:

CC: pt's main complaint/reason for seeking care (can be multiple)

HPI:

Start with pt's **age/sex and the cc**. **PQRST** (Provocative/palliative - precipitating/relieving Quality/quantity - character Region - location/radiation Severity - constant/intermittent Timing - onset/frequency/duration). Associated symptoms. Exacerbating/ relieving factors. Include pertinent **vitals** on ICU/SICU or severely ill pts. +/- pertinent **ROS** (to the cc). +/- pertinent **imaging/lab results** and **prior surgeries/procedures** (including colonoscope/endoscope/cardiac cath, etc).

PMH: All medical hx -pay attention to diseases processes that require steroid/antiplatelet/anticoagulation, and/or immunosuppressive therapies –this should trigger a more extensive medication hx below (address this in A/P as part of surgical pre-op).

PSH: All surgical hx -pay attention to any prior surgeries that may complicate access or exposure should surgery be required to manage current cc (discuss these prior to surgery w/ staff and/or resident).

Allergies: to meds, contrast, etc.

Meds: steroid/antiplatelet/anticoagulation, and/or immunosuppressive therapies (this may trigger/remind you to inquire PMH above)

SHx: EtOH (if positive and extensive ask about withdrawal hx), tobacco, drug hx (including marijuana)

FHx: Dictate all FHx –but present only pertinent FHx to cc. Note the age of family member and outcome.

ROS: Get used to dictating at least 10 systems (for future billing purposes) -**remember you already “presented”/ mentioned the pertinent findings in HPI** –this section mainly for documentation purposes.

See examples below:

- skin, hair, nails - lesions, rashes, pruritis, changes in moles; change in distribution;
- lymph nodes - enlargement, pain
- bones , joints muscles - fractures, pain, stiffness, weakness, atrophy
- blood - anemia, bruising
- head - H/A, trauma, vertigo, syncope, seizures, memory
- eyes- visual loss, diplopia, trauma, inflammation glasses
- ears - deafness, tinnitus, discharge, pain
- nose - discharge, obstruction, epistaxis
- mouth - sores, gingival bleeding, teeth, abn. taste, jaw pain
- throat - ST, hoarseness, voice changes, URI
- neck - swelling/stiffness, adenopathy, goiter,
- breasts - lumps, pain, nipple discharge, last mammogram

- endocrine - polyphagia/dipsia/uria, dec. energy/fatigue
- respiratory - dyspnea, orthopnea, wheezing, cough, sputum, hemoptysis, pain, pleurisy, night sweats, TB, #pillows, pneumonia, asthma
- CV (cardiovascular) - CP, palpitations, claudication peripheral edema, ascites, cold feet, phlebitis, cyanosis
- GI - appetite/wgt change, dysphagia, N/V, hematemesis, BRBPR, melena, abd, pain/colic, icterus, diarrhea, constipation, change in bowels, tenesmus, hemorrhoids, rectal pain, hernia
- GU - polyuria, oliguria, dysuria/strangury, hematuria, pyuria, incontinence, nocturia, pain passage of stones, UTI, pyelo & STD hx

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PE: (need at least 8 systems for billing purposes in your futures) - present pertinent systems (tailor to cc and PMH/PSH if it will influence surgical approach/exposure or risks pertaining to the surgery)

Vitals: always start w/ vitals even if mentioned in HPI above.

GEN- age, sex, well developed/nourished, appears stated age, NAD

head - normocephalic, no masses /lesions, cicatrices, malar flushing

eyes - visual fields intact (cut)by confrontation, PERRLA , conjunctiva clear, sclera white, anicteric, (1-2 beat nystagmus on lateral gaze.) EOMI, no ptosis; fundi: red reflex present (B). discs flat w sharp margins, vessels present w/o crossing defects, retinal hemorrhages

ears - TM's non-injected(erythematous, bulging), good light reflex, no protrusion or retraction; Weber midline

nose - nares patent, no deformity, septal deviation or perforation

throat - pharynx non-injected, palate rises symmetrically, gag present,

mouth - buccal mucosa, moist and intact, tonsils present, dentition intact, caries, tongue midline w/o fasciculations

neck, axilla & breasts - no LAD (lymphadenopathy), masses, or thymomegaly/focal lump, carotid pulses 2+ & = (B), no bruits, supple full ROM trachea midline, breasts symmetric, no retraction, lesions, masses or tenderness

Resp- chest expansion symmetric, CTA (clear to auscultation), eupnea, no adventitious sounds (rales, crackles, wheezes)

CV (cardiovascular) - RRR no m/r/g (systolic ejection murmur, rubs, gallops)

abdomen - soft non-tender w/o masses, tympany to percussion in all 4 quads, BS present (hyper/hypoactive, absent); no HSM (hepatosplenomegaly), no bruits

EXT- extremity size symmetric w/o swelling/atrophy, temp warm (B). All pulses present, 2+ & = (B), no LAD, skin - pink-tan color, good turgor w/o lesions, redness, cyanosis, edema or cicatrices;

nails - no clubbing or deformities w good cap refill

MSK- gait normal, able to tandem walk, no Romberg's sign; joints and muscles symmetric, no swelling, masses, deformity or tenderness to palpation; no heat or swelling of joints; full ROM; muscle strength 5/5- able to resist flexion against resistance & w/o tenderness

muscle grading – evaluate D (deltoid), T (triceps), B (biceps), WF (wrist flexion), WE (wrist extension), Quad (quadriceps), PF (plantar flexion) DF (dorsiflexion) scoring 0-5 out of 5 according to following scale:
5 Normal Complete ROM against gravity with full resistance

4 Good Complete ROM against gravity with some resist

3 Fair Complete ROM against gravity

2 Poor Complete ROM with gravity eliminated

1 Trace Evidence of slight contractility. No joint motion

0 Zero No evidence of contractility

genitalia/rectum - no lesions, inflammation or discharge from penis, rectum: no fissure, hemorrhoids, fistula or lesions in perianal area; sphincter tone good; prostate not enlarged, no masses, nodules or

tenderness. Stool brown, guaiac neg.

pelvic - no vaginal/cervical lesions, uterus size & position; no adnexal tenderness

nervous - (LOC, DTR's, MMS) - CN II-XII grossly intact, alert oriented, cooperative

sensory - pinprick, light touch & vibration intact; proprioception tested (unable to differentiate sharp/dull mid-calf

motor - no atrophy, weakness, tremors or clonus; RAM (rapid, alt. movement) finger-to-nose/heel-to-shin intact; Rhomberg negative

DTR's - all 2+ & = (B); Babinski absent toes upgoing, downgoing or equivocal (inconclusive); plantar response in extensor on (L); Naming & repetition intact; memory 3:3; (B) Pronator drift - (R)>(L); gaze preference; neglect; extinguishing sensory (light touch to ea. ext then to both simultaneously): extinguishes (L or R) side to direct sen. Stim.

Labs: Document all available **but present pertinent systems (tailor to cc and PMH/PSH if it will influence surgical approach/exposure or risks pertaining to the surgery)** For example wbc, electrolytes/Cr - unless emergent, electrolytes like K+/Phos must be corrected if severely depleted or elevated. If pt is cirrhotic or is on anticoagulation – must check and correct INR. Check H&H and transfuse prior to surgery if needed. (Address type and cross order for any transfused blood products including PRC, FFP, cryo, platlets, etc. in your A/P below). **Include new labs (with recent lab –to show trend – if it will influence surgical approach/exposure or risks pertaining to the surgical management even if not planning surgery ie pts with sepsis, bleeding, immunocompromised/suppressed or pts with hormonal imbalances effecting electrolyte levels like K+, Ca2+)**

Imaging: Document all available imaging **but present pertinent systems (tailor to cc and PMH/PSH if it will influence surgical approach/exposure or risks pertaining to the surgery) -include prior imaging results/findings for comparison.** If “pimped” on non-pertinent imaging, you will have them because you documented.

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A/P: This section is a bit tricky because everyone likes it done differently. There are essentially 2 ways of approaching this:

1. You can organize this by problem addressing each assessment and plan **separately**

For example:

A1

A2

A3

P1 (addressing A1)

P2 (addressing A2)

P3 (addressing A3)

2. You can organize this by problem addressing each assessment and plan **together**

For example:

A1-P1

A2-P2

A3-P3

Either way, start with a quick sentence summarizing admission/consult as such:

This is a age/gender presenting with cc/o found to have:

Start A/P

Make sure to have at least 3 plausible ddx (likely dx being #1) to present (know at least 5).

Make sure ddx address cc and are inline with HPI/PE/lab/imaging findings.

Present a plan for your likely dx (have plans available for the other ddx just in case you are asked).

-if further work-up needed include it in plan with your rationale

-include consultation order here

-include follow up orders here

-if you're planning surgery make sure to address all issues that will affect or hinder surgical complications/outcomes (ei transfuse blood products with needed for low H/H, platelets for pt with thrombocytopenia/on antiplatelet therapy – clopidogrel/ticagrelor [plavix/brilinta], FFP with elevated INR if urgent/emergent or Vit K otherwise, etc)

Academic Participation

Student responsibilities:

- **NEJM Healer:** The medical student will utilize the New England Journal Of Medicine Healer platform to complete the required modules during the clerkship. **Completion of 8 case modules, as assigned, is required to be completed by 11:59 pm the last Wednesday of the clerkship.**
- **Reading:** *Essentials of General Surgery and Surgical Specialties 6th Ed.* Read about the diseases and procedures you see each day. There are quizzes at the end of each chapter. In addition, there will be required topics that are essential for learning and passing the exam at the end of the rotation. In addition to this text, you may have suggested reading given to you by your attending surgeon. You should discuss these topics with the surgeon at your site.
- **Patient Encounter and Procedure Logs:** The Patient Encounter and Procedure Log for the Surgery Rotation is found in the New Innovations Software System. On a daily basis, the student should enter data from their clinical shift into the log. Input your procedures and all cases you scrub in for, into New Innovations. All logged patient encounters should include the following basic information: the date the patient was seen, the patient's age, and patient type if applicable. Students must submit their completed Patient Encounter and Procedure Log electronically through New Innovations. **This case log must be entered into the New Innovations no later than 11:59 pm on the last Wednesday of each rotation.**
 - Bedside procedures:
 - Staple or suture skin
 - Physical exam of an acute abdomen
 - Drain or staple removal
 - I and D or needle aspiration of an abscess
 - Dressing Change
 - IV placement or blood draw
 - Foley placement
 - Incentive spirometry teaching
 - NG Tube Insertion
- **Lecturio Quiz:** The medical student is required to take and pass, with a 70% or higher, the Lecturio Quiz associated with the rotation **by 11:59 pm the last Wednesday of the clerkship.**
- **Mid-Rotation Evaluation by Preceptor:** The medical student is required to meet with their preceptor and have them complete a mid-point evaluation of their performance, for each rotation. This evaluation must be uploaded into Leo for Clerkship Directors to review **by 11:59 pm the second Sunday of each rotation.**
- **Clerkship Evaluations:** The students must complete clerkship evaluation(s) in New Innovations regarding their rotation experience. Student feedback received from the evaluations will assist the Office of Clinical Education in the overall assessment and improvement of clinical rotations and the implementation of faculty development programs. The evaluations must be completed **by 11:59 pm the last Wednesday of each rotation.**
- **History and physical exam review:** A major portion of your time will be devoted to conducting patient histories and physical exams. This is a tremendous opportunity to learn how to interact, gather information and diagnose the disease and treat patients.

Failure to complete any of the pre-requisites for COMAT eligibility, in a timely manner, will result in disqualification from Honors and may result in a finding of non-professional conduct and may lead to a Corrective Action.

Content outline for the COMAT (Comprehensive Osteopathic Medical Achievement Test):

The student should be able to diagnose and manage patients and clinical cases that involve:

- 1) Hernias: adult and pediatric (Ch. 11, 13)
- 2) Breast and endocrine: thyroid, parathyroid, adrenals, pancreas, pituitary, and other glands (Ch. 18,19)
- 3) Fluids and Electrolytes: shock, fluid and electrolytes, surgical nutrition, coagulation and blood. (Ch. 2,3,4,5 and 6)
- 4) Gastrointestinal: esophagus, diaphragm, stomach, duodenum, small intestine, large intestine, rectum and appendix (Ch. 12,13,14,and 15)
- 5) Urology, gynecology, and pediatric general surgical issues: (Ch. 29)
- 6) Hepatobiliary: pancreas, biliary tract, liver and spleen. (Ch. 16,17, and 20)
- 7) Osteopathic principles and practice in surgical care: somatic dysfunction, viscerosomatic relationships and OMM treatment techniques. Use texts from your first 2 years.
- 8) Surgical oncology and pathology: (Ch. 22)
- 9) Trauma: musculoskeletal injury and fractures, blunt and penetrating chest injury. (Ch. 9, 28)
- 10) Wounds and infections: skin and subcutaneous tissue, immunology and transplantation (Ch. 7,8)

Review the surgery objectives and requirement on the NBOME website. www.nbome.org/comat-su.asp

Assessment and Grading

Elements of Core Clerkship Grading

Each core clerkship will have three elements contributing to the final grade and each element must be individually passed to Pass the clerkship:

- Clinical Performance-Preceptor Evaluation(s)
- Professionalism
- Cognitive Performance-COMAT

Clinical Performance-Preceptor Evaluation(s) will be graded by the supervising preceptor. This assessment (see Student Assessment Forms in the Clerkship Manual) includes eight (8) questions designed to assess academic skills and core competency acquisition. Students are expected to achieve a score of 3, 4, or 5 for each domain. An average score of at least 2.85 on all observed skills and competencies must be obtained to pass this element.

Professionalism is a graded component in every clerkship evaluation. Students must receive a minimum score of three (3) on the preceptor's assessment of Professionalism (Question 5) to pass this element.

Cognitive (COMAT) Performance will be measured by the end-of-rotation COMAT exam. The NBOME provides a conversion table to obtain a percentile rank from the student's raw score. A minimum raw score of 85 is needed to pass this element.

Eligibility to sit for COMAT

The students must complete the following pre-requisites to be eligible to sit for COMAT:

- a) The students must pass, with at least 70%, the associated specialty Quiz in Lecturio. This test is timed. In case of failure the student will have a chance to retake the quiz. The student will not be penalized for failing the quiz for the first time. The passing grade for the quiz must be received **by 11:59 PM the last Wednesday of the clerkship**. If a student fails the first attempt, one additional attempt will be granted before the deadline.
- b) Completion of all case modules is required to sit for COMAT. The deadline to complete the cases is **11:59 PM the last Wednesday of the clerkship**.
- c) Students must submit their completed Patient Encounter and Procedure Log electronically through New Innovations **by 11:59 PM, the last Wednesday of each rotation**.
- d) Students must submit the completed mid-point evaluation into the learning management system by **11:59 PM the second Sunday of each rotation**. This assessment includes eight (8) questions from the Clinical Performance evaluation, designed to assess academic skills and core competency acquisition. The purpose of this evaluation is for the student to receive feedback from the preceptor at the mid-point of the rotation, so they may improve over the course of the second half of the rotation. The student is responsible for obtaining this evaluation from their preceptor at the end of week two of all clinical rotations, and it must be uploaded into the learning management system (LEO) for the Clerkship Directors to review. A sample form is located at the end of the Student Clerkship Manual.

- e) The students must complete clerkship evaluation(s) in New Innovations. Students are required to complete evaluations in New Innovations regarding their rotation experience. Student feedback received from the evaluations will assist the Office of Clinical Education in the overall assessment and improvement of clinical rotations and the implementation of faculty development programs. An annual summary of student comments will be reported **anonymously** to preceptors and training sites to assist them in making improvements to the rotations that they provide. **The evaluations must be completed by 11:59 PM on the last Wednesday of each rotation.**

Failure to complete any of the pre-requisites for COMAT eligibility in a timely manner will result in disqualification from Honors and may result in a finding of non-professional conduct and may lead to a Corrective Action.

Failure of a Core Clerkship:

Failure of two or more elements of rotation grading (Evaluation, COMAT, Professionalism), including two failures of the same element, above will result in a failure of a clerkship and the student will be referred to Student Performance Committee (SPC) with recommendations from Clerkship Director.

Failure of the Professionalism element may result in a Professionalism Corrective Action, or Failure of a Clerkship, as determined by the Clerkship Director.

Students who fail a clerkship are ineligible for an Honors (H) designation in that specialty.

Corrective Action

Failure of one element of rotation grading generally does not constitute a failure of the entire clerkship. When a student does not meet expectations for a clerkship/course as defined in clerkship syllabi, the College may require a student to engage in corrective action to remedy the deficient academic grading requirements. The opportunity to engage in corrective action for the one element failed is at the discretion of the clerkship director of the specialty. This may occur at the end of a clerkship or in the middle of a clerkship/course.

If a student successfully completes the corrective action process, as determined by the Clerkship Director, the student will receive credit for the deficient academic grading requirement(s) and be eligible for a change in rotation grade [from I (Incomplete) to P]. If all assignments within the corrective action process are not completed successfully by the deadline the student will receive a failed grade (F) for the clerkship and will be referred to SPC for Failure of a Clerkship. Students who are provided a corrective action opportunity are ineligible for an Honors (H) designation in that specialty.

Attainment of Honors

Attainment of Honors (H) for each core rotation will be limited to the highest performing 10% of the class based on cumulative points earned for the rotation. Honors for all core rotations will be determined at the end of the academic year when all final assessments have been recorded. The Clerkship Directors will identify the top 10 % of students who will receive the honors designation.

All Year 3 requirements must be successfully completed to advance to Year 4. The need to repeat any failed clinical rotation(s) may result in a delay in graduation.

Course Communication

Students are expected to monitor their Burrell College of Osteopathic Medicine email and are responsible for all communications sent to their official email address. **Students are also expected to monitor E-mail, Leo, New Innovations, and other applicable platforms.**

Clerkship Director
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	El Paso Regional Assistant Dean	
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	Palm Beach, FL Regional Assistant Dean	
	Southwest, FL Regional Assistant Dean	
Amit Sharma, MD	Space Coast, FL RAC Regional Assistant Dean	amit.sharma@bcomnm.org
Jerald Moser, MD	Tucson Regional Assistant Dean	jmoser@burrell.edu

Policies and Procedures

Information regarding course grades, attendance (including excused absences), exam procedures, remediation, appeals, acceptable use of technology, honor code, professional attire, and related policies are stated in the current Student Handbook. Policies regarding non-discrimination, accommodations for disabilities, and Title IX are also referenced within the Student Handbook. All policies and procedures stated therein will apply during this course.

The [Student Handbook](#) may be accessed through the Burrell College of Osteopathic Medicine website.

For information regarding emergency or inclement weather, refer to the [Campus Safety and Security page](#) on the Burrell College of Osteopathic Medicine website.

For information regarding Clerkship Rotations, refer back to the [Student Clerkship Manual](#) on the Burrell College of Osteopathic Medicine Website.

Statement Regarding Reservation of Power

The curriculum, assignments, schedule, syllabus, and any information contained within the course can be altered or changed at any time. In the event of any alterations during the course, students will be informed officially through their Burrell College of Osteopathic Medicine email. It is the student's responsibility to obtain the changes or notices even if absent from class.

Appendix

A. Programmatic Level Educational Objectives

Graduates of the Burrell College of Osteopathic Medicine Doctor of Osteopathic Medicine degree program will be able to:

1. Integrate knowledge and skills acquired from the biomedical, clinical, social, and behavioral sciences to provide patient care in a supervised setting.
2. Demonstrate competence in the skills of osteopathic manipulative treatment and the application of osteopathic philosophy in patient care.
3. Demonstrate professionalism, characterized by honesty, integrity, ethical behavior, empathy, and responsibility.
4. Communicate effectively with patients, families, faculty, peers, and other members of the healthcare team.
5. Critically appraise, evaluate, and apply scientific evidence to inform patient care and research.
6. Demonstrate awareness of the roles and interactions of professionals within the healthcare system and identify resources to optimize patient care at the individual and community levels.
7. Identify the specific healthcare needs of diverse populations and the ways in which the medical community responds.

B. AOA Osteopathic Core Competencies

1. Osteopathic Philosophy and Osteopathic Manipulative Medicine
2. Medical Knowledge
3. Patient Care
4. Interpersonal and Communication Skills
5. Professionalism
6. Practice-Based Learning and Improvement
7. Systems-Based Practice

