grading medical student presentations created by a group of medical educators across many core specialties. The tool is comprised of 18 items divided into six sections, with an overall rating at the end. According to the original study, the tool had high inter-rater reliability, and a randomized controlled trial performed during a third-year pediatric clerkship showed that the intervention was significantly better than unstructured presentation feedback. We used this validated tool as a framework to create a rubric for EM-focused oral presentations using established EM guidelines. The critical elements of an EM oral presentation, as established by Davenport et al. in "The 3-Minute Emergency Medical Student Presentation: A Variation on a Theme," were built into our novel rubric. Following the tenets of the published EM literature, our rubric has an emphasis on pertinent information, a focused exam, concise summary without unnecessary information, and an assessment and plan that provides a differential diagnosis and addresses the most important issues.

Impact/Effectiveness: This rubric was used in our study of medical student presentations, "Teaching and Evaluating Medical Students' Oral Presentation Skills in Emergency Medicine," which documented an improvement in oral presentations after fourth-year medical students used a formalized self-didactic curriculum. We anticipate that this rubric will be incorporated into EM clerkships, improving educators' ability to grade and provide feedback on medical student oral presentations. In the long term, this rubric will allow for standardized evaluations of students from different backgrounds and medical schools.

STUDY ID: __________ Patient Presentations in Emergency Medicine: A Medical Student Curriculum
HSC-MS-17-0579

PATIENT PRESENTATION RATING TOOL

Evaluator ____________ **Month (circle):** July / August / September / October **Timing (circle):** Beginning of rotation / End of rotation

Note: Please use a score of 3 to indicate performance that is at the expected level for a fourth year student

HISTORY

1. Chief complaint noted as part of introductory sentence

1	2	3	4	5	Questions/Comments
No Chief complaint		**Chief complaint mentioned**		Chief complaint clear	

2. HPI starts with clear patient introduction including patient's age, sex, pertinent active medical problems

1	2	3	4	5	Questions/Comments
No introductory sentence		**Intro included CC and most pertinent information**		Intro painted a clear picture of patient	□ too much □ too little

3. The HPI includes only relevant PMH and ROS without non-relevant ROS or any physical exam findings

1	2	3	4	5	Questions/Comments
Information has no clear connection to the active medical problems		**Information adequately describes the patient's active medical problems**		Information completely and concisely describes all active problems	□ too much □ too little

PHYSICAL EXAM

4. Includes a targeted physical exam **including relevant vital signs** stating the positive and negative findings that distinguish the diagnoses under consideration and any other abnormal findings

1	2	3	4	5	Questions/Comments
Either too much or too little information given		**Most important information is given with vitals**		All important elements of vitals and PE given	□ too much □ too little

SUMMARY STATEMENT

5. Begins assessment with a summary statement that synthesizes the critical elements of the patient's chief complaint, HPI, and pertinent findings on physical exam

1	2	3	4	5	Questions/Comments
No summary statement or restatement of story without synthesis		**Most pertinent information synthesized; may repeat some unnecessary information**		Summary statement concisely synthesizes all key information	□ too much □ too little

ASSESSMENT AND PLAN

6. Provides an appropriate differential diagnosis including top "not to miss" diagnoses

1	2	3	4	5	Questions/Comments
No differential diagnoses are given		**A Ddx with several possibilities is given for major problems**		Extensive Ddx with most likely dx and "not to miss"	□ too much □ too little

7. States the diagnostic/therapeutic plan that targets each problem; each item in the plan relates to something listed on the prob list

1	2	3	4	5	Questions/Comments
Patient plan is not described or is unrelated to the problem list		**Plan for the patient addresses most important issues, may omit active but lower priority problems**		Patient plan is complete and relates directly to the problem list; all active issues are included	□ too much □ too little

GENERAL ASPECTS

8. Body language and speaking style

1	2	3	4	5	Questions/Comments
Difficult to understand with distracting gestures		**Mostly understandable and engaging with acceptable body language**		Understandable and engaging speaking style, professional body language	

9. Length of presentation

1	2	3	4	5	Questions/Comments
Too long or too short in length		**Mostly appropriate in length, may be a little too long or short**		Appropriate length for complexity of patient	

Comments:

34 Emergency Medicine Residents as Mentors: Toward a Curriculum on Mentoring

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Background: Mentorship is critical in all stages of career development. Emergency medicine (EM) is increasing in popularity as a specialty choice, which increases the need for emergency physicians who can mentor medical students pursuing careers in EM. Students have traditionally sought mentorship from EM faculty. However, students are not directly exposed to EM during the clerkship phase of the curriculum, limiting their interaction with EM faculty and making early mentor identification difficult. Simultaneously, while residents are expected to be educators, mentoring is often not explicitly taught or practiced. Thus, we created a resident-student mentoring program for students exploring careers in EM.

Educational Objectives: Our aim was to develop a resident-student mentoring program to provide senior medical students advice and support as they consider a career in EM and apply to residency, while providing EM residents a formal opportunity to develop mentoring skills.

Curricular Design: Interested senior medical students were assigned a volunteer senior resident mentor. Residents and students were introduced via e-mail. Contact information and mentoring program goals and expectations were provided. Residents were given core articles on mentoring. Residents and students attended two group events to discuss mentoring and pursuit of an EM career. Each dyad also arranged individual meetings.

Impact/Effectiveness: Of 26 residents**,** 25 (96%) volunteered; 15 residents and 15 students participated in the program. After the 2016 Match, participants completed surveys regarding their experiences: 6/15 (40%) residents and 10/15 (67%) students completed the survey. All (6/6) of the residents agreed or strongly agreed that "I enjoy being a mentor" and all (6/6) would recommend the program to a colleague. Of the nine students surveyed, eight (89%) reported they would recommend the program to other students. The mentoring program was feasible; students did not overwhelm residents with requests and students found residents welcoming and easy to contact. Both groups enjoyed the program. Further development of the program includes a formal curriculum on mentoring, relation of program participation and resident job satisfaction, and expanding to junior medical students.

Table: Comparison of resident and student responses regarding mentoring activities

Statement		**Resident Response (%)**	**Student Response (%)**
The amount of contact (either in person or via phone, text, etc.) was	Too little	5/6 (83)	3/10 (30)
	Just right	1/6 (17)	7/10 (70)
	Too much	0/6 (0)	0/10 (0)
The number of group activities was	Too little	3/6 (50)	2/10 (20)
	Just right	3/6 (50)	8/10 (80)
	Too much	0/6 (0)	0/10 (0)