CNCD Work Group on ED2/Core Curriculum

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ED2 Background

In June, 2007, the LCME amended its standards for all clinical clerkships and now requires that:

a system be established to specify the types of patients or clinical conditions that students must encounter and to monitor and verify the students' experiences with patients so as to remedy any identified gaps. The system, whether managed at the individual clerkship level or centrally, must ensure that all students have the required experiences. For example, if a student does not encounter patients with a particular clinical condition (e.g. because it is seasonal), the student should be able to remedy the gap by a simulated experience (such as standardized patient experiences, online or paper cases, etc.), or in another clerkship.

Purpose of Work Group

There is not currently an AAN recommendation that details how neurology clerkships should meet the ED2 requirement. Recognizing that each medical school and neurology clerkship will have individual needs and objectives, we sought to draft an AAN recommendation to provide support and guidance for minimal ED2 standards for neurology clerkships that are reflective of our AAN core clerkship curriculum.

Process Used

The work group members were volunteers from the April 2008 CNCD meeting. From 8/08–3/09 monthly work group meetings were held via conference call. We used the following principles in creating this guideline:

- Review of what clerkships are currently doing to meet the ED2 requirement, identifying common themes and priorities.
- Create recommendations that complement the AAN Core Curriculum and maintain its nomenclature.
- Recognize we are primarily educating future non-neurologists.
- Create a recommendation general enough so that it is easy to use and widely applicable to different clerkship structures.
- Focus on symptoms rather than diseases. We focused on symptoms presentation rather than diseases to allow for greater flexibility and allow for emphasis on the systematic evaluation and differential diagnosis of neurologic complaints, localization, and performing a competent neurologic examination based on the presenting symptom.

- Focus on most common symptoms and neurologic emergencies.
- Use of data collected and analyzed by Richard Isaacson and Alon Seifan on the frequency of different diagnoses seen in neurologic consultations.

ED2 Core Curriculum Recommendations

These suggested exposures can be met by a variety of different means: live patients, case discussion, written cases, simulated patients, standardized patients, web-based modules.

Symptom Complex	Examples
Transient or paroxysmal alteration of neurologic function	seizure, epilepsy, syncope, TIA, sleep disorders, vertigo, dizziness
Change in mental status	acute or chronic change in mental status, including: encephalopathy, coma, dementia, stroke, brain death, sleep disorders, developmental disorders, aphasia
Weakness of alteration in motor system	diffuse or focal weakness, clumsiness, involuntary movements, gait disturbance, diplopia, dysphagia, dysarthria, urinary or bowel incontinence; possible etiologies include: multiple sclerosis, stroke, Bell's palsy, developmental disorders, essential tremor, Parkinson's disease
Headache or focal pain	acute vs. chronic pain syndromes: migraine, tension headache, rebound headache, secondary headache, facial pain, neck pain, back pain, neuropathic pain
Numbness or paresthesia	sensory disorders associated with: peripheral nerve, nerve root, spinal cord or brain disorder. Possible etiologies include: stroke, multiple sclerosis, myelitis, carpal tunnel syndrome, diabetic polyneuropathy
Neurologic emergencies	Possible examples include: a. Acute stroke (ischemic or hemorrhagic) b. Status epilepticus c. Spinal cord or cauda equina compression d. Toxic-metabolic encephalopathy e. Meningitis/Encephalitis f. Head Trauma g. Subarachnoid hemorrhage h. Increased intracranial pressure i. Acute motor weakness or respiratory distress due to neuromuscular disease (e.g.,myasthenic crisis or acute demyelinating polyradiculoneuropathy) j. Sudden vision loss (e.g., acute monocular and acute binocular visual loss) k. Neuroleptic malignant syndrome l. Hypertensive encephalopathy m. Stupor and coma n. Sedative withdrawal and delirium tremens

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