Joseph Washburn: So, for today's meeting we're going to talk about, we're going to review some of the last terms clinical and field preceptor comments for some of the students what they said about our students. Maybe some areas we may need work on or something like that, and then you brought us some, from what I had done some clinical thus far since they haven't done a field, yet and then we need to make sure that we have this kind of as a regular meeting as part of your oversight to know what they're doing the clinical and field as well.

Dr. Rodi: So, for some said they had field time.

Joseph Washburn: Well none of them to have had field time that you have right now, because they don't start that summer so the only field time they would have had would have as an EMT

Dr. Rodi: maybe that's something that that's probably what they meant.

Joseph Washburn: Because the first part of the spring is with you and clinical and then in the summer it's more clinical but mostly we do OB and Peds and then they do that first.

Tammy: Some are working.

Joseph Washburn: yeah that's what they mean yeah and then we have a chunk of right time, in the summer and then they have a big chunk at the end of the year so. All right, so what you got?

April Bollinger: Okay, so this is for the 2019-2020 cohort. So, some positive that we received from preceptors was that they are displaying professional behavior, they've delivered high standard of care for patients, they anticipate patients needs before the patient has requested it. Some concerns that have been addressed are asking more questions.

Dr. Rodi: they're what they're asking more questions?

 April Bollinger: they want the student asking more questions.

Joseph Washburn: so probably I’m assuming and during their assessments, maybe they're not asking enough assessment question is. It could be that, or does it mean as a preceptor more questions yeah so. When we looked at those we tallied the most common ones, so maybe we need to dive deeper in our next cohort that we talk to the students saying listen if a preceptor needs to ask more questions asked them to clarify that already or is it oh yeah. So, if you see that, when they upload their documentation of preceptor who, that is if you give you the name, we can backtrack it to the to you know if it's Lee or Collier or wherever, and then we can maybe reach out to a preceptor and see if they can clarify that a little deeper for us.

Dr. Rodi: It could be either one.

 Joseph Washburn: your right, it could be, you know it's hard to say so.

April Bollinger: That was the only concerning clinical.

Dr. Rodi: Was that consistent?

Joseph Washburn: well yeah what we did is we tried to try to grab some consistency there so yeah.

Dr. Rodi: but not doesn't fit right, we need to start verifying. They asked questions of me. I don't see them the triage but the nurses in triage say they do a good job and ask questions and let them take some of the lead when they are out there. That’s only ability to get somebody that nobody else has seen or talked to yet so that they can't look at the charts oh well, you know.

Joseph Washburn: well April definitely feel if it is happening and just in clinic April will be able to talk to the people that are doing clinic with them outside of you like outside of ER the ones that are on all. You already know, will do their Peds or their Ob you'll be able to ask those preceptors right away if yeah if you see that so we'll be able to get clarification.

 Dr. Rodi: There are two techs that take them to do IV stuff and they always getting feedback and tell me how they are doing. So, she was the only one that seven some problems and tech told me, she was tentative and they're still.

April Bollinger: then in the field, so that was for clinical for that cohort and the fields some positives was choosing the correct treatment, great job with assessment treatment and interaction with patients, great IV skills and lead interpretation, differential diagnosis spot on a couple of them wrote that. For concerns again the same as clinical they said, ask for in-depth questions of patient when patient is vague. For field some concerns were low call volume. Starting an IV sooner, recognizing that they need to start it sooner and then continue to work on skill sets, taking into consideration priority tasks.

Joseph Washburn: So, I think that it will help them, because in the ER they start getting this triage. So, most patients are going to get an IV so, then that should reinforce the necessity of having a line. Unfortunately, in the field, I will get patients frequently that don't have IVS and should have had an IV and there'll be one excuse or another, I couldn't get, or we didn't have time. I see that in the field in the ER you don't see that you know nurses’ techs they go around and boom if there's any question they need labs they throw a line in. That should help enforce and assessing the having access, I think.

April Bollinger: And that was the pre-covid cohort.

Dr.Rodi: Some of my shifts I work six to four in the morning or four to two but in end up staying till five or six because it’s so busy. There is one doc till one or two, so I stay this way they can stay to see what's going on one guy wanted to stay for days, I said you can’t do that. I said, these other people right here, these other physicians and providers, they don't want you around.

April Bollinger: I’m sure, especially now with the trauma unit there it's even more interesting

Dr. Rodi: Oh, they don't even want to stay, providers not students, the docs don't even want to stay in the trauma surgeons once you're there to do the airway to help with sedation you know these guys they go and if they don't need an airway they leave we got an email about hey you know you're supposed to be in here, but I mean when you have four docs on it four PAs during the day, why aren't you I go in there it's just me. You know I have, I have a PA but that's not enough with 20 patients to be seen in the waiting room. So anyway, it's a change from the usual Monday garbage so I don't mind doing the trauma. Students love it.

April Bollinger: Alright, so now, this would be our cohort that went through the covid. So, some positives that we received back on them, so this was the most recent cohort that just graduated great patient assessments and clinically, great IV skills, great critical thinking skills and great treatment plans. They were strong group.

Joseph Washburn: For the for the covid I think so.

Dr. Rodi: So the current changes with EMS now will be starting within the next few months it's going to be the elimination of protocols> And I can call guidelines and they're going to be very expensive okay so there's no more, you have to go by the protocol, when we were going to fire you or you know, whatever they were doing so that's a good thing, Dr Perra is, you know very intent on putting out a document that will help support the medics will show them different treatment regimens because the agency's my agency and Keiths use treatments, we might go by county I mean they're in there, but we don't have other things, plus intubation is coming back or, RSI is coming back so. They will have a whole different experience if they come and work for Lee county EMS and what they used to have, which means currently people in the ride time and all that stuff will be actually starting. I would say, probably by the end of the summer, will have all the guidelines finish so they would actually start under a new format kind of.

Joseph Washburn: Well the would be good, because capstone starts in August, for this group, that we have now, and so they'll start their capstone under these new guidelines. That'll be that'll be good that'll be good, and then the new guidelines and they'll be able to do there are 300 hours ride during that new stuff so that'd be good to see.

Dr. Rodi: It will give them critical thinking experience outside what I do with the critical thing when I do the all the alerts and get that's what I take them with me and we do the alerts to be done. You know, have them give me their input, not in the beginning, the first couple I don't I just show. But then, after that, we talked about will be so on calling, because I have a little more time and those types of things I just don't with the regular patients. That's good, and so we do so you do a good job with assessment you do a good job with professionalism. The IV is a skill and you know people are good or bad right it's practice yes. Yeah, I mean it's the same with assessment and differentials, but when I do a lot.

Joseph Washburn: But I would say, with this group that you're talking about when they said they had good IV skills from the first group that you heard about I did increase the number of peers to peer as they had to do prior to getting signed off in their initial skills, plus.

Dr. Rodi: well, you can make the count of what they do with me, you can find out if you want to add more IVS because, believe me, there's least 50 or 60 on the shift yeah that I have that need IVS blood draws yeah and out of that probably 70% need EKGs and I want them to see the EKGS and how they're done, you know, and some of them have actually done the EKGS after they've been shown how to do them which is what I want done. What's important and what bothers me you know about the ER EKGS is you'll get a tech to do an EKG and they’ll hand it to you and I’ll say so, what is the show. I don't know how to read it. I think you do an EKG if you don't have to read it, you don't know where to put... Oh, I know where to put the leads, why do you put in there, I don't know. So, I tell the medics I said look, you need to understand these works right, I need understand why you're doing what you're doing and they've been good about. Some of that of them haven’t had cardiology EKGS so.

Joseph Washburn: While they're there they're wrapping that up now, but I will tell you that when we did their skills. The first semester, and we went over lead placements, and all of that, you know we do stress to them, the importance of proper lead placements and then they come back and say well you know when we get a ride time, they just put them here and here and I’m like okay well there's a right way to do it and that's what we're teaching you and then there's the well, I think I know better way and they put it on here, and I say to them, you need to do it the right way that's why we teach you this.

Dr.Rodi: So that's why, as an aside to say this to them, but that's why, when we get a call from Lehigh that’s a Stemi alert we snicker. Nobody in the group will call a Stemi based on the lead EKG why we're doing so, nobody calls stemi alerts, I mean it has to be just you know so obvious that we can't be anything other than a stemi and that's kind of where most of the stem you’re it's a call for instance, so we wait till the patient comes into that we too late. But that's just in that situation of that stuff everybody. So, what do they want to see more they tell you that?

April Bollinger: And they said they want kind of not really. We’ve asked the students this cohort to be more specific, when they're requesting comments, because these are broader so they yeah, they want to see more skills. They want to see them take charge more.

Dr. Rodi: wait okay so let's back up saying they want to see how to do more, skills and they were seeing more skills done by the ca’s in the medical field me?

April Bollinger: it says continue to build upon skills.

Joseph Washburn: so, I think the thing to Dr Rodi is that in our review of the comments, what I think really, we identified was there was more non-comments than there were comments right they were just scores. Like for nothing there, so what I asked April to do was now make it mandatory that they are to know to get at least one thing that they've done well, and one thing that they can work on from there preceptor. So, we're asking them to get both of those so that we can get a better assessment of them in the field.

Dr. Rodi: So, the only skills are going to see in the ER. Probably most common skill is going to be intubation that I do three or four every shift. Now central lines, the trend has been for years, getting away from central lines occasionally we do jugulars and actually one of the students got to do a jugular. We had like three of them that night and my tech who does them showed him how to do it, so he did watch it I’m going to do the next one, he let him try and he got it and then the third one, he let him put it as well, so I forget who was one of the guys didn't want to go home there was like two or three so. But that's not common to see yeah. Chest tubes I haven't been one instance that go girl came in that was run over by her father in the driveway and that's the three months so chest tubes aren’t common. What else are they doing needle thoracotomy we don’t do those we put a chest tube in. I've had one cric in the last four months. First, student did CPR trauma arrest where we did do chest tubes so that's student get to see all that. But yeah some more skill other than the basic stuff it's really hard yeah.

April Bollinger: So, if they get a comment like that need to ask them hey you need to ask your preceptor what exactly they are looking for so that we can we can help you. And then, for the field for this group is a good bit bedside manner, great interaction with patients again excellent differentials and then some concerns for this group was good scene presence, they needed they needed to establish that presence

Joseph Washburn: Well, I think what I think that some of them can be saying that towards is depending on when that person did their ride, you know some get intimidated right away and kind of try to try to fall back in the crowd not necessarily jump out into the lead, so it could be something as simple as that.

Dr. Rodi: You really and I don't mean it in a negative way not but all the guys have liked it. And it's fun to learn yeah they just want to you know, be able to make sure I do this and I did it and I go and watch this you know show them how to reduce some fractures. Good and I, like their attitudes. We just have to address some of these things I’m not sure I understand what it is they're asking what it is they are saying.

April Bollinger: Field medication knowledge, and priorities of life.

Dr, Rodi: what does that mean?

Joseph Washburn: So, I’m not positive about that, but sometimes I think that the students get so focused on. things that they want to do, and not really look at the patient right so what's the priority here on this patient's life is it your patients breathing do you need put your EKG on or do we really need to be ventilating. You know because you get you get some of those students that are so I need to get all this done but you're not looking at the patient realize that these are priorities in order to maintain their lives.

Dr. Rodi: So what I done with students to come with me for the patients sicker that I know I’m going to have to intubate, so I always start out by saying what is the LIFE threat. I don't know if we use that terminology, yes and class I would assume we did we do, because the LIFE threat is what you're there for my not there, because they stubbed their toe and it's broken you're there because we're having another issue is going to kill him if you don’t do something so they seem to get that I mean I don't see where they're know clueless so right, but I also don't know if I just happened to have the students that are more attuned to those things right now I mean I only had on the floor 10 maybe.

Tammy Mole’: Yeah last cohort he didn't get to see anybody.

Joseph Washburn: I can attest, as far as when it comes to the pharmacology. I definitely feel like I’ve made great strides in the last two classes you know, obviously it's time eyes every I deliver it based on Okay, this time I delivered it with no basis, so I learned from that one to deliver it with this group and learn okay I know what I need to do I caught what I missed here, but now there's other things that need to do for the next group I know what I need to deliver now to cover with I didn't catch with these two groups so it's just kind of like a work in progress, but I do know is that from our original site visit back in 2016 to today we are light years ahead of what we're putting out as far as pharmacological knowledge base, where you get a much better, much better is.

Dr. Rodi: I try to explain why I’m using particular medication it's, then I find that's really important and critical patients trauma alerts, for instance they'll come in and it depends on what's going on I’ll either dissociate them with ketamine will medicate them with some pain medicine. Some cases they're seizing so I always talk to them about okay I’m using this medication, what is it that's. Why am I using it this way? What are some of the problems associated with it, so in the beginning, when, and this is, in particular with the alerts whenever trauma, stemi. In the beginning, especially trauma trauma surgeons don't want them the bedside it gets too congested and but, once we do our initial assessment they're standing over here and they're seeing what we're doing once we do that, then I get them talking to me about what we're doing Why am I doing this, you know what should I be thinking, this is what you should be thinking of so. I think this is just going to get better yeah like if I don't retire in a year.

April Bollinger: This is the only two students, so far, we just implemented but going to be uploading your paperwork, so you can see it throughout the semester and not wait till the end so far, the Ryan and Sam for the two students that uploaded their paper work and they said great learner open willing eager to find experience. Provided age appropriate assessments this was on pediatric unit provided each size appropriate age size equipment for pediatric patients and then for Sam exhibiting professional knowledge. And I read these earlier, so I’d know what they said. Ask the questions towards patient and staff is confident in his abilities, it was a pleasure to work alongside.

Dr. Rodi: I have to say the current group is a lot different from when we first started doing this few years ago with those guys would sit in a room play on their phone or they would you know do some other busy work they didn't even go see patients, you know it's a you know to come see a patient or a triage and do some things using get the history, you know start from scratch for these people oh so umm.. never mind sit here.

Joseph Washburn: Well and I think I think that goes back Dr. Rodi to the fact that we, we are more selective to now before it was we let everybody in here, you know and that obviously, was a problem and so now we're really making people want to work to get into the program but wanted to be there yeah.

Dr. Rodi: that just proves what we have done in terms of changing the way we do yeah and selection change yeah.

Joseph Washburn: I think our selection is a difference, I also think that you know every semester there's something more that we raised the bar to make them reach for so.

Dr. Rodi: I have to tell you there's two students there from somewhere that they're different every weekend but there's two medic students I don't know what school or from I can't read, there are things there in these dark uniforms and they have red looking patches but I don't know what it says.

Joseph Washburn: you saying that they're good, are you saying?

Dr. Rodi: I’m saying that they sort of hang out in the back when our students are there.

Joseph Washburn: Maybe they're either Braxton or Hodges.

Dr. Rodi: They don't get involved. You know, like in the trauma room they'll be all the way in the back against the wall. They are not with anybody. That's what I mean they're sort of if I’m doing something with our medic student take your trauma stuff you know generally sick patients there in the room, listening to what I’m saying, but I don't know they're not with anybody there's no preceptor there.

Joseph Washburn: They can send them to the to the ER without necessarily having to be there, well I would say, the reason why they're there at night is because you know Lee is making it very challenging for us to even get spots in different areas, and so it could be, it could very well be .

Tammy Mole: we've really made it we've definitely improved upon the G report and making it known that hey you guys really need to get these done so they're not waiting until the very end to try not to try and get them in their capstone or something, but something like that you know. We make it very, very known to them from the very beginning in there in lab with Joe and you know lecture because we have Rima or whoever it is going there and say okay, this is your report, you need to familiarize yourself with it, you know you need to hit all these numbers, because if you don't you're not going to pass all this work and then.

Dr. Rodi: Oh they've been very good about writing down everything that I tell you put everything you see you putting the CSM number don't put a name just put a CSM Member and what you did and I mean they all nobody seen three people in 10 hours, so I know that they're involved in what the techs tell me.

Dr. Rodi: So did they give students give you anything indication of what they wanted more of.

April Bollinger: yeah no I have not looked at their paperwork and we probably have to. I will discuss it with them, because we have to have a meeting I got to figure out a date for a meeting to fill out paper work for the summertime.

Dr> Rodi: yeah just like to know what it is they, they want to see. Understanding that it's not as if you're going to a diner and order, a sandwich. No you're going to see what's what you see, but I can't control what we get like that so but it'd be interesting to see what it is they, like or don't like. That format that you use with their paperwork. Is that Coaemps or is that something.

Tammy Mole’: No I think it's a form that we created.

 Dr. Rodi: Because I find that for what I do what they're doing with me, that is not particularly useful.

Joseph Washburn: What would like to see change?

Dr. Rodi: I don't know I’m asking you, where this is from?

 Joseph Washburn: It is not it's not a Coaemps form, I think it was developed back when we had Corey and Chris and Joe Berry and all that, I think developed that form overtime.

 Tammy Mole’:Coaemps doesn't have a form either.

Joseph Washburn: So do you want something different for you, because we could do that

Dr. Rodi: yeah I think for what I do we have to look at it a little differently so, for instance let's just take the psychomotor skills was able to thoroughly to describe all elements of all procedures and could accomplish psycho motor skills independently and professionally, not usually not in the very beginning, maybe, by the time they've done the shift they could Okay, but I don't watch him start ivy's right. I go by what the techs say to me yeah he started at seven ivs and was great.

Joseph Washburn: let's create an evaluation throw so how about doing an eval for when they are with you separate of that.

 Dr. Rodi: yeah I think we should do something okay so.

Joseph Washburn: Is there something specific you want to see in your eval we will do a couple drafts.

 Dr. Rodi: I will try to critically think okay to be able to do it's an assessment and from what you're telling me it seems like they should be able to do that yeah and to offer treatment options. To be able to tell me or exhibit in their history of the patient, what is important and that's part of the assessment so but it's also critical thinking okay so. I also wanted the skills, I wanted to have is starting ivy's very important I have nurses or ER nurses and can't start a damn IV which cancels me off to no end, didn't get the IV you're an ER nurse she's been doing this for 20 years you can't get an IV. I’m too harsh because I tell them, you know what you've come to me, but you can't get an IV, you know i'm going to do i'm going to put one of their neck and then you're going to have to deal with It is, and then you know now you have to write this big thing, the same thing goes oh that's a source of infection right we don't want to do those I tend to this they'd love it when I do it, you know but they're not going to do it because of all that other stuff that goes on Oh, they got an infection it’s a central line. I'm interested in their practical skills and their ability to do an assessment at least have an idea of what the treatment is I don't I don't expect them to be detailed.

Joseph Washburn: April, and I will draft something will send it to you, you say ya nahh, we look at it, and if you have more to add what we'll do is we'll have a separate evaluation for when they are with you, that is more geared towards what you're doing with them. To provide to the file, then the generic

Dr. Rodi: yeah I want something I can say yes to have an interest, they were really you know involved in what we were doing, they were eager to learn as the appropriate questions. Okay, they had trouble starting IVS do wow yeah you know they haven't started that many, this is the first 10 ivy's they started and they missed five okay well Okay, so you know, in that sense. Because I there's things I can't right, we can do that that would be something I think I think it would be a little more geared for what I do and how their interaction with me.

Joseph Washburn: What about do you have anything to discuss as far as clinical placements or field issues that you anticipate or that's new or.

April Bollinger: As far as clinical placements all the requests have been sent so we're just waiting on Lee Health now pediatrics Ob or say we have a new placement at Park Royal. For our Psych rotation.

Joseph Washburn: But from my aspect in the ER it is next to impossible to get a baker act admitted into a psychiatric institution really it is next to impossible right there always will you can't do it at night, because on the on the only one here, so you have to call back at 7am so its 11 o'clock at night and you're telling me you can't what you have 20 patients you're doing assessments on and 11 from 11 to seven no because you don't want to do the work. So what happens they sit in the ER or what what happens that well magically at seven o'clock there's no beds. So then, what you do, or you can leave sitting ER for three days, even though, when they get admitted that's where they're going to be right, so now, you have to admit them and what it what kind of care do they get, they get what you want them to the hospital for this nothing zero. They’ll be there for a week. 24 seven for a week. This is just terrible know healthcare is terrible it's a terrible everywhere in this country, I wouldn't doubt it the only good thing we have is a baker act but it doesn't ensure that patient will get seen. If you have insurance Park Roayl usually take you but they won't take you right away, and the common way this works is that a patient goes to Salascare let's say, and this is more common in Salascare they go in there at eight o'clock in the morning. Because they want to sign themselves in to be seen. Now there still there at eight o'clock at night sitting that waiting room, what do they do the Salascare workers is Oh, we can't see you, you have to go get medically cleared, so they call an ambulance to take him to the ER now they sit there for five hours to get medically cleared. Then we call them back to okay your baker act as Oh well, we don't have any beds. Okay, and then, what do you want us to do and what you're just going to have to see that's the hell, they know now you know they get paid on these places to get paid. Salascare particular Park Roal does take insurance right the most people they get X number of dollars from the state of matter how many patients, they have they get X number of dollars, so these patients, they have more money they have available for other things, or for raises or whatever right and they don't have a mandate that they have to. Do it this way, since I’ve been here 91. It is it's horrible it's and then you get these people to play the game I’m going to kill myself really why because it's 35 degrees outside. You know, or they drink, they say, I want to go to detox well your alcohol level that's way too high. They wont put you in detox you know, I have a drinking problem, I want to stop yeah okay sure you do that you're too drunk for you to sign yourself in and we can't sign in because you're to drunk nobody will take us right so by the time they need so. 20 hours later, or like. I’m fine I’m not going anywhere right see two days later.

April Bollinger: They will have one shift at Park Royal. Still have another have some more adult ED rotations the summer and then that's an adult ED peds Ob and Psyche.

Dr. Rodi: I wish I could get Ashely to take students she is really good she is one of my associates, we hired her a few years ago and she's a DO from the same area from New York and New Jersey and she was a new resident finished her residency she was nights she only wanted to work nights. So a lot of shifts she did with me. We had some horrific cases, so what she's really good very smart there's things that she hasn't done like when we know physicians my step daughter is the same way she'll call me about something and Ill tell her what it is. She's a mentally overloaded with shifts and patient she doesn't have a scribe she hasn't dictate everything or so that slows her down. She's a really good physician though she has terrible nights, we all have terrible support nights and it's just that you get a lot of critical patients now, having said that, because LEE is taking this over and May. Ashley, Encarnacion and myself are pushing Lee to have a provider on all night long two providers not one so there's me and PA. But we're pushing them have two docs on because of patients crazy, you are my critical care time and Ashley’s critical care time because we work nights mostly. Are way above everybody else's because that's what we see at night critical patients right, you know are RVUS are way above everybody else because patients resource we can't see as many it's as they see because of that sick when you're just with them constantly yeah. I can't remember his name is a few weeks ago, so we're holding all these patients in the ER 50, 60 patients for days on end. I think we tubed one guy that student was with me watch the glide scope, I could see all you know it's a lot different than just sharing they can actually see what you're doing so, the nurse comes in says to me this patient I have rooms and admission, I talked to PA twice she wanted a blood gas because blood gases are terrible corporate back and she said, oh just put them on a bypap so I said well what's the patient do, and I said that's an admitted patient and that's supposed to be treating that you need to call the attendance, but that she was calling PA was all costs for the attendees so. She said I did, and this is what we did, and so she shows him the blood gas, and I said what they told you to do what to put Bpap on I said that's not going to fix this as patient bco2 is 145 Bipap isn’t going help him as pH is less than 7.0. So he needs to be intubated and she looked at me like. I went in the room, I looked at him I started talking to him shaking them that's. Great. I said he's one of the monitor, but the blood pressure it's only cycling every 15 minutes, just to get another set of vitals, she does is precious 60 over 40 I said Jesus Christ, so I tube him ventilate him put an n G tube down for gastric distinction and sharing 750 cc's of blood come out of the NG tube. Oh shit I said that anybody ever does anybody did they see this guy I said, look at these numbers, I said, and he said this way how long now? It's about an hour and a half ago, why didn't you say something shes good nurse, I mean she's only did I call them, and this is what they want me to do so, I said, you know better than this. Anyway, I ended up getting this guy the kitchen sink to get blood pressure back on this, I had to reverse his heparin and he was unhappy so now. You know that I checked on him a week later, they never scoped him they never did an EKG to see why. They put them into unit, he was in the unit, but nobody ever consulted GI. They had no explanation for why he had seven so I finally saw a console GI this past weekend, because my scribe said to me. Did you look at that guy chart, and I said no I’m going to do that tonight, because I always try to follow up on these things to see what's going on. She goes I looked at it, nobody from GI saw him I said get out of here she was no she said it's been a week, so I pulled it up here just seen the guy. And said Oh, you know he could have had a mallory tear that was a lot of blood it's hemoglobin with really high for some were using before that, so he was fortunate that. You know, he didn't bleed out but still keep last two and a half grams of hemoglobin probably some type of attention anyway. He said I’m going to do them in the morning, so, but that was after I went off duty and I hadn't been back so I’ll be back Saturday night I’ll see what we found and tell you one train wreck after another, but there's a student with before that he said, you know how to do all that stuff but I’ve been doing this 42 years I think I know what to do. He said that was intimidating to me said, well, first of all, you wouldn't be doing this to anybody right you'd be managing his airway making sure he had a line given them some fluid and then you would be here. So that was a great case to see the train wreak to see how you managed somebody that's. Right, well, they have to have been mismanaged and what you need to fix things so now these guys are really much better than all classes, I think, so I really do I don't even want to imagine what they were eight years ago.

Joseph Washburn: And you know we just keep moving the bar keep moving the ball down the field that's all we.

Dr. Rodi: Much rather put our 25th great students then 60 mediocre but we're down at now right maybe 18.

Joseph Washburn: alright so just to recap from today's meeting we're going to work on EVAL strictly for you, for the students when they go to do their ride with you for our next round of comments from field and clinical we should have I would say, better documentation this time because we're making students get you know, positive and something they can improve on and then we'll have the other ones so we'll just look at you know, making a better assessment for us, for us, this you know they're doing out there.

Dr. Rodi: Can we can pick their brains see what they would like to see more of. You know how they see what that rotation means for them, you know it's a shame that we can only do it one time. But that's the way I work on the work again sorry I’m sure they hate every weekend so far nobody said that but.