

Arnot*Health*

Graduate Medical Education

**ARNOT OGDEN MEDICAL CENTER
EMERGENCY MEDICINE RESIDENCY**

PROGRAM MANUAL:

A working guide to the EM program
For residents and faculty

2019-2020

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To our incoming Emergency Medicine Residents:

I want to personally welcome you to Arnot Health and the beginning of your formal education in Emergency Medicine. Emergency Medicine has become the 4th largest specialty in our nation. We have the opportunity to treat patients from all walks of life equally, regardless of insurance and without prejudice. We take care of patients on the worst day of their life. The breadth of knowledge required is always expanding and changing and is a lifelong pursuit to keep abreast. We care for the critically ill, then reassure a worried parent that their child will be fine. I look forward to sharing these experiences with you and overseeing your training.

Dr. Edwards started the Emergency Medicine residency 4 years ago now and I have had the opportunity to be a part of it from the beginning. I have watched and participated in its growth over the years as it has become the excellent training program it is now. During this time, we have recruited multiple wonderful faculty that are passionate about teaching and resident education that you will get to know well. We are proud of what we have accomplished here, but most proud of what our residents have become: competent, compassionate ER docs able to work anywhere they choose and who love what they do.

The following manual is an overview of our policies and meant as a reference for you over the next 3 years. My door is always open and phone always on to help in any way I can.

Sincerely,

James Bohan, MD, FACEP
Program Director

Arnot Health Mission/Vision/Values Statement

THE MISSION OF ARNOT HEALTH

We will partner with each patient we serve in order to maximize that individual's physical, emotional, social and spiritual health.

THE VISION OF ARNOT HEALTH

We will be recognized as the premier regional healthcare system delivering high quality, safe, cost effective, socially responsible health care services to all we serve.

THE VALUES OF ARNOT HEALTH

Excellence

- ✓ We strive for the highest clinical quality, patient safety, and patient, physician and employee satisfaction by continually measuring and improving our performance.

Patient-Centered Health Care

- ✓ We continually focus on the individuals we care for. We are skilled in communication, listening, and honoring the right of every individual. We teach and encourage our patients to participate in their care, to promote their wellness and to make well-informed decisions. We respect and honor the cultural, ethnic, and religious beliefs and practices of our patients in a manner consistent with the highest standards of care.

Compassion

- ✓ All that we do for our patients and communities is done in an attentive, caring, and empathetic manner in order to alleviate the suffering which arises with health issues.
- ✓ We strive to exceed our patients and our co-workers' expectations for comfort and care in the midst of suffering.

Teamwork

- ✓ We work together as trustees, administrators, staff, physicians, and patients to find new, creative and collaborative ways of improve the delivery of health care services.

Integrity

- ✓ We adhere to the highest ethical and professional standards by a commitment to honesty, confidentiality, trust, respect, and transparency.

Arnot Health Graduate Medical Education Mission Statement

Arnot Health's Graduate Medical Education Program is dedicated to providing excellence in training physicians to provide high-quality and compassionate care engaged in the practice of evidence-based empathetic medical care for our patients. An emphasis on primary health care and community health services reflects the program's original osteopathic philosophy, with specialty care demonstrating our commitment to innovation and quality in all endeavors. This philosophy will remain with us as we move into the world of ACGME accreditation under the new Single Accreditation System. We seek to develop clinically skillful, compassionate and culturally competent physicians from diverse backgrounds, who are prepared to become leaders in their communities.

Arnot Health's Graduate Medical Education Program provides a collaborative, learning-centered environment in which highly qualified and diverse faculty, staff, medical students, and physician trainees integrate teaching, research, scholarship, creative activity, and community service. Through intellectual, social and cultural contributions, the Graduate Medical Education Program enriches the lives of those in the community and surrounding region.

Facility Description

The Arnot Health system is one of the largest healthcare providers in the Southern Tier of NY. With over 440 beds at three different hospitals (Arnot Ogden Medical Center, St. Joseph's Hospital and Ira Davenport Memorial Hospital) the system offers Chemung County and the surrounding region a full spectrum of care in virtually every subspecialty.

The primary training site for the emergency residency program is the Arnot Ogden Medical Center (AOMC) in Elmira NY. AOMC is a tertiary care facility with 256 beds. Recognized for the excellence in its open heart surgery program and valvular open heart program, AOMC has over 300 physicians, and operates the Falck Cancer Center in Elmira as well.

Construction of a new ED is scheduled to begin during the fourth quarter of 2019.

Arnot Health is part of the Lake Erie Consortium for Osteopathic Medical Training (LECOMT). In 2012, Arnot Health made the decision to address the growing regional health care needs and physician shortage by developing a robust and comprehensive graduate medical education program. Now it is the site of multiple ACGME accredited residency training programs in Emergency Medicine, Internal Medicine, Family Medicine, Surgery, Radiology and Psychiatry, as well as fellowships in Cardiology, GI and Endocrinology.

EM Residency Contacts

Emergency Medicine Program Coordinator

Paula Mowry
pmowry@arnohealth.org

Program Leadership

James Bohan, MD, FACEP
Program Director
Associate Professor of Emergency Medicine
jbohan@arnohealth.org
570-854-7647

Jeremy Lux, DO, FACEP
Chair of Emergency Medicine; ED Medical Director
Associate Professor of Emergency Medicine
jlux@ah.arnohealth.org

Dylan Kellogg, MD, FAAEM
Associate Program Director; EM Research Director
Assistant Professor of Emergency Medicine
dkellogg@arnohealth.org

Emergency Medicine Faculty

Michael Witt, MD, FACEP
Core Faculty; Pediatric EM Director
Associate Professor of Emergency Medicine
mwitt@arnohealth.org

Timothy (Beau) Stokes, MD
Core Faculty; Ultrasound Director; Clerkship Director
Assistant Professor of Emergency Medicine
tstokes@arnohealth.org

Robert Wicelinski, DO
Core Faculty; EMS Coordinator
Assistant Professor of Emergency Medicine
rwicelinski@arnohealth.org

Frank Edwards, MD, FACEP
Professor of Emergency Medicine
fedwards@arnohealth.org

Steven Manganaro, MD, FACEP
Clinical Associate Professor of Emergency Medicine
Wilderness Medicine Track Director
smanganaro@arnohealth.org

Marc Immerman, MD
Clinical Associate Professor of Emergency Medicine
mimmerman@arnohealth.org

Kevin O'Connor, MD
Clinical Associate Professor of Emergency Medicine
koconnor@arnohealth.org

Rossi Brown, DO
Clinical Assistant Professor of Emergency Medicine
rbrown@arnohealth.org

Vincent Call, DO
Clinical Assistant Professor of Emergency Medicine
vcall@arnohealth.org

Chief Residents 2019-20

Stevley Koshy, DO
stevleykoshy@gmail.com

Kirsten Walton, DO
kirsten.walton35@gmail.com

Arnot Ogden Emergency Medicine Residency

General Educational Goals & Objectives

The Arnot Ogden Medical Center’s residency program in Emergency Medicine is designed to graduate emergency physicians with the necessary cognitive knowledge, procedural skills and confidence to begin practice without supervision in any emergency department setting, from community hospitals to teaching centers.

Throughout the three years of post-graduate training, the program engages residents in a rigorous clinical and didactic schedule that exposes them to the core content of emergency medicine^{1 2}, and allows for progressive responsibility in the care of patients, the supervision of junior residents, the teaching of peers, medical students and pre-hospital providers, and in the administration of an emergency department.

During their training, residents will participate in a scholarly endeavor, which may include such activities as an original research project, the preparation of a significant review article or case series, or becoming engaged in a substantial quality improvement project.

In their progress toward becoming board certified emergency medicine specialists, residents will be regularly assessed along the continuum defined by the six Core Competencies—*Medical Knowledge, Patient Care, Professionalism, Interpersonal Communication, Practice-based Learning, System-based Practice*--and the twenty-three Emergency Medicine Milestones articulated by the ACGME.

¹ 2013 Model Curriculum; Council of Emergency Medicine Residency Directors (CORD), <http://www.cordem.org/i4a/pages/index.cfm?pageID=3635>

² Appendix C: Emergency Medicine Goals and Objectives, CORD, <http://www.cordem.org/i4a/pages/index.cfm?pageID=3639>

Arnot Ogden Emergency Medicine Residency

3-year Clinical Training Block Paradigm

PGY-1

1 block **Orientation**

8.5 blocks **Emergency Medicine** (Arnot Ogden Memorial Hospital)

1 block **ICU**

0.5 block **OB**

0.5 block **Anesthesia**

0.5 block **EMS**

1 block **Toxicology** at Strong Memorial

PGY-2

10 blocks **Emergency Medicine** (9.5 at Arnot; 0.5 at Wilson Med Center/UHS)

1 block **Trauma** at University of Maryland Shock Trauma Center.

2 blocks **ICU**

PGY-3

9 blocks **Emergency Medicine** (8.5 at Arnot; 0.5 at Wilson/UHS)

1 block **Pediatric Emergency Medicine** at Strong Memorial Hospital

1 block **ICU**

0.5 block **ED Administration**

0.5 block **NICU**

1 block **Elective**

Emergency Medicine Didactics

EM residents are required to attend all emergency medicine didactic sessions unless unable owing to illness, P.T.O. or away rotations. (Residents working the Thursday ED overnight shift may be excused early). Per ACGME standards, residents must attend 70% of all didactics.

Emergency Medicine Teaching Day

Didactics occur every Friday from 0800 to approximately 1300. A schedule of each Friday's activities is available on a dedicated Google Calendar to which all residents have access. The location of these sessions may vary. Lunch is provided.

Didactics consist of a mixture of lectures, interactive board-review style question-and-answer sessions, small group breakout sessions, simulator sessions, and procedure workshops. We strive to have as much interactivity as possible. Lectures are given by faculty, residents and guest teachers.

One of the goals of the Arnot EM Residency is to help each resident develop excellent teaching skills. Beginning in the second half of their PGY-1 year, residents will present an assigned lecture of 45 minutes length 2 to 3 times per year. These topics will be known well in advance to allow for adequate preparation. Residents will also be scheduled to give brief lectures to the local paramedic training program (1 lecture a year during the first 2 years of training, and 2 lectures during the senior year). All residents will attend faculty member Dr. Dylan Kellogg's teaching session on the fundamentals of effective lecturing and the use of PowerPoint. 1 week prior to giving their lecture, residents will submit their PowerPoint file to Dr. Kellogg for critique.

During each three-year residency cycle, EM residents will have the opportunity to review the core curriculum of emergency medicine twice. The major EM texts are available digitally to residents through our library, free-of-charge.

To better prepare for the American Board of Emergency Medicine residency in-training examination each February, residents will be provided with the test question service ROSH Reviews. This program provides access to thousands of practice questions and tracks each resident's progress. Residents will be assigned a monthly content-based examination to be completed on a self-study basis. A full-length practice in-training exam will be assigned in December so that residents can identify areas in need of additional study prior to the real thing.

Emergency Medicine Journal Club

Monthly journal club is held every 4th Friday of didactics from 12-1pm. Location will be announced at didactics

Educational Attendance Policy

Arnot Ogden Emergency Medicine Residency

1. Emergency medicine academic conference is every Friday from 8am until 1pm. Each resident is expected to attend no less than 70% of didactic sessions per year throughout residency regardless of the rotation they are on. Attendance is monitored via a sign-in sheet, with records kept by the program coordinator. Didactics attendance is reviewed at each resident's semi-annual evaluation.

a. Residents on PTO excused from didactics, but are always more than welcome to attend if they are in town

a. Arnot EM blog:

a. Because writing blog posts is a form of asynchronous learning, Arnot EM Residents may earn didactics-attendance credit-hours by submitting, through Dr. Stokes, a post for our EM blog.

i. One hour of asynchronous credit will be awarded for each submission.

ii. Though a resident may submit an unlimited number of posts, no more than 5 hours of credit can be granted per year (i.e., one didactics day off).

b. Posts can consist of case vignettes, brief topic reviews, CME questions, war stories, and anything else of relevance.

c. Cases must be scrubbed of identifying information and altered to the degree necessary to protect confidential information.

d. The resident will be responsible for keeping track of credit earned and notifying the program coordinator of the day off desired.

Chart Completion Policy

Arnot Ogden Emergency Medicine Residency

Whenever possible, charts should be completed before you leave the ED at the end of your shift. Should circumstances prevent that, however, under no circumstances should the chart remain incomplete after 24 hours. It is perfectly acceptable to finish a chart via remote access at home, and there will be one or more computers in the medical library loaded with PulseCheck so that you can finish charts there if needed. The 24-hour rule is inviolable and will be considered a measure of professionalism. Those residents who do not have remote access should obtain it post haste.

Policy

Resident performance on the annual

ABEM In-training Examination (ITE)

1. All residents at each level of training will take the annual ABEM ITE.
2. Residents will be expected to receive a score indicating a 75% or greater likelihood of passing the national ABEM written certification examination after graduation.
3. Residents not in their final year of training:
 - a. Residents who receive a score indicating a less than 75% chance of passing the national certifying examination will be required to acquire an EM board preparation course (using their professional development funds), or to synthesize their own self-directed program of study, acceptable to the program leadership.
 - b. The resident will submit a written plan of study to be signed off by the program director. This plan must be completed prior to the following year's ITE.
 - c. The resident will also continue to participate in the program's routine didactic curriculum, including regular quizzes and practice exams.
 - d. The resident will meet monthly with a designated faculty advisor to discuss the progress being made in their independent study program.
4. Residents in their final year of training
 - a. Residents who receive a score in the annual ITE indicating a less than 75% chance of passing the national certifying examination will obtain an EM board preparation course (using their professional development funds) acceptable to the program leadership.
 - b. The resident will submit a written plan of independent study to be signed off by the program director. This plan will be completed prior the resident being eligible for graduation.
 - c. The resident will discuss their progress twice a month with a designated faculty advisor.
5. To be eligible for moonlighting, a resident must have achieved a score on their most recent ITE indicating an 80% or greater likelihood of passing the national certifying examination.

Emergency Medicine M & M Conference

Morbidity and Mortality Conferences are a rich and fundamental learning experience. We will hold 12 M&M sessions over the course of the year, starting in Block 2, with the expectation that each upper level resident (R2 & R3) will be responsible for a single one-hour case presentation annually. Residents will be informed of their assigned block at the start of the academic year.

Appropriate M&M cases will be chosen by a combination of faculty, department administrators, and the AOMC QI department. Approximately one month prior to the day the assigned resident is to present an M&M conference, the resident will be given a preselected case. Importantly, the chosen case will not involve the assigned resident. This will help the resident view the case objectively and develop his/her ability to address departmental QI issues.

The resident will review all clinical documentation on the case, interview the providers (and possibly the nurses) involved in the case, and outline the key issues that contributed to the failures in the case.

The resident will meet with Dr. Kellogg in person prior to presenting the case to review his/her presentation to make sure that they are putting together a presentation that will maximize learning for the group.

The recommended format for presentation is to present the facts of the case sequentially from the time of arrival to the emergency department to the time of departure. Information including history, physical, and diagnostic studies, should ideally be presented in the order they were available to the treating clinicians. Hospital course, transfer records, etc. should be summarized at the end of the case as relevant.

A brief review of the medical issues in the case should be included.

After the case, the presentation should walk through aspects of the medical system that may have contributed to errors. This list includes: patient factors, outside systems, ED access / EMS, triage, human error, teamwork failures, local ED environment, hospital environment, hospital administration / third parties, and community, society and healthcare policy.

Finally, the presentation should end with take-away points from this particular case that we can apply to other cases to improve our department going forward.

Emergency Medicine Ultrasound Training:

Arnot Ogden Medical Center EM residents will graduate with a full set of EM specific point-of-care ultrasound skills. Training for the interns begins with a focused workshop during the orientation block. There will then be an ultrasound workshop each subsequent block during didactics. In addition, each block there will be 4 hours of hands on ultrasound instruction with the Ultrasound Director for the first year residents.

Simulator workshops devoted to ultrasound guided central lines and peripheral IVs are integrated into the curriculum.

EM faculty and upper level residents will mentor junior residents in ultrasound techniques on a daily basis during their EM blocks. Residents will submit their studies digitally to be critiqued and applied toward their required number of studies (150) for graduation.

A detailed description of the ultrasound curriculum follows:

Emergency ultrasound can be classified into the following functional clinical categories:

1. *Resuscitative*: ultrasound use as directly related to an acute resuscitation
2. *Diagnostic*: ultrasound utilized in an emergent diagnostic imaging capacity
3. *Symptom or sign-based*: ultrasound used in a clinical pathway based upon the patient's symptom or sign (eg, shortness of breath)
4. *Procedure guidance*: ultrasound used as an aid to guide a procedure
5. *Therapeutic and Monitoring*: ultrasound use in therapeutics or in physiological monitoring

Core emergency ultrasound applications:

Trauma, Pregnancy, Cardiac /Hemodynamic assessment, Abdominal aorta, Airway/Thoracic, Biliary, Urinary Tract, Deep Vein Thrombosis (DVT), Soft-tissue/Musculoskeletal (MSK), Ocular, Bowel, and Procedural Guidance.

Point of Care Ultrasonography ED Focus Position

Goals and Objectives:

Goals: The resident will do the following:

- Patient Care: become proficient in performing accurate examination of patients with bedside ultrasonography, image optimization, image acquisition, and recognize “can’t miss” findings on examination in accordance with emergency ultrasonography.
- Medical knowledge and skills development: acquire the knowledge and skills necessary to utilize focused, bedside ultrasonography for image acquisition, learn to adjust portable ultrasound devices to optimize image viewing with adjustments for depth, gain, and modes of imaging. Obtain experience in advance ultrasonography techniques.
- Systems-based practice: understand the benefits and limitations of bedside, focused ultrasonography as well as its role as an adjunct to confirmatory studies. Obtain experience in administrative ultrasonography including billing, quality improvement, credentialing, and establishing a program.
- Practice-based learning: become more comfortable and familiar with the use of bedside ultrasonography as a specialized extension of their physical exam; utilize focused ultrasonography to guide diagnosis and monitor interventions related to critical care.
- Interpersonal skills and professionalism: demonstrate respect to patients during ultrasonography examinations; communicate with patients and/or their families during performance of bedside ultrasonography, integrating them into the patient’s care; demonstrate professional behavior and patient respect during portions of the exam which may expose a patient’s body; communicate bedside findings with other team members involved in a patient’s care

Objectives:

- Recognize the normal appearance of anatomy on ultrasonography
- Describe the appearance of common pathologic diseases seen on POCUS
- Describe the appropriate selection of a probe based on desired examination
- Demonstrate the ability to save images acquired from a bedside ultrasonography for later review and accreditation
- Discuss the appropriate use and limitations of bedside ultrasonography as well as when to obtain a further, complete/confirmatory study
- Discuss the correlation of clinical symptomatology to visualization of affected organ systems through POCUS
- Define “B” (brightness or 2D) scanning, “M” (motion) mode scanning, pulsed wave Doppler (or spectral Doppler imaging), color flow imaging, and power Doppler imaging
- Describe the indication, or use, for each of the aforementioned imaging modalities demonstrated
- Demonstrate a systematic approach to interpretation of acquired point of care ultrasound images
- Describe the integration of POCUS into bedside clinical decision making algorithms
- Demonstrate professional interactions with physicians, staff, and patients while performing POCUS
- Demonstrate the ability to improve image quality during bedside ultrasonography by direct observation and quality improvement review of their saved images.

Educational Strategies

Content:

- Basics of focused ultrasonography: introduction to ultrasound physics as well as device use (“knobology”)
- Cardiac: parasternal long and short axis, apical 2 and 4/5 chamber views, subxyphoid cardiac and inferior vena cava, estimation of ejection fraction (given importance and complexity of echocardiography, these will be divided into sections of normal anatomy, pathology, and advanced hemodynamic assessments).
- Pulmonary: evaluation for pneumothorax (pleural sliding, beach sign, bar code sign), pulmonary edema (curly b-lines/comet tails), pleural effusions
- Focused abdominal sonography for trauma (FAST) exam: subxyphoid 4 chamber cardiac view, morrison’s pouch (hepatorenal recess), splenorenal recess, bladder
- Abdominal: evaluation for abdominal aortic aneurysm (AAA), measurement at proximal, mid, distal aorta in transverse and longitudinal view inclusive of celiac, super mesenteric arteries, and common iliac arteries
- Evaluation of gallbladder (transverse and longitudinal views and common bile duct)
- Renal: kidneys (in 2 planes), bladder
- OBGYN: evaluation for pregnancy as well as normal and pathologic gynecologic anatomy
- Vascular: evaluation for deep venous thrombosis (DVT), vascular access
- Procedural guidance: central venous catheterization, thoracentesis, paracentesis, nerve blocks
- Misc: evaluation for soft tissue infections (abscess vs cellulitis), ocular (optic nerve diameter, retinal detachment)

Methods and Requirements:

The mini fellowship will mirror the ACEP Emergency Ultrasound Fellowship Guidelines.

- The resident will complete at least 500 ultrasounds during their mini fellowship
- The resident will participate in at least one ultrasound related QI or research project during the mini fellowship
- The emergency ultrasound mini fellow must be involved with the various administrative and quality assurance duties involving emergency ultrasound. Such duties include but are not limited to internal billing audits, interdepartmental meetings, and monitoring the credentialing process of colleagues.
- The emergency ultrasound mini fellow will prepare and deliver at least 4 lectures to the department and colleagues
- The resident will participate in at least 10 hours a month of hands on teaching. This includes but is not limited to didactic lectures, bedside teaching, research involvement of residents or faculty, and QA education.

Shift Requirements on EM Blocks

PGY-1 residents on EM rotation will work 20 shifts of 10-hour duration per block.

PGY-2 residents on EM rotation will work 19 shifts of 10-hour duration per block.

PGY-3 residents on EM rotation will work 18 shifts of 10-hour duration per block.

EM residents will be scheduled for two 1 week blocks of PTO during their EM blocks

IM and FM residents will work 20 shifts of 10-hours duration per EM block, minus clinic days.

EM Block Resident shift hours

- 1) Saturday - Wednesday
 - a. 6a-4p
 - b. 10a-8p
 - c. 4p-2a
 - d. 8p-6a
- 2) Thursday
 - a. 6a-4p
 - b. 10a-8p
 - c. 4p-12a
 - d. 12a-7a
- 3) Friday
 - a. 1p-9p
 - b. 4p-12a
 - c. 8p-6a
- 4) Occasional PIT shifts from 10a-10p or 11a-11p

Arnot Ogden Emergency Medicine Residency

Away Rotations for EM Residents

- 1) Arnot EM residents will do one block of toxicology during their first year and one block of Pediatric Emergency Medicine during their third year at the University of Rochester, Strong Memorial Hospital. Convenient housing in Rochester will be provided. Strong is an internationally recognized teaching hospital.
- 2) Arnot EM residents will also do a 1-block rotation during their R2 year on the acute trauma service at the University of Maryland's world-renowned Shock Trauma Center. Housing assistance will be provided.
- 3) The Arnot EM residency program now has a secondary training site at the Wilson Hospital ED of the University Health System in Binghamton, NY. The Wilson ED is a level II trauma center and sees approximately 40,000 patients a year. Upper level Arnot EM residents (R2, R3) will spend 1/2 a block per year rotating through the Wilson ED. Housing will be provided, though Binghamton is close enough to Elmira that some residents may prefer to commute during all or part of a given rotation there.

These rotations will round out the educational experience of the Arnot EM residents, exposing them to a wide variety of critically ill patients under the supervision of qualified teaching faculty.

Arnot Ogden Emergency Medicine Residency

Progressive Responsibility for EM Residents

The emergency medicine residency program is designed to allow for progressive responsibility in the areas of supervision, clinical activities, teaching and administration.

1) The **PGY-1**'s primary duty is to learn to perform a focused, age-appropriate history and physical examination, and to formulate an appropriate differential diagnosis. Each patient is discussed with an emergency medicine attending or the most senior available EM resident (PGY-3 or PGY-2). All PGY-1s are directly supervised in procedures until competency is obtained.

2) **PGY-2s** take-on additional responsibility throughout their second year of training. They will assume a greater degree of responsibility for the airway management of trauma and critically ill patients, as well as the performance of additional procedural skills such as complex laceration repair, regional nerve blocks, and procedural sedation. They present cases to an EM attending or PGY-3 EM resident.

Additionally, PGY-2s are expected to act as team leaders in non-traumatic arrest patients and to communicate with patients' families when patients are either critically ill or have died. When the PGY-2s are scheduled for shifts with PGY-1s, they will accept presentations and to help PGY-1s start managing their patients.

3) **PGY-3** residents work as junior attendings in the Emergency Department. They will take report from all residents working in the Emergency Department and any advanced practitioners assigned to the main ED area. All patients will still need to be presented to the EM attending.

The PGY-3 resident is expected to be the team leader in all arrests. They participate in the training and supervision of pre-hospital personnel, medical students and the junior residents in the Emergency Department.

Arnot Ogden Medical Center Emergency Medicine Residency

Policy for EM residents to initiate procedures without direct supervision

When senior emergency medicine residents (R2 and R3 level) have reached a certain level of competency, they may begin initiating and performing specified invasive, skill-intensive procedures without direct faculty supervision. This represents another aspect of progressive responsibility and is crucial to the growth of a resident toward the graduation goal of practicing independently without supervision.

After a senior resident has performed the following procedure numbers under direct faculty/attending supervision at the primary training site, the resident will request the program director to clear them to perform the following procedures at the primary site under indirect supervision alone.

Note that competency in intubation requires a demonstration of direct laryngoscopy skills along with a full knowledge of RSI medications, along with an understanding of back-up airway techniques to include use of a video laryngoscope, use of a bougie, and cricothyroidotomy. Clearance for intubations means that the resident does not require direct supervision to perform emergent intubations on patients in severe respiratory distress or respiratory arrest anywhere in the hospital. While in the emergency department, however, there must be an attending in the room during all intubations.

Indirect supervision means that an EM faculty member, EM attending, or another attending physician credentialed to perform the procedure in question (e.g., an intensivist during the EM resident's ICU rotations) is not in the patient's room, but is available to assist the resident within a reasonable period of time.

When the program director clears a resident to perform a procedure under indirect supervision alone, a note indicating this will be sent to the program coordinator and maintained in the resident's file.

Procedure	Minimum number to request clearance
RSI Intubation	10
Central Venous Access	5 (site specific)
Chest tubes	7

Arnot Ogden Medical Center Emergency Medicine Residency

Policy on Procedural Supervision of EM Residents on ICU Rotations

This pertains to the indirect supervision of EM senior residents (R2 & R3) doing procedures (rapid sequence intubation, insertion of central lines, arterial lines and chest tubes) in the ICU at night when intensivists are not immediately available.

- 1) If a patient needs a procedure on an immediate life-saving basis (e.g. intubation in a crashing patient) the most skilled physician available, including a resident, is expected to immediately attempt that procedure without regard to supervision.
- 2) When the procedure is urgent but not immediately time-critical, the resident will contact the attending hospitalist or intensivist to discuss. If this attending agrees, the EM resident may perform the procedure under the indirect (back-up if needed) supervision of the on-duty emergency medicine attending.
- 3) The EM resident would need to contact the on-duty emergency medicine attending in the ED to likewise obtain their agreement.
- 4) This would only apply to senior EM residents who have been cleared by the program director to perform this procedure under indirect supervision.
- 5) Note that this only applies during ICU rotations. While on ED rotations, EM attendings will be present to one degree or another for all major procedures being performed by residents under their supervision.

Arnot Ogden Medical Center Emergency Medicine Residency

Academic and Scholarly Expectations for EM Residents

The emergency medicine residency program at Arnot Ogden Medical Center is committed to involving its residents in department quality improvement activities and the process of peer review. They will also be exposed to the basic steps of conducting clinical research, and will have opportunities to become more deeply involved in generating and publishing original research.

Arnot Ogden Medical Center EM residents will be expected to:

- 1) Prepare and give 2 - 3 lectures per year at the Friday morning EM didactic session on a subject from the assigned reading material.
- 2) Deliver one lecture per year to local EMS providers during their R1 and R2 years, and 2 lectures during their R3 year.
- 3) Present a case every year at the emergency medicine M & M conference.
- 4) To be actively involved in at least one formal emergency department quality improvement project.
- 5) To be involved in the preparation and presentation of a quality improvement, literature review or research project at the annual Arnot GME Poster Presentation Symposium.

Arnot Ogden Medical Center Emergency Medicine Residency

Medical Student Precepting

The teaching of medical students provides a resident with an excellent opportunity to expand and solidify their knowledge base. A number of LECOM medical students, as well as auditing medical students from schools across the country, rotate through the Arnot ED.

EM residents will precept all cases seen by medical students. Medical students will be assigned to a senior resident to work with for a shift. It is expected that the precepting resident will go into the patient's room with the medical student and introduce the student.

Medical students will not be precepted by TRIs or by off-service residents, unless expressly approved on an individual basis by an ED attending or senior resident.

Arnot Ogden Medical Center Emergency Medicine Residency

Graduating E.M residents will have completed these procedures:

Procedure	# performed on patients	# performed in lab/simulation
Adult medical resuscitation	45	10
Adult trauma resuscitation	35	10
Cardiac pacing	6	6
Central venous access	20	0
Chest tubes	10	3
Cricothyrotomy	3	3
Dislocation reduction	10	0
Intubations	35	0
Lumbar Puncture	15	5
Pediatric medical resuscitation*	15	5
Pediatric trauma resuscitation *	10	3
Pericardiocentesis	3	3
Procedural sedation	15	0
Vaginal delivery	10	0

* Ages 0-18 years

Arnot Ogden Medical Center Emergency Medicine Residency

Electives

Arnot Ogden Emergency Medicine residents have 1 elective block during their 3rd year. Residents will have substantial latitude in selecting their elective, though it is expected that electives will mirror the EM subspecialty fields, to include (but not limited to):

Critical Care

EMS

Ultrasound

Wilderness Medicine

Pediatric Emergency Medicine

International Medicine

Medical informatics

Research

Review article preparation

ED Administration

EM Simulation Training Studies

Arnot Ogden Medical Center Emergency Medicine Residency Program

Policy on Work/Educational Environment and Duty Hours

- 1) Regarding the program environment(s), the program director will:
 - a. administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency area;
 - b. oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;
 - a. approve a local director at each participating site who is accountable for resident education;
 - b. approve the selection of program faculty as appropriate;
 - c. evaluate program faculty;
 - d. approve the continued participation of program faculty based on evaluation;
 - e. monitor resident supervision at all participating sites;
 - f. prepare and submit all information required and requested by the ACGME, which includes but is not limited to the program application forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;
 - g. ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution (Arnot Ogden Medical Center), under the overall supervision of the DIO;
 - h. provide verification of residency education for all residents, including those who leave the program prior to completion;
 - i. implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:
 - i. distribute these policies and procedures to the residents and faculty;
 - ii. monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements (no less than monthly);
 - iii. adjust schedules as necessary to mitigate excessive service demands and/or fatigue;
 - iv. and adjust schedules as necessary to mitigate excessive service demands and/or fatigue, and monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
 - j. comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;
 - k. be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;
 - l. obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including:
 - i. all applications for ACGME accreditation of new programs;
 - ii. changes in resident complement;

- iii. major changes in program structure or length of training;
- iv. progress reports requested by the Review Committee;
- v. responses to all proposed adverse actions;
- vi. requests for increases or any change to resident duty hours;
- vii. voluntary withdrawals of ACGME-accredited programs;
- viii. requests for appeal of an adverse action;
- ix. appeal presentations to a Board of Appeal or the ACGME;
- x. and, proposals to ACGME for approval of innovative educational approaches.
- m. obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to Common Program Requirements of the ACGME that addresses:
 - i. program citations;
 - ii. and/or, requests for changes in the program that would have significant impact, including financial, on the program or institution.

2) Resident Duty Hours:

- a. Maximum Hours of Work per Week Duty hours in the emergency department must be limited to 60 hours per week, averaged over a four-week period, inclusive of moonlighting. (Other than on EM rotations, the work week limit is 80 hours).
- b. PGY-1 residents on EM rotation will work 20 shifts of 10-hours duration per block.**
- c. PGY-2 residents on EM rotation will work 19 shifts of 10-hours duration per block.**
- d. PGY-3 residents on EM rotation will work 18 shifts of 10-hours duration per block.**
- e. IM and FP residents will work 20 shifts of 10-hours duration during their EM block. Shifts decreased for their clinic days.**
- f. The program director will ensure that the program encourages residents to use alertness management strategies in the context of patient care, to include strategic napping.
 - i. The program director will ensure that a sleeping area is available for resident and faculty use.
- g. In the interest of patient safety and resident education, residents may be allowed to remain on-site in order to accomplish complex transitions of care during periods of high patient volume in the ED; however, this period of time must be no longer than an additional four hours.
- h. Residents will not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
- i. In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.
 - i. Under those circumstances, the resident must:
 - 1. Appropriately hand over the care of all other patients to the team responsible for their continuing care; and, document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

- ii. The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.
- j. Minimum Time Off between Scheduled Duty Periods:
 - i. PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
 - ii. Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods.
 - 1. They must have at least 14 hours free of duty after 24 hours of in-house duty.
 - iii. Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80-hour maximum duty period length, and one-day-off-in seven standards.
 - iv. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

Arnot Ogden Medical Center Emergency Medicine Residency

Moonlighting Policy

1. Moonlighting is defined as clinical activities outside of the residency program for which the trainee is paid on an hourly or other rate, in addition to the approved program salary for a trainee at his/her training level.
2. New York State places significant restrictions on the qualifications a physician must have to work independently in an emergency department. These qualifications are as follows:
 - i. The physician must be currently licensed in New York State and be board certified in Emergency Medicine, Family Medicine, Internal Medicine, Pediatrics or Surgery, and possess a current ACLS and ATLS certificate; or,
 - ii. Be currently licensed in New York State, have one year of post-graduate training, and within the past five years have accumulated 7,000 documented patient contact hours or hours of teaching medical students, physicians-in-training, or physicians in emergency medicine, and possess a current ATLS and ACLS certificate. Up to 3,500 hours of documented experience in hospital-based settings or other settings in the specialties of internal medicine, family practice, surgery or pediatrics may be substituted for the required hours of emergency medicine experience on an hour-for-hour basis.
3. Currently there are no such restrictions in New York State, as outlined in paragraph 3 above, that pertain to moonlighting in free-standing urgent care centers.
4. Under the proper circumstances, as defined below, moonlighting can enhance the trainee's profession development—but it must never interfere with the program's educational goals, standards and policies.
5. Moonlighting is prohibited under the following conditions to the extent that it might interfere with training program responsibilities.
6. **PYG-1 residents may not moonlight under any circumstance.**

7. To qualify for moonlighting, the emergency medicine resident must have received a score on the most recent in-training examination indicating an 80% or greater likelihood of passing the national certifying exam.
8. No resident may be required to moonlight.
9. Prior to seeking such employment, must have written approval from the Program Director.
10. To moonlight, the EM resident:
 - i. Must be in good standing in the training program in full time status and have a score on their most recent In-Training Exam indicating an 80% or greater likelihood of passing the ABEM national certifying examination;
 - ii. Must seek written assurance of malpractice and workers' compensation coverage from any outside employer;
 - iii. Must have a valid New York State medical license;
 - iv. May use the institutional DEA number assigned to the affiliated hospital at which the resident is moonlighting, though a better alternative would be for the resident to obtain his or her own Federal DEA number;
 - v. Must have completed at least one year of training in the Arnot Ogden Medical Center Emergency Medicine Residency program;
 - vi. Must have his/her performance monitored by the program director to ensure that he/she remains in good standing in his/her training program, as documented by satisfactory evaluations.

11. If the trainee receives an unsatisfactory evaluation at any time or is terminated from the program, the moonlighting appointment will be immediately terminated, and moonlighting privileges may not be renewed for the remainder of the training program. The GME department and Medical Staff Office will be notified in the event;
12. Approval to moonlight is granted through the end of the current academic year and must be requested for each subsequent year.
13. If a resident engages in moonlighting, the hours devoted to that activity must be added to the training program work hours and be reported on the Graduate Medical Education work-hours survey, and be reported to the program director.
14. The trainee is responsible for reporting all moonlighting activity to the GME office and program director.
15. Per ACGME standards, the resident can not work more than 60 scheduled hours per week seeing patients in the emergency department, and no more than 72 duty hours per week. (Duty hours comprise all clinical duty time and conferences, whether spent within or outside the residency program, including all on-call hours).
16. The program director is responsible for monitoring the trainee's moonlighting activity and maintaining records of the activity in the trainee's departmental file through Med Hub. The total hours must comply with the number of hours a resident may work as detailed in the Arnot Ogden Medical Center's duty hour policy. Usual trainee duty hours plus moonlighting (extra shift) hours added together must not cause trainees to violate duty hour limits.
17. Residents may not moonlight in the ED at the Arnot Ogden Medical Center (primary training site), or in the secondary training sites (Strong Memorial Hospital and UHS/Wilson); however, moonlighting may take place at the two other institutions operated by the Arnot Health System (St. Joseph's Hospital and the Ira Davenport Memorial Hospital), which are not training sites for emergency medicine residents.
18. The employing moonlighting institution is responsible for maintaining records that the trainee has been appropriately credentialed.

19. Those training with a J-1 or H-1B visa are not eligible for moonlighting privileges. Trainees must be a US citizen or have a permanent residency card.

Arnot Ogden Medical Center Emergency Medicine Residency

Appointment and Duties of Chief Residents

- 1) The program will select two PGY-3 Chief Residents annually. This year's chiefs are Dr. Stevley Koshy and Dr. Kirsten Walton
- 2) Chief Residents receive an honorarium along with protected administrative time during EM blocks.
- 3) The duties of Chief Residents include scheduling, participation in faculty meetings, staff meeting attendance, and assistance in the organization of the teaching schedule. Chiefs play a vital role as mentors for junior residents and medical students, and they also function in a liaison between residents and the PD/APD.
- 4) The two chiefs will alternate semi-annually between administrative and academic responsibilities.
- 5) In March of every year, a request will go out to all the second years with the opportunity to apply for the Chief position. If interested, a personal statement reflecting the reason for the interest is required. The final decision will be made by the Program director based on the personal statement, a resident vote, faculty feedback, and academic status.

Arnot Ogden Medical Center Emergency Medicine Residency

Emergency Medicine Residency Program PTO Guidelines

- I. Definitions
 - a. PTO = Paid Time Off; 1 day will generally refer to one shift or 1 academics day.
 - b. GME = Graduate Medical Education
 - c. ACGME = Accreditation Council for Graduate Medical Education
 - d. Week of PTO = 5 days; thus 3 weeks = 15 PTO days
- II. Need for this document
 - a. Emergency Medicine is unlike other specialties in that the coverage is always 24/7 in the emergency department. Physicians work scheduled shifts to accommodate the department's needs. Emergency Medicine residents and interns also work shifts and work a variety of weekdays, evenings, overnight, and weekend shifts. This document aims to address some of the scheduling challenges that may be encountered in the Emergency Medicine Residency and allow greater flexibility among trainees with regards to their schedules while still adhering to New York State and ACGME duty hour restrictions.
- III. PTO process
 - a. EM residents must take their PTO in separate 1 week blocks.
 - b. In general, an EM resident may take no more than 1 week of PTO per block, and it must be taken during an EM block.
 - c. The entire year's PTO schedule will be created before the beginning of that year based upon seniority ranked requests submitted to the chief residents.
 - d. During an EM block during which an EM resident takes a week of PT, they still must work the following minimum number of shifts during that block:
 - i. R1 – 15 shifts
 - ii. R2 – 14 shifts
 - iii. R3 – 13 shifts.
- IV. Trading Shifts.
 - a. When an EM resident wishes to trade shifts in order to accommodate a personal scheduling need, it must be done with either another R1, in the case of interns, or an R2/R3 in the case of upper level residents.
 - b. The scheduling chief resident must be notified when such a schedule shift is arranged. Schedule shifts must not violate work hour rules.
- V. Holiday coverage
 - a. Every attempt will be made to allow for the fair distribution of holiday shifts.
 - b. regardless of if you were working on an Arnot holiday (e.g. Christmas day) or not.
- VI. Off service residents
 - a. PTO requests from off-service residents during an EM block must be approved by EM chief resident(s) and the off-service resident's respective chief resident.

Arnot Ogden Medical Center Emergency Medicine Residency

Dress Code

- 1) EM residents will be issued navy blue scrubs and a white coat.
- 2) While on duty in the ED, the ICU, and during other off-service or away rotations, EM residents are expected to wear these scrubs or a set of an identical color.
- 3) Identification tags must be worn at all times.
- 4) It expected that residents will present a professional, well-groomed and neat appearance at all times.

Arnot Ogden Medical Center Emergency Medicine Residency

Calling in Sick

If it becomes necessary to call in sick, the EM resident will immediately contact the Program Director (or Associate Program Director) and the scheduling (administrative) Chief Resident.

Arnot Ogden Medical Center Emergency Medicine Residency

ED Rotation for Off-service Residents

The attendings and EM residents of the Arnot ED sincerely welcome the opportunity to help train our off-service residents and TRIs. Here are some basic features of this rotation:

- 1) Off-service residents will work 20 ED shifts, but will get a shift credit for each day of clinic. Off-service residents will be assigned to a pattern of day, afternoon, evening and night shifts by the EM resident scheduler.
- 2) If you take PTO during your EM block, you will still need to work a minimum of fifteen shifts.
- 3) Off-service residents will be expected to attend EM didactics every Friday or their own didactics. Didactics begin at 8 am and usually run until noon or 1 pm. They are held in the Petri conference rooms and lunch will be provided.
- 4) Dress code for work in the ED is scrubs and lab coat.
- 5) The ED has a separate electronic documentation system (PulseCheck). Please follow this link to some excellent training videos before the start of your ED rotation: <https://www.youtube.com/watch?v=VmVdq7HzcRI&index=1&list=PLeU9P0zpaNypqtQmsBZLHmPcLu5aPsGih> You will also be oriented to the system on your first day. This is how you will document your patient encounters.
- 6) When you see a patient in the ED you will present the case to an ED attending or to a senior EM resident if an attending is not available.
- 7) Make your presentation **immediately** after seeing the patient and before ordering anything beyond the most routine of lab or radiographic studies.
- 8) If you encounter a patient who appears in significant distress or is in any way unstable, notify an attending or senior EM resident immediately.
- 9) **Every patient's disposition must be completely discussed with the attending before a patient is discharged or admitted. No patient may be discharged without the attending's awareness and approval.**
- 10) Please feel free to contact one of the EM Chief Residents if you encounter difficulties of any

nature during this rotation.

Arnot Ogden Medical Center Emergency Medicine Residency

Leave of Absence Policy

The EM residency program adheres to the GME department's standard policy pertaining to a leave of absence. The federal Family and Medical Leave Act allows a resident who has completed 12 months of training to be granted up to 12 weeks of non-compensated leave-of-absence time owing to critical personal or family health care issues.

A full copy of this policy can be obtained from the GME department.

Moonlighting is not permitted under any circumstances while a resident is on Family or Medical Leave.

The Emergency Medicine Curriculum

Delineation of Skills and Competencies to be attained by Graduation

By the time of graduation, emergency medicine residents will be able to:

ADMINISTRATION

1. Discuss the following concepts as they relate to Emergency Medicine: credentialing; career development; recruitment; budgeting; health care financing; managed care; personnel management; public relations; marketing; hospital administration; practice management; contracts; and work schedules.
2. Discuss cost containment as relates to Emergency Medicine.
3. Discuss JCAHO requirements relating to the Emergency Department with emphasis on: staffing; equipment and supplies; facility; quality assurance; and patient transfer regulations.
4. Discuss hospital and Emergency Department administrative organization.

ANESTHESIA

1. Demonstrate correct use of the bag-valve-mask device.
2. Demonstrate knowledge of the anatomy of the upper airway.
3. Demonstrate detailed familiarity with endotracheal intubation by various means, including direct laryngoscopy and video laryngoscopy, as well as the use of back up airways devices such as the L.M.A and the Combitube and King Airway devices.
4. Refer to the dosages, indications and contraindications for intravenous analgesic and anesthetics, and neuromuscular blocking agents for patients of all ages.
5. Demonstrate ability to use standard monitoring techniques.
6. Demonstrate ability to manage a patient on a ventilator.
7. Demonstrate knowledge of the principles of regional anesthesia and be able to discuss metacarpal, digital, radial, median, ulnar, tibial and sural nerve blocks.
8. Demonstrate ability to administer local anesthetics and be familiar with agents, dosing, side effects, and techniques to monitor pain.
9. Recognize and manage an obstructed airway.
10. Perform all types of procedural sedation.
11. Understand facial nerve blocks to include supra orbital, infra orbital, mental and auricular nerves.
12. Demonstrate appropriate judgment regarding the need for airway intervention.
13. Demonstrate skill in the use of anesthetics and neuromuscular blocking agents including conscious sedation and rapid sequence intubation in all age groups.
14. Demonstrate ability to obtain a surgical airway.
15. Demonstrate ability to perform dental block.

CARDIOVASCULAR

1. Demonstrate the ability to perform an appropriate history and physical examination on the patient presenting with cardiac symptomatology.
2. List items elicited from the history of patient with chest pain to suggest a risk for cardiac etiology.
3. Discuss limitations in differentiation of cardiac chest pain from non-cardiac pain in patients with risk factors.
4. Describe the pathophysiology of cardiac ischemia, acute angina chest pain, and acute myocardial infarction.
5. Describe the typical electrocardiograph findings of patients with myocardial ischemia, subendocardial infarction and myocardial and transmural infarction.
6. Discuss differential diagnosis of atypical chest pain.
7. Discuss atypical presentations for acute cardiac ischemia and myocardial infarction.
8. Discuss the sensitivity and specificity of ancillary studies for chest pain presentations including EKG, chest x-ray, cardiac enzymes, and arterial blood gases.
9. Differentiate between stable and unstable angina and outline the initial treatment of patients with unstable angina including the use of nitrates, beta blockers, calcium channel blockers, etc.
10. Discuss the concept of "silent" myocardial infarction and ischemia.
11. Differentiate between transmural versus subendocardial infarction.
12. Discuss the significance of acute complete atrio-ventricular block with inferior myocardial infarction versus anterior myocardial infarction.
13. Demonstrate knowledge of AHA recommendation for the treatment of acute ventricular fibrillation, ventricular tachycardia, asystole, pulseless electrical activity, atrial flutter and fibrillation, junctional ectopy, pre-excitation, supraventricular tachycardia, and bradycardia, sick-sinus syndrome, atrial ventricular blocks (first degree, second degree and third degree) and bundle branch blocks.
14. Describe the clinical findings of cardiogenic shock and outline therapy for cardiogenic shock.
15. Differentiate cardiogenic shock from other etiologies for shock.
16. Describe the clinical presentation for pericardial disease and outline the appropriate initial therapy and management for pericardial disease.
17. Describe the presentations for myocardial infarction and their association with vessel involvement.
18. List the indications, contraindications and complications of thrombolytic therapy for acute myocardial infarction.
19. Describe the clinical presentation, etiologies for pathophysiology of, and current therapy for acute congestive heart failure.
20. Describe the valvular anatomy of the heart and list etiologies for valvular heart disease.
21. Describe the clinical findings of a mitral valve prolapse, valvular aortic stenosis, aortic regurgitation, tricuspid stenosis, tricuspid regurgitation, and pulmonary stenosis, and discuss management of each of these valvular abnormalities.
22. List complications of prosthetic cardiac valves and appropriate emergency department management.
23. Differentiate between congestive cardiomyopathy, hypertrophic cardiomyopathy and restrictive cardiomyopathy and discuss therapy for each.

24. Define myocarditis and describe the EKG findings and acute management of myocarditis.
25. Discuss the pathophysiology of acute pulmonary embolism and the predisposing factors for pulmonary embolism.
26. Discuss the sensitivity and specificity of the various tests used to diagnosis pulmonary embolism including arterial blood gases, EKG, chest x-ray, etc.
27. Discuss the sensitivity and specificity of CT scans and ventilation perfusion scans in acute pulmonary embolism.
28. Outline treatment for acute pulmonary embolism.
29. Differentiate between acute hypertensive emergencies, hypertensive urgency, and uncomplicated hypertension.
30. Discuss the indications for treatment of hypertension in the emergency department.
31. Describe the syndrome of hypertensive encephalopathy.
32. Outline the treatment for acute hypertensive emergency and differentiate treatment in the setting of thoracic aortic dissection.
33. Differentiate between primary agents for hypertensive emergency to include their advantages and disadvantages.
34. Describe the clinical presentation of acute mesenteric ischemia and discuss the inherent difficulties in the diagnosis as well as the emergency department management.
35. Discuss the pathophysiology, etiology, and overall morbidity and mortality of patients presenting with acute aortic dissection.
36. Explain the emergency department management of acute aortic dissection.
37. Differentiate between expanding, ruptured, and dissecting aortic aneurysms.
38. Describe the pathophysiology and clinical presentation for acute peripheral ischemia and outline the emergency department management.
39. Differentiate between superficial and deep venous thrombosis.
40. Outline the emergency management of acute thrombophlebitis.
41. Discuss the pathophysiologic connection between thrombophlebitis and pulmonary embolism.
42. Discuss the use of thrombolysis in acute pulmonary embolism.

CRITICAL CARE AND RESUSCITATION

1. Demonstrate ability to rapidly perform history and physical exams in critically ill patients of all ages.
2. Demonstrate a knowledge of the indications and contraindications and the ability to perform the following procedures for patients of all ages: oral endotracheal intubation, nasotracheal intubation, cricothyrotomy, needle thoracostomy, tube thoracostomy, central intravenous placement, transvenous and transcutaneous cardiac pacing, arterial line placement, ABG, and foley catheterization.
3. Demonstrate the ability to use and interpret data from ECG monitors, ECGs, cardiac outputs, hemodynamic monitoring, arterial blood gases, pulse oximetry, end tidal CO₂ monitors and respirators.
4. Describe the dosages, indications and contraindications of pharmacologic interventions for shock, cardiac failure, dysrhythmias, sepsis, trauma, toxins, respiratory failure, hepatic failure, renal failure, and neurologic illnesses.
5. Demonstrate the ability to manage a patient on a ventilator.

6. Demonstrate appropriate judgment in the management of critically ill patients.
7. Demonstrate appropriate prioritization of diagnostic and therapeutic interventions in critically ill patients.
8. Demonstrate ability to diagnose and treat shock, sepsis, fluid and electrolyte abnormalities, cardiac failure, cardiac dysrhythmias, renal failure, hepatic failure, and toxicologic emergencies.
9. Demonstrate an understanding of the appropriate use of consultants in critically ill patients.
10. Demonstrate an understanding of the ethical and legal principles applicable to the care of critically ill patients.
11. Demonstrate knowledge of the various etiologies of cardiac arrest and the corresponding therapeutic approaches.
12. Demonstrate knowledge of the factors affecting blood flow, oxygen delivery and oxygen consumption during cardiac arrest.
13. Demonstrate ability to recognize dysrhythmias associated with cardiac arrest and knowledge of ACLS protocols for their treatment.
14. Demonstrate ability to manage the airway during cardiac arrest, including mouth-to-mouth ventilation, bag-valve-mask ventilation, endotracheal intubation, cricothyroidotomy, and recognition of the obstructed airway.
15. Demonstrate ability to perform external closed chest cardiopulmonary resuscitation.
16. Discuss the dosages, indications and contraindications for pharmacologic therapy during cardiac arrest and following resuscitation. Demonstrate knowledge of the techniques for drug administration including peripheral and central venous, endotracheal, intraosseous and administration.
17. Demonstrate ability to safely perform internal and external defibrillation.
18. Demonstrate understanding of "Do not resuscitate" orders, advance directives, living wills and brain death criteria.

DERMATOLOGY

1. Demonstrate ability to diagnose and treat dermatitis and eczema.
2. Demonstrate ability to diagnose and treat soft issue infections.
3. Demonstrate ability to diagnose and treat maculopapular lesions.
4. Demonstrate ability to diagnose papular and nodular skin lesions.
5. Demonstrate ability to diagnose and discuss the etiologies of erythema.
6. Demonstrate ability to diagnose and discuss the etiologies of vesicular and bullous skin lesions.
7. Demonstrate ability to diagnose common skin cancers.
8. Demonstrate knowledge of the cutaneous manifestations of acute systemic illnesses.
9. Discuss the indications for emergent dermatologic consultation.
10. Discuss the common pharmacologic agents used to treat dermatologic disorders and their indications.

EMERGENCY MEDICAL SERVICES

1. Actively participate in the operations and education of an EMS system.
2. Describe local, state and national components of EMS.

3. Demonstrate ability to use all elements of the EMS communication system.
4. Demonstrate ability to provide initial and continuing education to all levels of EMS personnel
5. Demonstrate familiarity with research methodologies relating to EMS and disaster management.
6. Discuss medicolegal liability issues relating to EMS.
7. Participate in EMS continuous quality improvement.
8. Participate as an observer or team member in ground and air medical transport systems.
9. Discuss development of EMS prehospital care protocols.
10. Discuss basic concepts of mass casualties.
 - 10a. Discuss basic concepts of disaster management.
11. Demonstrate understanding of appropriate utilization practices for ground and air medical services.
12. Discuss the process of disaster management notification, response, and medical care on a local, state and national level.
13. Discuss the importance of and methods for medical control in EMS systems.
14. Discuss the differences in education and skill level of various EMS providers.
15. Describe common environmental, toxicologic, and biological hazards encountered in the prehospital care setting as well as injury prevention techniques.

ENVIRONMENTAL ILLNESS

1. Demonstrate the correct care for burn victims of all ages.
2. Demonstrate the ability to calculate surface area burned for various age groups using a Lund-Browder chart.
3. Demonstrate the method for determining the correct maintenance fluid regimen for the burned patient.
4. State the admission criteria for the burned patient, including criteria for burn unit admission.
5. State the chemical mechanism of injury for hydrochloric and sulfuric acids, hydrofluoric acid, alkaline burns, and white phosphorous burns.
6. List the differences between alkali and acid burns.
7. State the treatment for an acid burn, alkali burn, hydrofluoric acid burn, and white phosphorous burn.
8. Appropriately manage acute chemical burns in the Emergency Department.
9. State the common injuries/conditions which are associated with electrical injuries.
10. Demonstrate appropriate clinical and diagnostic evaluation of the electrically-injured patient.
11. List the complications resulting from electrical injuries.
12. State the common injuries and conditions associated with lightning injuries.
13. List the appropriate clinical and diagnostic evaluation of the lightning-injured patient.
14. Demonstrate the ability to evaluate and treat lightning injury.
15. State the conditions which are associated with radiation injuries.
16. State the appropriate clinical and diagnostic evaluation of the radiation-injured patient.
17. List the decontamination procedures required for the radiation-injured patient.
18. State the pathophysiologic mechanisms associated with inhalation injury.
19. State the indications for intubation in the smoke inhalation patient.
20. List the common toxins commonly associated with a house fire.

21. Demonstrate appropriate management of inhalation injuries, and recognize those patients who require emergent intubation.
22. Demonstrate the correct care for the frostbite victim.
23. Discuss the criteria for superficial frostbite and for deep frostbite.
24. Demonstrate the correct care for the hypothermic patient.
25. State the various techniques for passive and active rewarming.
26. Discuss the appropriate interpretation of blood gases in the hypothermic patient.
27. State specific considerations regarding intubation, use of external cardiac compression, and use of cardiovascular medications in the hypothermic patient.
28. Demonstrate the correct care for the heat cramp, heat exhaustion, and heat stroke patient.
29. State the definition for heat stroke and list the patients at risk for heat stroke.
30. State the criteria that differentiate various types of heat illness.
31. Demonstrate the correct care for the near-drowning/drowning patient.
32. State the pathophysiologic processes associated with immersion.
33. List the complications resulting from near-drowning/drowning.
34. State the pathophysiology of barotrauma of descent, barotrauma of ascent, air embolism, and decompression sickness.
35. Discuss the appropriate therapy for dysbaric injuries.
36. List the indications for hyperbaric oxygen therapy.
37. Discuss emergency first aid for a diving accident at sea.
38. State the symptoms associated with acute mountain sickness, high altitude cerebral edema, high altitude pulmonary edema, and high altitude retinopathy.
39. Discuss the appropriate therapy for mountain sickness, high altitude cerebral edema, high altitude pulmonary edema, and high altitude retinopathy.

ETHICS AND PROFESSIONALISM

1. Discuss the historical, philosophical, and practical implications of beneficence, autonomy, justice, truth telling and confidentiality to emergency medical practice and research.
2. Demonstrate ability to assess patients' decisional capacity/competency.
3. Discuss laws relating to drug dispensing, regulation, and abuse.
4. Discuss the importance of proper documentation in medicolegal proceedings.
5. Demonstrate ability to apply ethical principles to resuscitation, including advance directives, decision to forgo resuscitation, euthanasia, and organ transplantation.
6. Demonstrate knowledge of cost containment, resource allocation, quality of care and access to care issues.
7. Describe basic principles of medical malpractice.
8. Demonstrate familiarity with managed care plans.
9. Discuss the components of hospital administration and interactions as they relate to emergency medicine.
10. Discuss the components and responsibilities of physician-physician relationships.
11. Demonstrate knowledge of laws regarding reportable diseases, patient care, and patient transfers.
12. Demonstrate knowledge of laws regarding reporting of deaths and appropriate documentation.

GENERAL MEDICINE

1. Demonstrate appropriate history taking skills for patients presenting to the emergency department.
2. Demonstrate the ability, based on the history acquired, to do an immediate assessment and initial stabilization, followed by a complete directed examination.
3. Combine the knowledge defined in the objectives below with the history and physical examination, to develop an appropriate differential diagnosis for all presentations.
4. Demonstrate knowledge of the causes, presentation, and management of esophageal problems.
5. Describe the etiologic agents, pathophysiology, and management of infectious diarrhea.
6. Demonstrate the ability to evaluate, manage, and appropriately disposition patients with gallbladder and liver disorders.
7. Demonstrate knowledge of the presentation, diagnosis, and management of obstructive lesions of the alimentary tract.
8. Demonstrate the ability to perform intubation procedures of the alimentary tract, including, but not limited to, NG tube insertion and anoscopy.
9. Describe the presentations, work-up, and appropriate treatment of patients with inflammatory processes of the alimentary tract.
10. Demonstrate familiarity with the evaluation, treatment, and appropriate disposition of patients with gastrointestinal bleeding.
11. Demonstrate knowledge of the proper evaluation and treatment of the patient with sickle cell disease.
12. Describe the appropriate steps in the assessment and treatment of the patient with bleeding disorders.
13. Demonstrate knowledge in the work-up, treatment, and appropriate disposition of the patient with anemia.
14. Demonstrate understanding of the appropriate use of transfusions of blood components, including diagnosis and treatment of transfusion reactions.
15. Demonstrate familiarity with the mechanism and manifestations of immune compromise, including that caused by infection with HIV.
16. Discuss and be able to differentiate non-AIDS causes of immune hypofunction.
17. Discuss the manifestations, initial treatment, and appropriate disposition of patients with rheumatologic and autoimmune diseases.
18. Demonstrate understanding of the work-up and treatment of patients with hypersensitivity reactions, including transplant rejection.
19. Demonstrate knowledge of the concepts of cellular and humoral immunity and the proper use of immunizations in patients presenting to the emergency department.
20. Demonstrate familiarity with the manifestations of, evaluation for, and treatment of bacterial infections, especially including gonorrhea, syphilis, tuberculosis, and tetanus.
21. Describe the diagnostic criteria for, and the treatment of, toxic shock syndrome.
22. Know the characteristics of sepsis in different age groups.
23. Demonstrate knowledge of the appropriate initial treatment of the patient with possible sepsis.
24. Demonstrate knowledge of the vector, predisposing factors, clinical course, work-up, and treatment of rickettsial diseases.
25. Discuss the manifestations of, treatment of, appropriate disposition for, and immunization (when appropriate) of patients with viral infections.

26. Demonstrate knowledge of the time course, vectors, and treatment of the more common protozoal diseases.
27. Demonstrate familiarity with the causes, presentation, initial management and disposition of patients with glomerular disorders.
28. Describe the common etiologic agents, and appropriate work-up and disposition of patients with infections of the renal system.
29. Discuss the common causes, metabolic manifestations, treatment (including dialysis) and disposition of patients with renal failure.
30. Describe the common complications of dialysis therapy and how they manifest in patients presenting to the emergency department.
31. Define the etiologies, and demonstrate understanding in the evaluation and treatment of patients with acid/base disorders.
32. Demonstrate understanding of the etiologies, manifestations, and treatment of fluid and electrolyte abnormalities.
33. Discuss the manifestations, work-up, treatment, and disposition of patients with disorders of glucose metabolism.
34. Demonstrate understanding of the common endocrine abnormalities, especially regarding presentation, initial evaluation and management, and disposition.
35. Discuss acute treatment for patients presenting with disorders of severe malnutrition.
36. Demonstrate knowledge in the etiologic agents causing, presentation and evaluation, and disposition of patients with infections of the respiratory system.
37. Describe the etiology, manifestation, and treatment of patients with acute and chronic airway disease.
38. Discuss the predisposing factors, presentation, and appropriate treatment of patients with pulmonary embolus.
39. Demonstrate knowledge of the potential presentation, work-up, treatment and appropriate disposition of patients with chest masses.
40. Demonstrate knowledge of the presentation, work-up, treatment, and disposition of patients with chronic granulomatous disease.
41. Demonstrate knowledge of the appropriate evaluation of patients with abnormalities of the lymphatic system.
42. Demonstrate knowledge of the presentation, treatment, and disposition of patients with malignancies of the hematopoietic system.
43. Demonstrate understanding of the etiologies, diagnosis, and treatment of adult respiratory distress syndrome and multisystem organ failure.

GENERAL SURGERY

1. Demonstrate ability to perform an appropriate history and physical exam in patients with general surgical disorders, including an appropriate preoperative evaluation.
2. Discuss the differential diagnosis of acute abdominal pain and demonstrate ability to evaluate, treat and obtain appropriate consultation.
3. Demonstrate ability to diagnose and treat common disorders of the breasts.
4. Demonstrate ability to diagnose and treat common disorders of the anus and rectum.

5. Demonstrate ability to perform common procedural skills including gastric intubation, tube thoracostomy, placement of central venous lines, wound closure, and abscess incision and drainage.
6. Demonstrate ability to assist in the operative and perioperative therapy of surgical patients.
7. Discuss the common fluid and electrolyte disturbances in surgical patients and demonstrate ability to manage patients with these disorders.
8. Demonstrate appropriate prophylaxis and treatment of surgical infections.
9. Demonstrate ability to manage pain in surgical patients.
10. Discuss the role of abdominal imaging in the evaluation of abdominal pain and demonstrate ability to appropriately order and interpret imaging modalities in surgical patients.
11. Demonstrate ability to rapidly recognize and treat patients with abdominal aortic aneurysm.
12. Demonstrate ability to manage patients with acute and chronic peripheral vascular insufficiency.
13. Demonstrate ability to manage patients with soft tissue infections.
14. Demonstrate ability to diagnose common structural defects of the abdominal wall.

GERIATRICS

1. Demonstrate a sensitivity to the special needs of elderly patients and respect for their ability to make decisions.
2. Demonstrate the ability to do a formal mental status exam for the elderly patient in the emergency department environment.
3. Demonstrate the ability to assess decision-making capacity in the elderly; discuss the types and meaning of advance directives.
4. Discuss which laboratory tests are physiologically altered with aging and which tests are not changed.
5. Discuss which common diseases (appendicitis, myocardial infarction, etc.) present in elderly patients with atypical signs and symptoms that are different than the presentations in younger patients.
6. Demonstrate the ability to do functional assessments evaluating activities of daily living (ADL) of elderly patients in an emergency department setting.
7. Demonstrate the ability to define and diagnose dementia and delirium in elderly patients.
8. Discuss the etiologies and pathophysiology of falls in the elderly; demonstrate the ability to care for the elderly fall victim.
9. Discuss the management of elderly patients who present with polypharmacy.
10. Demonstrate the ability to detect depression, alcohol and drug abuse, and anxiety disorders in elderly patients.
11. Demonstrate the ability to detect and manage elder mistreatment, including physical abuse, sexual assault, physical neglect, and psychological abuse and neglect.
12. Demonstrate the ability to diagnose and treat myocardial infarction in elderly patients; discuss the importance of myocardial salvage for elderly patients with acute myocardial infarction.
13. Demonstrate the ability to diagnose and treat elderly patients with cerebral vascular accidents.
14. Demonstrate the ability to diagnose and manage trauma and acute abdominal emergencies in the elderly patient; discuss the differences in the approach to elderly patients with surgical emergencies compared to the non-elderly.

15. Demonstrate the ability to manage elderly patients presenting with syncope, dizziness, bleeding disorders, and acute infections.
16. Demonstrate the ability to address the psychosocial needs of the elderly being discharged from the emergency department.

NEUROSCIENCES

1. Demonstrate a brief and a complete neurological history and examination on patients with various levels of consciousness, including trauma patients.
2. Demonstrate knowledge of neuroanatomy and application of this knowledge in the neurological examination to localize neurological disorders.
3. Demonstrate the ability to recognize and manage cerebrovascular ischemic disorders, seizure disorders, headache, spinal cord compression, shunt malfunction, neurological infections, and neurological inflammatory states.
4. Demonstrate the ability to recognize and manage cranial nerve disorders, demyelination disorders, neuromuscular disorders, pseudotumor cerebri, normal pressure hydrocephalus, and peripheral neuropathy.
5. Demonstrate skill in the initial evaluation and management of blunt and penetrating traumatic injuries of the CNS.
6. Describe initial management of fractures, subluxations, and dislocations of the spine.
7. Demonstrate the ability to recognize and manage acute cerebrovascular and spinal cord disorders that are amenable to neurosurgical intervention.
8. Describe the main classifications of headaches and state the doses, indications, and contraindications for agents used to manage each of these types of headaches.
9. Describe the indications, techniques, and contraindications for neurological imaging procedures including plain radiographs, computerized tomographic scans, magnetic resonance imaging, tomography).
10. Demonstrate accurate interpretation of neurological imaging studies including plain radiographs and computerized tomographic scans.
11. Demonstrate skill in the performance and interpretation of spinal fluid studies.
12. Discuss the indications, contraindications, and dosages of agents used to treat neurological infections in pediatric and adult populations.
13. Demonstrate spinal immobilization techniques.
14. Demonstrate ability to recognize and manage spinal cord compression due to non-traumatic causes.
15. Describe the indications and techniques for control of intracranial pressure.

OBSTETRICS/GYNECOLOGY

1. Demonstrate ability to correctly perform a complete gynecologic exam.
2. Discuss the differential diagnosis and demonstrate ability to evaluate and treat patients with vaginal discharge.
3. Discuss the differential diagnosis and demonstrate ability to evaluate and treat patients with pelvic pain.

4. Discuss the differential diagnosis and demonstrate ability to evaluate and treat vaginal bleeding in pregnant and non-pregnant women.
5. Demonstrate ability to evaluate and treat patients with genitourinary infections including PID, UTI, STD, TOA and vaginitis.
6. Describe the symptoms and differential diagnosis of toxic shock syndrome.
7. Demonstrate ability to perform perinatal and neonatal resuscitations.
8. Describe the relative effectiveness and complications of various contraceptive methods, including post-coital douche, coitus interruptus, condoms, diaphragm, rhythm method, oral contraceptives, injectable hormonal agents and IUD.
9. Demonstrate ability to evaluate and manage the care of patients with suspected ectopic pregnancy.
10. Discuss the signs, symptoms and treatment of placenta previa.
11. Discuss the signs, symptoms and treatment of abruptio placenta.
12. Discuss the signs, symptoms and treatment of preeclampsia and eclampsia.
13. Discuss the normal stages of labor and the time course for each.
14. Demonstrate ability to determine the APGAR score and discuss the significance of different values.
15. Define the following according to ACOG guidelines: rape, statutory rape, sexual molestation, and deviant sexual assault.
16. Demonstrate ability to evaluate and treat sexual assault victims, including evidence collection, appropriate patient counseling and pregnancy prevention.
17. Discuss the differential diagnosis and demonstrate ability to diagnose and treat genital ulcerations.
18. Discuss the pathophysiology, differential diagnosis, signs, symptoms and treatment of ovarian torsion.
19. Discuss the management of trauma during pregnancy. Discuss the indications for perimortem caesarian section and describe the technique.
20. Demonstrate ability to perform uncomplicated full-term deliveries.
21. Demonstrate ability to manage patients with hyperemesis gravidarum.
22. Discuss the diagnosis and treatment of complicated labor including premature rupture of membranes, premature labor, failure to progress, fetal distress, and ruptured uterus.
23. Describe the management of complicated deliveries, including prolapsed cord, uncommon presentations, dystocia, uterine inversion, multiple births and stillbirth.
24. Demonstrate ability to diagnose and manage postpartum complications including retained products, endometritis and mastitis.
25. Discuss RH incompatibility.
26. Describe the presentation a patient with hydatidiform mole.
27. Describe the classification scheme for abortion.

OPHTHALMOLOGY

1. Demonstrate an understanding of normal ocular anatomy.
2. Demonstrate ability to perform an ocular exam.
3. Recognize and discuss the differential of abnormal fundoscopic findings.

4. Demonstrate the technique of slit lamp examination.
5. Demonstrate ability to measure intraocular pressures.
6. Demonstrate knowledge of the dosages, indications and contraindications of topical and systemic ophthalmologic medications.
7. Discuss the differential diagnosis of acute loss of vision.
8. Discuss the differential diagnosis and demonstrate correct evaluation of patients presenting with a painful eye.
9. Discuss the differential diagnosis and demonstrate correct evaluation of patients presenting with a red eye.
10. Demonstrate ability to evaluate and manage chemical injuries of the eye.
11. Demonstrate ability to evaluate and manage blunt and penetrating trauma to the eye and surrounding tissues.
12. Demonstrate ability to evaluate and manage ocular foreign bodies.
13. Discuss the presenting signs, symptoms and management of acute angle closure glaucoma.
14. Discuss the presenting signs, symptoms and management of orbital and periorbital cellulitis.
15. Describe and identify the various patterns seen on fluorescein staining of the eye.
16. Discuss the ocular manifestations of systemic disease.
17. Discuss the indications for emergent ophthalmologic consultation

ORTHOPEDICS

1. Develop ability to correctly perform a history and physical in patients with musculoskeletal disorders.
2. Demonstrate ability to correctly order and interpret radiographs in patients with orthopedic injuries.
3. Demonstrate knowledge of standard orthopedic nomenclature.
4. Demonstrate knowledge of appropriate aftercare and rehabilitation of orthopedic injuries.
5. Demonstrate knowledge of the differences in pediatric and adult skeletal anatomy and indicate how those differences manifest in clinical and radiographic presentations.
6. Demonstrate ability to apply orthopedic devices, including compressive dressings, splints and immobilizers.
7. Demonstrate skill in performance of the following procedures: fracture/dislocation immobilization and reduction, arthrocentesis, extensor tendon repair.
8. Demonstrate ability to prioritize and manage the treatment of orthopedic injuries in multiple trauma patients.
9. Describe the presentation of patients with inflammatory and infectious disorders and demonstrate ability to diagnose and treat them.
10. Demonstrate ability to diagnose and treat soft tissue foreign bodies.
11. Describe the presentations, complications, diagnosis, management and prognosis of patients with human and animal bites.
12. Describe the presentations, complications, diagnosis and management of compartment syndromes.
13. Demonstrate ability to provide regional anesthesia, including hematoma blocks, Bier blocks and radial, ulnar, median, axillary, posterior tibial and sural nerve blocks.

14. Discuss the dosages, indications, contraindications and side effects of standard analgesic and sedative agents used to treat patients with acute orthopedic trauma and demonstrate skills in their use.
15. Discuss the dosages, indications, contraindications, side effects and relative potency of standard oral analgesics used in treatment of patients with musculoskeletal disorders.
16. Discuss the differential diagnosis, historical features, physical and examination findings of patients with low back pain.
17. Demonstrate ability to recognize and treat soft tissue infections involving muscle, fascia, and tendons.
18. Describe diagnosis and treatment of overuse syndrome.
19. Describe how to evaluate and preserve amputated limb parts.
20. Demonstrate knowledge of joint injuries, evaluation and grading of joint injuries, treatment of joint injuries and prognosis.
21. Discuss evaluation and treatment of soft tissue injuries such as strains, penetrating soft tissue injuries, crush injuries, and high-pressure injection injuries.

OTOLARYNGOLOGY

1. Demonstrate ability to correctly perform a history and physical in patients with disorders of the head, ears, nose, pharynx, neck and larynx.
2. Demonstrate ability to diagnose and treat infections of the head and neck including rhinitis, otitis, labyrinthitis, sinusitis, mastoiditis, laryngitis, pharyngitis, epiglottitis, stomatitis, and gingivitis.
3. Demonstrate ability to control anterior and posterior epistaxis including placement of nasal packing.
4. Demonstrate ability to diagnose and treat disorders of the tympanic membrane and middle ear perforation.
5. Demonstrate ability to perform incision and drainage of oropharyngeal abscesses.
6. Demonstrate knowledge of common dental emergencies and indications for emergent referral.
7. Demonstrate ability to evaluate and manage disorders of the mandible, including fractures, dislocations, and infections.
8. Demonstrate ability to evaluate and manage trauma to the head, neck, face, teeth.
9. Demonstrate ability to diagnose and treat disorders of the salivary glands.
10. Demonstrate ability to remove foreign bodies from the ears, nose and throat.
11. Demonstrate ability to perform direct and indirect laryngoscopy.
12. Demonstrate knowledge of the indications, contraindications and complications of surgical airway techniques and demonstrate ability to perform a cricothyroidotomy.
13. Demonstrate ability to obtain airway control in patients with major facial trauma.
14. Demonstrate ability to perform facial nerve blocks including supraorbital, infraorbital, mental, auricular and dental blocks.
15. Demonstrate knowledge of uncommon but life threatening infections of the head and neck including cavernous sinus thrombosis, Ludwig's angina, and malignant otitis.

PEDIATRICS

1. Demonstrate correct airway management including pediatric endotracheal intubation.
2. Demonstrate ability to obtain and utilize intravenous access including venipuncture, intraosseous needle placement, and administration of appropriate dose of emergency medications.
3. Demonstrate knowledge of the significance of fever in children of various ages, and the ability to perform an "optimal resuscitation" including Yale Observation Score of the febrile child.
4. Demonstrate knowledge of common infectious diseases of childhood, including appropriate work-up and treatment of meningitis, sepsis, pneumonia, urinary tract infection, and bacteremia.
5. Demonstrate ability to properly perform a pediatric lumbar puncture.
6. Demonstrate knowledge of the pathophysiology and manifestations of common and/or serious diseases of the gastrointestinal tract and abdominal cavity of children, including gastroenteritis, intussusception, volvulus, Meckel's, anaphylactoid purpura, and appendicitis.
7. Discuss the differential and preliminary work-up of abdominal masses found in the pediatric patient.
8. State the appropriate management of children with seizures, both febrile and afebrile.
9. Demonstrate familiarity with the diagnosis and management of Reye's syndrome.
10. Demonstrate knowledge of hydrocephalus, its differential, treatment and the management of neurologic shunt problems.
11. Calculate fluid and electrolyte requirements of a dehydrated child.
12. Discuss the diagnostic work-up and disposition when child abuse and/or neglect is suspected.
13. Demonstrate ability to perform a history and physical exam of an alleged victim of sexual abuse.
14. Demonstrate ability to direct a pediatric trauma resuscitation.
15. Demonstrate knowledge of the significance and correct treatment of various patterns of burns in pediatric patients.
16. Interpret a series of pediatric EKG's, showing awareness of the normal physiologic differences from adult EKG's.
17. Discuss the common pediatric dysrhythmias, their diagnosis and treatment.
18. Discuss the types of congenital cyanotic and non-cyanotic heart disease, their complications and treatment.
19. Demonstrate ability to read pediatric chest x-rays.
20. Demonstrate ability to identify a patient who needs prophylaxis for rheumatic fever or subacute bacterial endocarditis.
21. Discuss the differential diagnosis of chest pain in children and adolescents, noting differences from adults, and demonstrating knowledge of proper work-up and treatment.
22. Discuss the differential of congestive failure in the pediatric patient and demonstrate knowledge of appropriate treatment.
23. Discuss the anatomy and physiology of the respiratory tract in children.
24. Demonstrate correct performance of peak expiratory flow measurement, pulse oxymetry and end-tidal CO₂.
25. Demonstrate management of patients with upper airway infection suspected of having epiglottitis.
26. Correctly interpret soft tissue lateral neck x-rays in children.
27. Discuss the etiologies and demonstrate correct management of children with lower and upper airway diseases including asthma, bronchiolitis, cystic fibrosis, and pneumonia.

28. Demonstrate correct management of foreign bodies of the upper airway and ability to diagnose and arrange disposition for patients with lower airway foreign bodies.
29. Demonstrate correct management of the pediatric patient with diabetes and/or diabetic ketoacidosis.
30. Demonstrate knowledge of the etiologies of anemia in children and the appropriate diagnostic evaluation.
31. Demonstrate knowledge of the differential diagnosis and work-up of the jaundiced child.
32. Discuss the differential diagnosis and work-up of the child with evidence of a bleeding disorder.
33. Demonstrate correct evaluation and treatment of a child with dysuria or a suspected urinary tract infection.
34. Demonstrate knowledge of the evaluation and treatment for phimosis, paraphimosis, balanitis.
35. Demonstrate knowledge of the evaluation and treatment of testicular disorders including torsion and epididymitis.
36. Discuss the differential and required workup for a pediatric patient with a limp.
37. Demonstrate x-ray interpretation and perform proper splinting for a variety of pediatric fractures, distal radius and ulna, and distal tibia and fibula.
38. Demonstrate ability to perform and interpret the results of an arthrocentesis.
39. Discuss the findings and disposition of a patient with a suspected autoimmune syndrome such as juvenile arthritis, lupus, or dermatomyositis.
40. Demonstrate ability to perform reduction of a dislocated joint.
41. Discuss the etiology and treatment of acute soft tissue infections and perform an
42. Correctly diagnose common pediatric exanthemas including varicella, measles, monilia, roseola, rubella, pityriasis, scabies, and erythema infectiosum.
43. Demonstrate knowledge of the differential diagnosis and evaluation of children with petechiae.
44. Demonstrate ability to correctly perform and interpret the exam of the ears, nose and throat.
45. Demonstrate knowledge of pediatric facial and orbital infections and their treatment.
46. Discuss the causes of neonatal shock and demonstrate the ability to perform and infant resuscitation, including endotracheal intubation and insertion of an umbilical venous catheter.
47. Demonstrate proper performance of a suprapubic bladder aspiration.
48. Discuss the findings and differential of sudden infant death syndrome, and demonstrate knowledge of the proper legal steps and ability to support the family.
49. Discuss the differential diagnosis and acute treatment of the weak infant and child, including polio, botulism and the Landry-Guillain-Barre syndrome.
50. Demonstrate knowledge of the evaluation and treatment of children with diarrheal illness.
51. Demonstrate knowledge of the common poisonings of childhood and their treatments.
52. Manage the care of a child with immersion/drowning.
53. Manage the care of a child with a foreign body ingestion, discussing the complications, diagnostic steps and treatment.
54. State the differential diagnosis of a child with upper or lower GI bleeding, and discuss the evaluation and treatment.
55. Discuss the differential diagnosis and work-up of renal failure or anuria in children.
56. Demonstrate ability to evaluate children with syncope and discuss its differential diagnosis.
57. Discuss the signs, symptoms, treatment and complications of Kawasaki disease.
58. Discuss the risk factors associated with teenage suicide.

59. Discuss the differential of abnormal vaginal bleeding in childhood and demonstrate ability to perform a complete genital exam on children of various ages.
60. Demonstrate ability to evaluate and treat a child with altered mental status and interpret a pediatric cranial CT scan.
61. Discuss the technique for reducing an incarcerated inguinal hernia.
62. Discuss the common pediatric malignant tumors.
63. Differentiate between the presentation, diagnostic test results and treatment of transient synovitis and septic joint.

PSYCHIATRY

1. Demonstrate ability to conduct an interview in patients with acute psychiatric disorders.
2. Demonstrate ability to perform a mental status exam in patients with normal and altered mental status.
3. Discuss the indications for emergent psychiatric consultation.
4. Discuss the indications for routine psychiatric consultation.
5. Demonstrate ability to assess suicide risk.
6. Demonstrate ability to interact with violent emergency department patients and discuss protection techniques for patients and staff members.
7. Discuss techniques of avoiding an acute psychiatric crisis in the emergency department.
8. Define major categories of psychiatric illness including thought, mood, anxiety, somatoform and personality disorders.
9. Discuss the pharmacokinetics, indications, contraindications and side effects of the major classes of psychotherapeutic agents including major tranquilizers, sedative/hypnotics, and antidepressants.
10. Discuss the process of voluntary and involuntary commitment.
11. Discuss the indications for physical and chemical restraint and demonstrate ability to use restraint appropriately.
12. Discuss the difference between pseudodementia (depression) and true dementia in the elderly.
13. Discuss organic causes of altered mental status including dementia and delirium.
14. Demonstrate ability to differentiate organic and functional causes of altered mental status.
15. Demonstrate ability to diagnose and manage common intoxication and withdrawal syndromes.
16. Discuss the common complications of alcohol and drug abuse and demonstrate ability to diagnose and manage these complications.
17. Demonstrate ability to interact effectively with patients with personality disorders including antisocial, borderline, compulsive, dependent, histrionic and passive-aggressive personalities.

RESEARCH

1. Demonstrate an understanding of the advantages and disadvantages of various study designs, including the randomized clinical trial and case control, cohort, and cross sectional studies.
2. Demonstrate an understanding of null and alternative hypotheses.
3. Demonstrate an understanding of the practical and ethical ramifications of implied and non-implied consent as they apply to hospital and pre-hospital research.

4. Understand the differences between interval, ordinal, nominal, parametric, and non-parametric data.
5. Understand the differences between independent and dependent variables.
6. Demonstrate an understanding of methodologies and variable types analyzed by the following statistical tests: t test, analysis of variance, chi square, Fischer exact test, and non-parametric tests for interval and nominal data.
7. Demonstrate an understanding of the terms "paired" and "tailed" (one and two).
8. Demonstrate an understanding of type I and type II errors as they relate to sample size and variance.
9. Demonstrate an understanding of alpha, beta, and statistical power.
10. Demonstrate an understanding of the differences between statistical and clinical significance.
11. Define sensitivity, specificity, positive predictive value, and negative predictive value.
12. Define mean, median, mode, standard deviation, and variance.
13. Demonstrate an understanding of confidence intervals.
14. Describe correlation and regression to the mean.
15. Discuss the advantages of single and double blind studies.
16. Demonstrate facility with at least one computer statistical program.
17. Demonstrate an understanding of basic ethical issues in research including consent and researchers' interactions with corporate funding sources.
18. Demonstrate an understanding of research funding.
19. Demonstrate the skills necessary to write a publishable manuscript.

TOXICOLOGY

1. Demonstrate the ability to perform gastric lavage, whole bowel irrigation, skin and eye decontamination, and administration of activated charcoal.
2. Discuss the indications, contraindications, dosages, and side effects of the currently available antidotes and antivenins.
3. Demonstrate clinical recognition of toxidromes associated with drug overdose and drug withdrawal.
4. Demonstrate knowledge of the principles of hemodialysis and hemoperfusion and the toxic agents that can be removed by these methods.
5. Demonstrate ability to recognize common venomous animals and oisonous plants and their clinical presentations and treatments.
6. Demonstrate knowledge of the diagnostic laboratory including methods, limitations and costs.
7. Demonstrate knowledge of the drug interactions, side effects, and therapeutic levels of the commonly used therapeutic agents.
8. Demonstrate the proper technique for handling a HAZMAT contaminated patient in the emergency department and the prehospital environment.
9. Demonstrate knowledge of the common household poisons, pesticides, hydrocarbons and metals, their effects and treatments.
10. Demonstrate the knowledge and clinical skills necessary to manage a patient poisoned by any of the following: acetaminophen, amphetamines, anticholinergics, aspirin, barbiturates, benzodiazepines, beta blockers, calcium channel blockers, carbon monoxide, caustics, cocaine,

cyanide, cyclic antidepressants, digitalis, ethanol, ethylene glycol, INH, iron, lithium, methanol, opiates, organophosphates, phenytoin, theophylline and venomous animals.

11. Demonstrate knowledge of basic principles of drug absorption, redistribution, metabolism, and elimination.

TRAUMA

1. Demonstrate ability to rapidly and thoroughly assess victims of major and minor trauma.
2. Demonstrate ability to establish priorities in the initial management of victims of life-threatening trauma.
3. Demonstrate ability to manage fluid resuscitation of trauma victims.
4. Demonstrate ability to manage the airway of trauma victims.
5. Discuss the continuing care of the trauma victim, including operative, post-operative and rehabilitative phases of care.
6. Demonstrate ability to perform the following procedures: oral and nasogastric intubation, venous cut downs, insertion of large bore peripheral and central venous lines, insertion of arterial lines, tube thoracostomy, local wound exploration, peritoneal lavage, vessel ligation, repair of simple and complex lacerations, splinting of extremity fractures, and reduction and immobilization of joint dislocations, cricothyroidotomy, resuscitative thoracotomy (including pericardiotomy and basic cardiorrhaphy), aortic cross-clamping, and extensor tendon repair.
7. Demonstrate ability to interpret radiographs on trauma patients, including chest, cervical, thoracic and lumbar spine, pelvis and extremity films.
8. Discuss the importance of mechanism of injury in the evaluation and treatment of the trauma victim.
9. Demonstrate ability to calculate the Glasgow Coma Score and discuss its role in the evaluation and treatment of head injured patients.
10. Demonstrate ability to use spine immobilization techniques in trauma victims.
11. Demonstrate ability to diagnose and manage trauma victims with extremity fractures, dislocations and subluxations.
12. Demonstrate ability to manage soft tissue injuries including lacerations, avulsions and high-pressure injection injuries.
13. Discuss the diagnosis and management of compartment syndromes.
14. Discuss the diagnosis and management of urogenital injuries.
15. Demonstrate appropriate use of analgesics and sedatives in trauma patients.
16. Demonstrate appropriate use of antibiotics in trauma patients.
17. Demonstrate ability to direct a trauma team during complex resuscitations.
18. Demonstrate ability to coordinate consultants involved in the care of multiple trauma patients.
19. Demonstrate ability to use and interpret imaging modalities in the evaluation of trauma patients.
20. Demonstrate ability to arrange appropriate consultation and disposition of trauma patients.
21. Demonstrate ability to direct the care of trauma victims in the pre-hospital setting.
22. Discuss principle of disaster management and participate in disaster drills.
23. Discuss the role of pre-hospital systems in the management of trauma patients.
24. Discuss factors unique to the evaluation and management of pediatric trauma.
25. Demonstrate ability to direct pediatric trauma resuscitations.
26. Discuss factors unique to the evaluation and management of geriatric trauma.

27. Demonstrate ability to direct geriatric trauma resuscitations.
28. Discuss factors unique to the evaluation and management of trauma in pregnancy.
29. Discuss the evaluation and management of spinal cord injuries.
30. Demonstrate ability to diagnose and manage tendon injuries.
31. Demonstrate ability to manage amputation injuries and discuss the potential for re-implantation.
32. Demonstrate the ability to manage the acutely burned patient, including minor and major injuries.
33. Demonstrate the ability to diagnose and treat smoke inhalation.
34. Discuss indications and procedures for transfer of an injured patient to a trauma center.
35. Demonstrate the ability to assess and manage facial trauma.
36. Demonstrate the ability to evaluate and manage anterior neck injuries.
37. Demonstrate the ability to assess and manage penetrating and blunt chest trauma.
38. Demonstrate the ability to evaluate and manage blunt and penetrating abdominal trauma.
39. Demonstrate the ability to diagnose and treat pelvic fractures.

UROLOGY

1. Discuss the pathophysiology, differential diagnosis and management of pre-renal, renal and post-renal failure.
2. Demonstrate ability to diagnose and manage the complications of chronic renal failure and dialysis, including electrolyte imbalance, dialysis disequilibrium, pericarditis, and subdural hematoma.
3. Discuss the indications for emergent dialysis.
4. Discuss the indications and demonstrate ability to interpret intravenous pyelography, urogenital US or helical CT.
5. Discuss the indications for the use of urinary tract antibiotics.
6. Discuss the indications for suprapubic catheters.
7. Demonstrate ability to perform and interpret retrograde urethrograms and cystograms.
8. Demonstrate ability to diagnose and treat infections of the urinary tract including pyelonephritis, cystitis, prostatitis and urethritis.
9. Demonstrate ability to diagnose and treat testicular disorders, including torsion, epididymitis, torsion of the appendix testis, and orchitis.
10. Discuss the indications for doppler examination and testicular scanning.
11. Demonstrate ability to diagnose and treat disorders of the penis, including priapism, fracture of the penis, phimosis, paraphimosis, Fournier's gangrene, and balanitis.
12. Demonstrate ability to diagnose and treat urinary retention.
13. Demonstrate ability to diagnose and treat renal colic and nephrolithiasis.
14. Demonstrate ability to evaluate and treat patients with blunt and penetrating urologic trauma.
15. Describe the indications for emergent urologic consultation.
16. Describe the indications for routine urologic consultation.

WOUND MANAGEMENT

1. Demonstrate ability to perform appropriate history and physical exams in patients with traumatic wounds.
2. Demonstrate an understanding of wound pathophysiology, including cellular response, static and dynamic wound tensions, growth factors and tensile strength.
3. Demonstrate an understanding of the predictors of wound sepsis.
4. Demonstrate effective wound cleansing skills.
5. Describe the appropriate use, limitations and potential complications of wound cleansing solutions.
6. Describe the appropriate use, limitations and potential complications of antimicrobials in the management of traumatic wounds.
7. Demonstrate an understanding of various imaging modalities in the detection of soft tissue foreign bodies.
8. Demonstrate appropriate use of universal precautions in wound treatment.
9. Demonstrate skill in various wound closure techniques including intradermal suture, fascial closure, interrupted skin sutures, running skin sutures, vertical and horizontal mattress sutures, half-buried horizontal mattress sutures, tape closure and use of staples.
10. Understand the role for delayed wound closure.
11. Demonstrate the technique of delayed primary closure.
12. Demonstrate appropriate management of special wound types, including skin ulcers, human bites, animal bites, snake bites, plantar puncture wounds, dermal abrasions and tar burns.
13. Demonstrate skill in the management of complex lacerations.
14. Demonstrate skill in the provision of analgesia and anesthesia to patients with traumatic wounds including use of local infiltration, topical administration and conscious sedation.
15. Demonstrate ability to apply wound dressings.
16. Demonstrate ability to thoroughly document historical and physical exam data relating to wound care.

ULTRASONOGRAPHY

1. Demonstrate familiarity with the controls and transducers of commonly used bedside ultrasound devices.
2. Demonstrate an understanding of the physical principles of ultrasonography, including the generation of images and the origin of artifacts.
3. Display an ability to utilize bedside, focused ultrasonography to perform the following studies:
 - a. F.A.S.T. exam
 - b. Cardiac exam to assess for right and left ventricular function.
 - c. Chest exam to assess for pulmonary edema or pneumothorax
 - d. Exam of the IVC to assess for a patient's volume status.
 - e. Gall bladder study
 - f. Abdominal ultrasound to assess for abdominal aortic aneurysm
 - g. Abdominal ultrasound to assess for hydronephrosis and urinary bladder distension.
 - h. Pelvic ultrasound to assess for intrauterine pregnancy or ectopic pregnancy and free pelvic fluid.
4. Demonstrate the ability to obtain ultrasound-guided central and peripheral venous access.
5. Demonstrate the ability to use ultrasonography to localize soft-tissue foreign bodies.

6. Demonstrate the ability to use ultrasonography to assess for the presence of subcutaneous abscesses.

Appendix B

Arnot GME Remediation Process

- 1) PD identifies academic or professional difficulty with trainee
- 2) PD discusses situation with the trainee in presence of the program coordinator, who will keep minutes of the discussion. (PDs should never meet with trainees to discuss remediation without the program coordinator present to record the discussion).
- 3) PD then writes a specific remediation plan.
- 4) PD gives plan to program coordinator who will load it onto the approved form.
- 5) Program coordinator gives to GME coordinator for administrative review.
- 6) Once reviewed and approved, form will be returned to the program coordinator.
- 7) Program coordinator returns form to PD for final approval.
- 8) PD, program coordinator, and trainee meet and trainee signs the remediation plan.
- 9) Plan goes into effect.

Arnot Ogden Medical Center Emergency Medicine Residency

Clinical Competency Committee

- 1) The C.C.C. will be appointed annually by the program director and consist of three or more Arnot emergency medicine faculty members, to include the program director &/or associate program director.
- 2) The program director may appoint additional Arnot health professionals who have experience with the program's residents inpatient care performance.
- 3) The C.C.C. will meet semi-annually in the months of November/December and May/June.
- 4) The C.C.C. will review all resident evaluations and ensure the reporting of Milestone evaluations to the ACGME for each resident semi-annually.
- 5) The C.C.C. will advise the program director regarding resident progress, including promotion, remediation, and dismissal.

Appendix D

Arnot Ogden Medical Center Emergency Medicine Residency

Program Evaluation Committee

- 1) The P.E.C. will be appointed annually by the program director and will consist of no less than two faculty members, including the program director or associate program director, as well as no less than one resident.
- 2) The P.E.C. will meet semi-annually in the time frames of December/January and April/May. The P.E.C. will be charged with the responsibility of planning, developing, implementing, and evaluating educational activities of the program.
- 3) The P.E.C. will review and make recommendations for revision of competency-based curriculum goals and objectives.
- 4) The P.E.C. will address areas of non-compliance with ACGME standards.
- 5) The P.E.C. will perform these functions using evaluations from faculty, residents and others.
- 6) The program director will ensure that residents and faculty have the opportunity to reevaluate the program confidentially and in writing, and that these reports are seen by the P.E.C.
- 7) The P.E.C. will discuss progress on the previous year's action plans.
- 8) The P.E.C. will prepare a written plan of action annually to document initiatives to improve performance, as well as to delineate how such initiatives will be measured and monitored.
- 9) The P.E.C.'s reports will be presented at the Graduate Medical Education Committee.

Appendix E

Arnot Ogden Medical Center

Department of Graduate Medical Education

GENERAL POLICY ON RESIDENT SUPERVISION

STATEMENT OF GENERAL POLICY

An appropriate level of supervision is required of all residents during clinically relevant activities.

DEFINITIONS

- A. Supervision - Supervision refers to the dual responsibility that an attending physician has to enhance the knowledge of the resident and to ensure the quality of care delivered to each patient by any resident. Such control is exercised by observation, consultation and direction. It includes the imparting of the attending physician's knowledge, skills, and attitudes by the attending physician while ensuring that patient care is delivered in an appropriate, timely, and effective manner.

- B. Resident - The term "resident" refers to an individual who is engaged in a graduate training program in medicine (which includes all medicine specialties, e.g., emergency medicine, family medicine, internal medicine, surgery, psychiatry, radiology, and issued broadly to include interns), and who participates in patient care under the direction of the attending physicians. The term "resident" includes individuals in approved subspecialty graduate medical education programs who historically have also been referred to as "fellows."

POLICY

The intent of this policy is to ensure that patients will be cared for by clinicians who are qualified to deliver care and that this care will be documented appropriately and accurately in the patient record. This is fundamental, both for the provision of excellent patient care and for the provision of excellent education and training. Faculty supervision of residents assures resident education. The quality of patient care, patient safety, and the success of the educational experience are inexorably linked and mutually enhancing. Incumbent on the clinical educator is the appropriate supervision of the residents as they acquire the skills to practice independently and simultaneously provide the highest standard of patient care. Additionally, it should be understood that documentation of patient care acceptable for purposes of third-party billings, is governed by guidelines that are defined by payers, such as the Centers for Medicaid and Medicare Services (CMS) or third-party insurers.

SCOPE

- A. Attending physicians are responsible for the care provided to each patient, and they must be familiar with each patient for whom they are responsible. Fulfillment of that responsibility requires personal involvement with each patient and with each resident who is participating in the care of that patient. Each patient must have an attending physician of record whose name is recorded in the patient chart. It is recognized that other attending physicians may, at times, be delegated responsibility by the attending physician of record. In this case, the Attending physician of record is responsible to be sure that the residents involved in the care of the patient are informed of such delegation and can readily access an attending physician at all times and the attending of record, if necessary
- B. Within the scope of the training program, all residents must function under the supervision of an attending physician. On-call schedules and rotation schedules for each residency program are to be developed on a periodic basis to provide residents with a variety of patient care educational experiences consistent with the program requirements of that particular program. Backup must be available at all times through more senior residents and appropriately credentialed attending physicians. It is the responsibility of each program director to establish categories of all resident activities according to graduated level of responsibility and appropriate levels of supervision outlined below. The requirements for on-site supervision will be established by the program director for each residency program in accordance with AOA, ACGME, AMA, DNV, CMS guidelines and should be monitored through periodic departmental reviews, with institutional oversight through the GMEC internal review process. The type of supervision (physical presence of attending physicians, home call backup, etc.) required by residents at various levels of training, must be consistent with the requirement for progressively increasing resident responsibility during a residency program and the application program requirements of the individual departmental, as well as common, standards of patient care. The levels of supervision are:
- a. **Direct Supervision:** The attending physician is physically present with the resident and patient.
 - b. **Indirect Supervision:**
 - i. With direct supervision immediately available. The supervising physician is physically within the hospital or other site of patient care and is immediately available to provide direct supervision.
 - ii. With direct supervision available. The supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide direct supervision present in the operative/procedural suite or on the unit and immediately available for consultation.
 - c. **Oversight:** The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
- C. In order to ensure patient safety and quality patient care while providing the opportunity for maximizing the educational experience of the resident in the ambulatory setting, it is expected that an appropriately privileged attending physician will be available for supervision during

clinic hours. Patients followed in more than one clinic will have an identifiable attending physician for each clinic. Attending physicians are responsible for ensuring the coordination of care that is provided to patients.

POLICY STANDARDS

Quality graduate medical education can occur only in settings that are characterized by the provision of high quality patient care. As a practical matter, preparing future practitioners to meet patients' expectations for excellence requires they learn in environments epitomizing the highest standards of medical practice. Even more important, as an ethical matter, justifying the participation of residents in the care of patients requires adherence to uncompromised standards of quality medical care.

- B. The attending physician of record is responsible for the quality of all of the clinical care services provided to his or her patients.
- C. All clinical services provided by resident physicians must be supervised appropriately to maintain high standards of care, safeguard patient safety, and ensure high quality education, based on patient acuity and a resident's graduated level of responsibility.
- D. Attending physicians directly responsible for the supervision of patient care services provided by resident physicians must be as available to participate in that care as if residents were not involved; the presence of residents to "cover" patients on inpatient services or to provide care in ambulatory settings does not diminish the standards of availability required of the physician of record.
- E. Attending physicians are responsible for determining when a resident physician is unable to function at the level required to provide safe, high quality care to assigned patients, and must have the authority to adjust assigned duty hours as necessary to ensure that patients are not placed at risk by resident physicians who are overly fatigued or, otherwise, impaired.

PROCEDURES

- A. All patient care performed by residents during training will be under the supervision of an attending physician credentialed to provide the appropriate level of care. The specifics of this supervision must be documented in the medical record by the attending physician or resident according to Medical Staff rules and regulations.
- B. The supervising/attending physician must be immediately available to the resident in person or by telephone 24 hours a day during clinical duty. Residency Program Directors must assure this occurs. Residents must know which supervising/attending physician is on call and how to reach this individual.
- C. Inpatient supervision: The supervising/attending physician must obtain a comprehensive presentation from the resident including a history and physical with co-signed attending attestation for each admission. This must be done within a reasonable time, but always within 24 hours of admission. The supervising/attending physician must also require the resident to present the progress of each inpatient daily, including discharge planning. All required supervision must be documented in the medical record by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.

- D. Outpatient supervision: The supervision/attending physician must require residents to present each outpatient's history, physical exam and proposed decisions. All required supervision must be documented in the medical record by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.
- E. Consultative Service supervision: The supervising/attending physician must communicate with the resident and obtain a presentation of the history, physical exam and proposed decisions for each referral. This must be done within an appropriate time but no longer than 24 hours after completion by the resident of the consultation request. All required supervision must be documented by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.
- F. Procedural supervision: The supervising/attending physician must ensure that procedures performed by the resident are warranted, that adequate informed consent has been obtained and that the resident has an appropriate level of supervision during the procedure to include sedation. The level of supervision (according to the four levels outlined previously in this policy) must match both the resident's ability to determine the appropriateness of the procedure and the resident's ability to perform the procedure. All required supervision must be documented by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.
- G. Emergency supervision: During emergencies, the resident should provide care for the patient and notify the supervising/attending physician as soon as possible to present the history, physical exam and planned decisions. All required supervision must be documented by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.
- H. The GME Department has specific guidelines concerning resident supervision and submits them to the GMEC for approval. These must include the following key principles:
 - a) Clinical responsibilities must be conducted in a carefully supervised and graduate manner, tempered by progressive levels of independence to enhance clinical judgment and skills.
 - 1. This supervision must supply timely and appropriate feedback about performance, including constructive criticism about deficiencies, recognition of success, and specific suggestions for improvement.
 - 2. Resident supervision must support each program's written educational curriculum.
 - 3. Resident supervision should foster humanistic values by demonstrating a concern for each resident's well-being and professional development.
 - 4. Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.
 - b) Residents are supervised by teaching staff in accordance with these established guidelines.
 - c) Faculty call schedules are structured to assure that support and supervision are readily available to residents on duty.
 - d) The quality of resident supervision and adherence to the above guidelines are monitored through annual review of the resident's evaluations of their faculty and rotations by the GMEC (see Evaluations of Rotations and Faculty Members by Resident Policy).
 - e) For any significant concerns regarding resident supervision, the appropriate Residency Program Director will submit a plan for its remediation to the GMEC for approval.
 - f) The appropriate Residency Program Director will submit monthly progress reports to the GMEC until the situation or issue is resolved.

