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Program Philosophy and Mission Statement

The Emergency Medicine Residency Program of Charleston Area Medical Center is dedicated to excellence in the training of Emergency Medicine Residents. The goal of the training program is to provide the graduating residents with the tools, skills, empathy and knowledge to practice in any Emergency Department of their choosing. The residency program strives to continuously improve upon its program, training facilities and academic curriculum to achieve the ultimate goal of the Department of Emergency Medicine: “Excellence in patient care”. We have incorporated the CAMC mission statement, which is: “Striving to provide the best health care to every patient, every day.”

Educational Philosophy

As you read this manual keep in mind the following ideas:

1. This program is designed for adult learners. Therefore, the extent of your reward, or education gained, is highly dependent on your input and effort.
2. We do not attempt to teach as much as we attempt to assist you with your learning process.
3. Each adult learner will have unique strengths and needs. A large portion of our evaluation process is based on helping to identify these opportunities.

Welcome

The faculty of the Emergency Medicine Residency welcomes all the new and returning residents to a promising year for our program. Competition for emergency medicine residencies is fierce; congratulate yourself on achieving this high level of success.

Charleston Area Medical Center (CAMC) is partnered with the Mountain State Osteopathic Postdoctoral Training Institutions, Inc. (MSOPTI), the West Virginia School of Osteopathic Medicine, and West Virginia University. Becoming a resident in training at CAMC, means becoming part of a well-respected team at an academic medical center, which encourages innovation. Because we are a 908-bed, tertiary care health care system with an affiliation with West Virginia University, we can offer a balanced experience in both private practice and academia. At CAMC you will have the benefit of interacting with Emergency Medicine faculty who are all residency-trained, board certified/board prepared in Emergency Medicine, or have completed a residency in another discipline and has special qualifications in Emergency Medicine. In addition, you will be working with residents from Family Medicine, Internal Medicine, Internal Medicine/Pediatrics, Internal Medicine/Psychiatry, Psychiatry and Behavioral Medicine, Obstetrics and Gynecology, Osteopathic Medicine, Pediatrics, Surgery, Orthopedics and Urology. Residencies in Pharmacy are also associated with CAMC. We also provide rotations for interns and pre-doctoral clinical rotations for medical students and Physician Assistant students.

As a resident in the CAMC Osteopathic Emergency Medicine Program you will be exposed to learning opportunities afforded only at major teaching institutions. This year, CAMC will experience over 100,000 emergency room visits. You will have a diverse experience of facilities and patient populations. The General Hospital campus is home to our Neurosciences Center, Level I Trauma Center, Medical Rehabilitation Center, Center for Joint Replacement, Facial
Surgery Center, Stroke Center, and Charleston’s only accredited Sleep Center. Each year, our experienced Trauma Center staff treats nearly 3,200 level I and II trauma patients. An average of 1,500 patients also receives neurosurgery and medical rehabilitation services here. The Memorial Hospital campus is home to the nation’s fourth largest cardiology program. Here, physicians perform more cardiac catheterizations than Johns Hopkins or the Mayo Clinic, and excel in bypass surgery. Memorial Hospital is also the site of the Cancer Patient Support Program and a comprehensive diabetes center, as well as other clinics and general medical-surgical inpatient services. The Robert C. Byrd Health Sciences Center of West Virginia University/Charleston Division is also located on this campus. Women and Children’s Hospital has more than 3,000 babies born yearly, many of which are high-risk births. The hospital is home to the region’s largest and busiest Level III Neonatal Intensive Care Unit and Pediatric Intensive Care Unit. The pediatricians of West Virginia University/Charleston Division provide specialty consultation in Endocrinology, Surgery, Trauma and Critical Care. Charleston Division Obstetrics and Gynecology faculty provide high-tech maternal-fetal medicine and gynecologic cancer services.

Our educational philosophy is that this program is designed for adult learners. Therefore, the extent of your reward, or education gained, is highly dependent on your input and effort. We do not attempt to teach as much as we attempt to assist you with your learning process. Each adult learner will have unique strengths and needs. A large portion of our evaluation process is based on helping to identify these opportunities. As adult learners and future leaders in the profession, you will often be directed to participate in teaching, research projects, community service, various committees, and other opportunities as they arise. It is important to keep in mind that this residency will prepare you to lead and teach, in addition to the complex task of running an emergency department.

Your residency years will be memorable and you will grow as a physician and as a human being. On behalf of the Emergency Medicine Residency Administration and Faculty, WELCOME!!!

<table>
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<tr>
<th>Goals of the Emergency Medicine Residency</th>
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<tr>
<td>a. Provide learning experiences based on measurable objectives for the education of residents during a four-year training program.</td>
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<td>b. Promote a broad understanding of the role of Emergency Medicine as it relates to other medical specialties.</td>
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<td>c. Integrate the sciences applicable to Emergency Medicine with clinical experiences in a progressive manner.</td>
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<td>d. Provide the Emergency Medicine resident with progressive responsibilities, commencing with general medical skills, and progressing to complete care of patients in need of emergency care.</td>
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<td>e. Provide training that will enable the Emergency Medicine resident to rapidly evaluate, initiate treatment, and prescribe the appropriate therapy of the emergency patient.</td>
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<td>f. Develop the teaching skills of the residents in Emergency Medicine.</td>
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<td>g. Develop the skills necessary for problem solving in the Emergency Medicine environment.</td>
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<td>h. Develop professional leadership and management skills.</td>
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<td>i. Promote lifelong learning in medical education.</td>
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<td>j. Develop interest in, and understanding of, research in Emergency Medicine.</td>
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k. Prepare the resident to meet certification requirements of the AOA through the American Osteopathic Board of Emergency Medicine.

Discrimination Policy

Acceptance to CAMC Osteopathic Emergency Medicine Residency Program is not influenced by race, gender, religion, creed, national origin, age, sexual orientation, marital status, veteran status, disability, or other legally protected status.

Evaluations

We believe that if you know ahead of time how you will be evaluated, it will help you achieve your goals and successful completion of the residency. Keep in mind that the entire evaluation process should be a learning experience for both the learner and the evaluator.

Feedback

There are three ideal times for feedback. “Brief” feedback is spontaneous and occurs at the point of contact. A faculty member may give you brief feedback when observing a physical examination of a patient, performance of a procedure, or when monitoring a presentation of a patient’s medical history and examination in the clinical or didactic venue.

“Formal” feedback is provided when a period, (usually 5 to 10 minutes), is set aside to deliver feedback. Formal feedback may relate to the management of a particularly difficult or confusing case, to a medical mistake, or to a behavioral issue. Formal feedback is best given at the end of a shift. You are encouraged to ask for specific comments on your performance and areas to improve at the end of each shift.

“Major” feedback consists of scheduled session’s midway through your rotation. These sessions, held in private, typically last for 15 to 30 minutes. You will be advised ahead of time when your major feedback session will occur. This session is critical so that you can be given areas to work on, and remediate during the remainder of the rotation, instead of discovering at the end of the rotation that there were deficiencies. This is also an excellent time for you to address issues you may be having in obtaining the goals set forth for you, especially any difficulty in attainment of an appropriate number of clinical procedures and skills.

Summative and Formative Evaluation

Evaluations are structured, and contain summative and formative evaluation processes. Summative evaluation involves making judgments about your concrete achievements during the rotation; it is the mechanism by which you are “accountable” for what you have learned during the rotation. Summative evaluation is primarily a retrospective process in which learners’ accomplishments and habits are documented. This may include weekly testing, standardized
written exams, such as the PEER or resident in service exam, or individual end of rotation exams. We also will use daily and composite scores of your evaluations, tracked block to block and over a period of time, to accomplish this goal.

Formative evaluation focuses on identifying your strengths (for subsequent amplification) and weaknesses (for remediation). Formative evaluation is primarily a prospective process in which the intern or resident’s strong and weak points are assessed with an eye toward improvement in future evaluations. Optimally applied, formative evaluation helps you develop good habits. Many types of formative evaluation can also be used as aids for summative evaluation, and vice versa. For example, testing can be used, at least in part, for both types of evaluation. The periodic standardized patient encounters are an example of this type of evaluation.

**Direct Observation**

Direct observation during history taking, physical examination, or procedures in the clinical setting, allows evaluation of your ability based on pre-specified performance-based criteria.

**Shift Evaluation**

An evaluation in the clinical setting will be done by each attending you work with for every rotation. The competencies that will be assessed are based on milestones created by The Accreditation Council for Graduate Medical Education and The American Board of Emergency Medicine. They will serve as an objective marker to indicate your progression throughout your training. A copy of these milestones will be provided to you.

**Standardized Patients and Simulation Lab Experience**

One of the things that probably attracted you to this residency is the educational process and its unique delivery in the EM Residency at CAMC. A large portion of this delivery includes the Simulation Lab. Extensive resources (money, time, space, material and manpower) have been invested to provide you with a state of the art facility in which to advance your learning. We have designed, and continue to develop, models for simulated patient encounters, procedures, and practice development.

We approach this as the safest, most efficient way to help you learn to be outstanding Emergency Medicine physicians. This is also the ideal setting to assess your mastery of the core competencies, while identifying both strengths and opportunities for growth.

**Examinations**

Examinations (written or oral) may be incorporated into the evaluation of your knowledge base, and will correlate with the educational core topics. Objective testing will be supplemented by
other evaluation mechanisms, including “at the moment” evaluation at patients’ bedside, case presentations, and simulated patient encounters. Understand that the educational goal is not short-term retention of factual knowledge, but rather longitudinal, practical, and applicable knowledge and skills.

**Procedural Evaluations**

Evaluation of procedural skills can be measured against a checklist of essential actions during direct observation of clinical work, during procedural workshops and simulated patient encounters. In addition, you are required to log all procedures on New Innovations.

**Evaluation of the Faculty and Rotation**

All persons completing the Emergency Medicine rotation will have the opportunity to give feedback about their educational experience. You will be able to provide us with anonymous feedback about your teachers, the curriculum, the clinical experience, and any other aspects of the rotation you wish to share. Results may be useful for individual faculty development and promotion, for identification of institutional problems, and to provide evidence for resource allocation.

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<th>Core Competencies</th>
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The six general competencies endorsed by the ACGME (Accreditation Council for Graduate Medical Education) at its September 1999 meeting are: patient care, medical knowledge, interpersonal and communication skills, practice-based learning and improvement, professionalism, and systems-based practice. The AOA has adopted these criteria with the addition of a seventh competency in osteopathic principles and practices. Language related to the general competencies has been added by the Residency Review Committees to each set of Core Program Requirements and by the Institutional Review Committee to the Institutional Requirements. The competencies act as organizing principles for the curricula of all core specialty programs, and reflect the expectation that graduating residents should exhibit behaviors reflective of these competencies at a level appropriate to an independent practitioner. The core competencies can also be effectively evaluated using a comprehensive analysis of the aforementioned milestones. The American Board of Medical Specialties (ABMS) has also endorsed the general competencies for use by certifying boards in the examination and re-certification of physicians.

Osteopathic Emergency Medicine residents are expected to obtain competence in the seven domains. The seven general competencies form the basis for the goals and objectives of each rotation. Specific knowledge, skills, behaviors, and attitudes required will be specified in the clinical rotation summary for each rotation.** Patient Care:** Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
Among other things, residents are expected to:

- Gather accurate, essential information in a timely manner.
- Generate an appropriate differential diagnosis.
- Implement an effective patient management plan.
- Competently perform the diagnostic and therapeutic procedures and emergency stabilization.
- Prioritize and stabilize multiple patients and perform other responsibilities simultaneously.
- Provide health care services aimed at preventing health problems or maintaining health.
- Work with health care professionals to provide patient-focused care.

**Medical Knowledge:** Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences, and the application of this knowledge to patient care.

- Among other things, residents are expected to:
  - Identify life-threatening conditions, the most likely diagnosis, synthesize acquired patient data, and identify how and when to access current medical information.
  - Properly sequence critical actions for patient care, and generate a differential diagnosis for an undifferentiated patient.
  - Complete disposition of patients using available resources.

**Practice-Based Learning:** Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

Among other things, residents are expected to:

- Analyze and assess their practice experience, and perform practice-based improvement.
- Locate, appraise, and utilize scientific evidence related to their patient’s health problems.
- Apply knowledge of study design and statistical methods to critically appraise the medical literature.
- Utilize information technology to enhance their education and improve patient care.
- Facilitate the learning of students and other health care professionals.
**Interpersonal and Communication Skills:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates.

Among other things, residents are expected to:

- Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences.
- Demonstrate effective participation in, and leadership of the health care team.
- Develop effective written communication skills.
- Demonstrate the ability to handle situations unique to the practice of Emergency Medicine.
- Effectively communicate with out-of-hospital personnel, as well as non-medical personnel.

**Professionalism:** Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

- Residents are expected to demonstrate a set of model behaviors that include but are not limited to:
  - Treat patients/family/staff/paraprofessional personnel with respect.
  - Protect staff/family/patient’s interests/confidentiality.
  - Demonstrate sensitivity to patient’s pain, emotional state, and gender/ethnicity issues.
  - Able to discuss death honestly, sensitively, patiently, and compassionately.
  - Unconditional, positive regard for the patient, family, staff, and consultants.
  - Accept responsibility/accountability.
  - Openness and responsiveness to the comments of other team members, patients, families, and peers.

**Systems-Based Practice:** Residents must demonstrate an awareness of, and responsiveness to the larger context and system of health care, and the ability to effectively call on system resources to provide care that is of optimal value.

Among other things, residents are expected to:

- Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal emergency care.
- Understand different medical practice models and delivery systems, and how to best utilize them to care for the individual patient.
- Practice cost-effective health care and resource allocation that does not compromise quality of care.
o Advocate for and facilitate patients’ advancement through the health care system.

**Osteopathic Principles and Practices**: Residents must demonstrate an awareness of the basic tenets of osteopathic philosophy and ability in basic manipulative medicine.

Among other things, residents are expected to:

- Understand the interdependence of the musculoskeletal/lymphatic system and other organ systems.
- Understand that the mind, body, and spirit all interact in the promotion of health and well-being.
- Demonstrate the ability to utilize osteopathic manipulative medicine as a part of their patient care regimen.

<table>
<thead>
<tr>
<th>Core Faculty</th>
<th>Board Certification</th>
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<tbody>
<tr>
<td>Dave E. Seidler, MD, FACEP</td>
<td>ABEM</td>
</tr>
<tr>
<td>William N. Payne, MD</td>
<td>ABEM</td>
</tr>
<tr>
<td>Jeffrey M. Mullen, DO</td>
<td>ABEM</td>
</tr>
<tr>
<td>Jessica Sop, DO</td>
<td>AOBEM</td>
</tr>
<tr>
<td>Barry Mitchell, MD</td>
<td>ABIM, ABP, ABEM</td>
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<th>Non-Core Faculty</th>
<th>Board Certification</th>
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<tbody>
<tr>
<td>Brendan L. O’Hara, MD</td>
<td>ABEM</td>
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<tr>
<td>Gregory D. Kelly, DO</td>
<td>AOBEM</td>
</tr>
<tr>
<td>Edward Wright, MD</td>
<td>ABEM</td>
</tr>
<tr>
<td>Leon Kwei, MD</td>
<td>ABEM</td>
</tr>
<tr>
<td>Kimberly F. Ewing, MD</td>
<td>ABP, ABP-EM</td>
</tr>
<tr>
<td>Nimish Mehta, MD</td>
<td>ABP</td>
</tr>
<tr>
<td>Bonnie Bailey, MD</td>
<td>ABP</td>
</tr>
<tr>
<td>Piayon Kobbah, MD</td>
<td>ABP</td>
</tr>
<tr>
<td>Michael Peterson, DO</td>
<td>AOBEM (in progress)</td>
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<td>Myles Austin, DO</td>
<td></td>
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<tr>
<td>Steve Berry, MD</td>
<td></td>
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<tr>
<td>Shane Bowen, MD</td>
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<tr>
<td>Jessica Mills, DO</td>
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**Residency Faculty - Emergency Physicians**

Abbreviations:
AOBEM: American Osteopathic Board of Emergency Medicine
ABEM: American Board of Emergency Medicine
FACOEP: Fellow, American College of Osteopathic Emergency Physicians
FACEP: Fellow, American College of Emergency Physicians
ABP: American Board of Pediatrics
Residency Positions Available

As of November 2008 the CAMC Emergency Medicine Residency is approved by the American Osteopathic Association for the following positions:

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<td>PGL2</td>
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<td>PGL3</td>
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<td>PGL4</td>
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Charleston Area Medical Center Policies

The policies of this manual are applicable only to residents enrolled in the CAMC Emergency Medicine Program. All such policies are subject to institutional approval, and must conform with all related institutional policies currently in effect, or that may be approved within the coming academic year. In the event of a conflict, institutional policy shall prevail.

It is expected that each resident become familiar with the guidelines approved by Charleston Area Medical Center for the postgraduate physicians. Additional copies of the Charleston Area Medical Center 2015-2016 House Staff Handbook may be obtained by calling the Graduate Medical Education office at 304-388-9947. This is also available online at [http://camc.wvu.edu/pdf/staffhandbook.pdf](http://camc.wvu.edu/pdf/staffhandbook.pdf).

Ethics

The confidential nature of information pertaining to the patient must be respected. Patients or hospital affairs should not be discussed in public, this includes through social media such as Facebook or Twitter.

You may question the attending physician with regard to anything you do not understand concerning a patient. You may not discuss this with other hospital personnel, nor should this be discussed in front of the patient or family.

Personal conversations should not be held in the presence of patients, visitors or hospital personnel.

Arguments with patients are not permitted. If difficulties arise, the attending physician or the nursing supervisor should be called for assistance.

Disrespectful conversations about peers, staff, attending, patients, or anyone will not be tolerated.
Chain of Command/Supervision

As an Osteopathic Emergency Medicine Resident at Charleston Area Medical Center you are a member of a multilevel health care team. Your primary responsibilities are to pursue an education and patient safety. To this end you must understand and believe it is never appropriate to allow patient safety to be jeopardized by any chain of command. Even as a junior resident, if a patient or other member of the team is in immediate danger, if you are unable to contact the senior resident, or if such contact will be delayed (e.g. the senior resident is involved in surgery, a procedure or a code), you should not hesitate to contact the responsible attending.

Each off-service assignment will have its own chain of command, which ultimately begins and ends with the attending physician. Most of these rotations, however, will have a Chief or Senior resident who is responsible for decisions made on that service. This resident is also responsible for the actions of assigned junior residents. Although the Chief or Senior Resident is responsible for guiding patient management through his/her junior residents, (by assigning cases and directing their management), a team approach is emphasized to facilitate communication at all levels. You are to follow each service’s specific Chain of Command when training on that service. Generally, it is at the responsible senior resident’s discretion that a faculty member be contacted during an unexpected clinical event.

This sequence varies somewhat when, as an Emergency Medicine Resident, you are working in the Emergency Department. As your training progresses you will find that on many occasions you are the Senior Resident in the department. You may be assigned junior residents from within our residency, off-service residents and/or students to directly supervise. The ultimate responsibility will always rest with the attending physician you have been assigned to work with on that particular shift. The actual conduct of the service will rest within the authority of that attending. All attending staff members are encouraged to see every patient. You are required to keep that attending abreast of your decisions in a timely manner including those concerning diagnostic studies and treatment plans. You must inform your attending about any unexpected or critical changes in a patient’s clinical course. You are also required to inform your attending of all disposition plans, or when end-of-life decisions are being made for your patients in the ED. If conflict arises between yourself and other members of the health care team, you are encouraged to attempt prompt professional resolution of the conflict while utilizing the attending physician as a resource, mentor, and even a safety net.

Should there arise an occasion where a conflict cannot be resolved using the above process, such as a conflict between yourself and the attending, or an issue of patient safety, you are required to always place patient safety above other possible issues. Once this requirement has been met, you are encouraged to explore other avenues of conflict resolution. These may include, but are not limited to, seeking assistance from the charge nurse, contacting the residency program director or contacting the department chair. Refer to the House Staff Handbook for CAMC resident supervision policies.
Hours of Duty

The CAMC EM residency adheres to all national, state and local laws, rules and regulations governing professional activities. Additionally, we conform to all AOA, ACOEP, and institution policies governing hours of duty. It is recognized that duty hours are different in each training program. Night schedules, weekend duty schedules, and holiday schedules are the responsibility of the Program Director. Residents will not go off duty if service to the patient requires that he/she remains to meet demands of care. Before going off duty, the resident must make certain that his/her relief is present, as well as to report to him/her all seriously ill and critically ill patients. The resident on-call will remain at CAMC according to departmental policy. At no time may a medical student cover a service. All residents must adhere to institutional and program policies regarding duty hours.

In accordance with ACGME/AOA program requirements, **duty hours** are defined as all clinical and academic activities related to the residency program, i.e. patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences.

Duty hours do not include reading and preparation time spent away from the duty site. Duty hours during your emergency medicine months are different from those when on off service rotations. **When on emergency medicine you must not work more than 60 hours per week, averaged over a four-week period, inclusive of all non-clinical activities.** Your shifts cannot exceed 12 hours and you must have equal time off between scheduled work periods, meaning that if you worked a 12 hour shift, you must have 12 hours off before returning to work or if you worked a 10 hour shift you must have 10 hours off, etc. When you are not on emergency medicine, you may not work more than 80 hours per week averaged over a 4 week period. PGY-1 residents cannot work more than 16 hours straight and PGY-2 residents and above may not be scheduled for more than 24 hour work periods. At the conclusion of a 20-24 hour work shift, residents must have a minimum of 12 hours off. When completing a 12-20 hour shift, residents must have a minimum of 10 hours off. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of all call time. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour duty free periods between shifts. The objective of **on call activities** are to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal workday when residents are required to be immediately available in the assigned institution. In-house call must occur no more frequently than every third night, averaged over a four-week period. Continuous onsite duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care (unless further limited by the relevant Program Requirements). No new patients may be accepted after 24 continuous hours on duty. A new patient is defined as any patient for whom the resident has not previously provided care (unless otherwise defined in the relevant Program Requirements). Hours spent on at-home call must count towards the 80-hour maximum work week.
Moonlighting (see below) must be counted toward the 60/80-hour weekly limit on duty hours as defined by institutional policy and ACGME institutional requirements. Residents are responsible for adhering to duty hour requirements, and for reporting areas of noncompliance to program and administrative officials in a timely fashion. Residents must also provide accurate and truthful documentation, attestation or other reports required by the program or institution for the purpose of moonlighting practices or duty hour requirements.

All residents are required to record duty hours on New Innovations at minimum every 72 hours.

Further discussion of duty hours may be found in the *Charleston Area Medical Center Health System, Inc. 2015-2016 House Staff Handbook*

**Moonlighting Policy**

Moonlighting is defined by the ACGME/AOA as “professional and patient care activities that are external to the educational program.” The ACGME/AOA prohibits any requirement of resident/interns to perform moonlighting services.

Moonlighting must be counted toward the 60-hour weekly limit on duty hours as defined by institutional policy and ACGME institutional requirements.

Residents are not being required to engage in moonlighting, and moonlighting is not encouraged. Residents who engage in moonlighting must not allow such activity to interfere with the ability of the resident to achieve the goals and objectives of the program. The program director is responsible for monitoring resident performance, and for determining the potential impact of moonlighting practices on the clinical or educational performance of resident or patient safety. The program director shall monitor the number of hours, and the nature of the workload of residents engaging in the moonlighting experience. **All residents must obtain written permission from the program director prior to engaging in moonlighting.**

CAMC as the sponsoring institution is not responsible for any action or problem arising from professional activities which are initiated by the resident, and do not involve any agreement between the sponsoring institution and an external employer. You must understand the implication of this statement. **If you were to require time off due to an event related to moonlighting, you would be required to use your time, such as vacation, or extend your program beyond your graduation date.**

Professional liability insurance coverage is not provided for moonlighting activities. Residents are responsible for securing confirmation of malpractice coverage outside the scope of the residency training assignment.

All residents engaged in moonlighting must be licensed for unsupervised medical practice in the state where the moonlighting occurs. The program director shall not approve moonlighting for any unlicensed resident.

Residents must obtain a separate DEA certificate for use in prescribing medications as part of any moonlighting activity.
The Graduate Medical Education Committee or Charleston Area Medical Center may choose to monitor policy compliance at any time.

The primary responsibility of the resident is to the service or activity to which the resident is assigned. Moonlighting MUST NOT interfere with clinical and educational performance. The resident must obtain permission for moonlighting and adhere to criteria for moonlighting that is set forth in this policy and the *Charleston Area Medical Center Health System, Inc. 2013-2014 House Staff Handbook.*

The residency program director has authority to restrict moonlighting at any time. Permission will be based on individual academic, clinical and professional performance; an adverse effect on performance may lead to withdrawal of permission.

The following guidelines will be applied:

a) Residents must have satisfactorily completed requirements for the second post-graduate year in the residency program.

b) “Sunlighting” (working for income during hours when an individual has duties and responsibilities to the service on which he/she is training) is not permitted at any time.

c) Residents must be in good academic standing within their residency-training program, demonstrating overall satisfactory performance. Effective with exam dates after January 1, 2003, residents must demonstrate in-training exam scores at the national median or 50th percentile for residents in training at the comparable training level in order to be granted permission to moonlight.

**Process for Requesting Permission to Moonlight:**

All residents desiring to engage in moonlighting must complete a Request for Permission to Moonlight Form (“the Form”) prior to engaging in any moonlighting activity. It is the responsibility of the individual resident to complete the form, and to provide reporting as required.

a) Permission to moonlight will be granted for a maximum 6-month time period, at which time a new request form must be submitted. The program director or coordinator may require interim reporting.

b) A Form is required for each employer of a moonlighting resident. Multiple sites staffed by the same employer may be listed on one form, and may be updated at any time prior to the resident performing services at a new location.

c) A copy of the resident’s license, DEA certificate in his/her name, and confirmation of malpractice insurance at the moonlighting institution must be submitted with the Form.

d) Upon completion of the Form, one copy will be placed in the resident’s institutional file; originals will be placed in the resident’s permanent program file.
Reporting Requirements:
The program director is required to monitor hours and location of moonlighting throughout the academic year. Permission to moonlight is based on a maximum number of hours per week, and is specified by location. Any change that results in additional moonlighting hours or changes in locations will require an updated written permission from the program director. The GMEC, the Director of Medical Education, or the DIO may require summary reports from programs at any time. The President of the CAMC Health Education and Research Institute has ultimate authority to permit, restrict or withdraw permission to moonlight. Once moonlighting commences, all hours must be recorded on New Innovations and a copy of the moonlighting schedule must be provided to the program director each month.

<table>
<thead>
<tr>
<th>Promotion and Termination/Resident Grievance Procedure</th>
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<tbody>
<tr>
<td>Institutional policies and procedures for supervision and evaluation of residents, due process (i.e., grievances, disciplinary action, academic deficiencies or failure), and appeal process are found in the document entitled “House Staff Handbook”.</td>
</tr>
<tr>
<td>This can also be found on line at: <a href="http://camc.wvu.edu/pdf/staffhandbook.pdf">http://camc.wvu.edu/pdf/staffhandbook.pdf</a>.</td>
</tr>
<tr>
<td>The policy and procedures for the Emergency Medicine Residency as it relates to these topics follow exactly those outlined by the institution.</td>
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<table>
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<tr>
<th>Vacations and Leaves</th>
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<tr>
<td>All residents’ leave time is subject to review by all parties involved with the resident assignment with sufficient advance notice and consideration of appropriate provision of patient care services. The Program Director and the attending of the service to which the resident is assigned must approve all vacation and educational leave in advance. All vacation requests must be submitted by June 1st of the end of the training year for the next academic year, except for PGY1, who will submit their request by July 15th for the remainder of the academic year. No PGY1’s will be allowed to take vacation during the block one/orientation month. No one is allowed to take vacation during the last 7 days of December and the first 7 days of January.</td>
</tr>
<tr>
<td>All residents are allocated 20 days of vacation to be taken over 4 time periods. All vacation must be approved in advance by the Program Director. All vacation will be assigned on a seniority basis (PGY4, then PGY3, then PGY2, then PGY1). No more than two members of the residency may be on vacation at one time. Vacation may only be taken on Emergency Medicine rotations. Once approved vacation dates may not be changed except under the most unusual circumstances and only after approval by the program director in writing.</td>
</tr>
<tr>
<td>The Program Coordinator in conjunction with the Chief Resident maintains the vacation calendar. Unused vacation days will not be paid upon completion of training unless the resident terminates or is terminated by the Program Director. The AOA allows for a total of 20 days of</td>
</tr>
</tbody>
</table>
leave each year. If you exceed these days with vacation, illness or personal leave, you are required to extend your residency.

Education leave is provided at the discretion of the program director for purposes of supporting educational activities that require the resident to be excused from clinical duty. Up to a maximum of seven (7) additional days can be approved during an academic year for the purpose of attending medical meetings or other medical education activities. Such meeting time may not be extended unless the additional time is counted as vacation leave. Educational leave time may not be accumulated and carried over to the following academic year. Education and leave time may not be converted to vacation days and shall not be used for other purposes. Up to three (3) professional leave days may be used over the duration of your residency for the sole purpose of interviewing for residency, fellowship or practice positions. Residents may be required to provide documentation of an interview to their Program Director. Requests for educational days must be submitted in writing as soon as possible, but no later than 30-days in advance. Requests submitted after this may not be approved. The Program Director and the attending of the service to which the resident is assigned must approve all educational leave in advance.

The following is a partial list of reasons educational leave might be granted by the Program Director.

- To attend a conference, board preparation course, or other off-site educational program. Usually two to four days depending on the length and location of the conference.
- To study for Part III of boards. Up to four days may be used in the PGL1 year for this activity, (only while you are on an EM rotation).
- To attend an MS OPTI function or 2-day ATLS course. Generally an intern or resident will not be forced to expend an education day for this purpose, but you might choose to use such a day to lessen your work load during that block.
- To study for certifying exam or Part 3, up to three days may be used in the PGL1 or PGL4 year for this activity, (only while you are on an EM rotation).
- Educational days may not be used to study for the rise exam.
- Educational days may not be used to complete your research requirement. These are however, available for presentation of research papers at off campus venues.

Medical Legal Advice

Any problems of a medico legal nature should be referred to the Program Director, Chairman or Operational Medical Director of the Department of Emergency Medicine. The resident is a hospital employee and as such, is required to speak with the hospital’s Risk Management Department. It is recommended that all cases/issues be discussed with the Chairman of the Department of Emergency Medicine, or the Program Director first.
Media Policy

No Emergency Medicine resident will speak to the news media at any time without permission of the ED attending and the Charleston Area Medical Center Public Relations Department.

Financial Arrangements, Including Housing, Meals, and Other Benefits

Being part of a much larger program affords the CAMC Emergency Medicine Resident a wide array of benefits. These are too numerous to list in detail here, but can be found at the following sites:

http://camc.wvu.edu/info/salary_benefits.htm

http://camc.wvu.edu/info/housing.htm

Further questions and clarification can be obtained from the program director or coordinator or by contacting: Graduate Medical Education, 3110 MacCorkle Ave. S.E. Charleston, WV 25304, or call (304) 388-9948. Email: gme@camc.org

Dress Code

For safety considerations, and to enhance communication and cultural sensitivity, residents are required to place a high value on personal appearance, including appropriate attire. Patient trust and confidence in the health care provider are essential to successful treatment experiences and outcomes. Professional dress and appearance plays a fundamental role in establishing trust and confidence, and in considering the cultural sensitivities of patients and co-workers. On all off-service rotations, residents shall conform to the standard dress set forth by the designated mentor, while conforming to the standards set forth in the Charleston Area Medical Center Health System, Inc. 2015-2016 House Staff Handbook. Residents should remember that on ALL rotations, you are a representative of the program, and of the hospital.

Non-Clinical Assignments

While in lectures or other activities that do not involve patients, residents should wear neat, clean and professional attire, and avoid dress or attire that could be potentially offensive to the public, your peers, patients, faculty and co-workers. ID badges must be worn at all times while on assignment. Denim jeans, flip-flops, shorts or scrubs are not appropriate.

General Requirements

CAMC ID Badges are worn at all times, above the waist and in view. Good personal hygiene is to be maintained at all times. This includes regular bathing, use of deodorants/antiperspirants, and regular dental hygiene. Avoid distracting perfumes or colognes. They may precipitate allergies or sensitivities.
Scrubs

These are to be worn in specific patient care areas only, i.e. ED, OR, ICU’s, or as required. They are property of the hospital, and are not to be defaced, altered or removed from the hospital premises. If a scrub suit must be worn outside clinical areas, it must be clean, and then covered with a clean, white lab coat. Shoe covers, masks, and hair covers must be removed before leaving the clinical area. Stained or soiled scrub suits must be changed as soon as possible (source of contamination).

Items Specifically Prohibited (in any hospital or clinical facility/location)

Blue jeans, regardless of color, or pants of a blue jean style.

Shorts

Open-toed, high-heeled or canvas shoes, or flip-flops. This is to prevent blood or needles from penetrating the fabric or skin.

Midriff tops, tee shirts, halters, translucent or transparent tops, shirts or tops with plunging necklines, tank tops or sweatshirts.

Buttons or large pins that could interfere with work function, transmit disease, or be grabbed by a patient.

Visible body tattoos or visible body piercing.

It is CAMC and CHERI policy that the program director or hospital administration may at any time prohibit a resident from any location based on appropriate and professional dress code and standards.

Tardiness

Residents are expected to be on time for all clinical and educational assignments, regardless of service. When assigned to the emergency department, residents are expected to arrive 15 minutes before the designated start time of each shift. If you show up to a shift more than 1 hour late, you will have to complete the shift and make up another shift during the month scheduled at the discretion of the chief resident. When residents are assigned to other service areas, they are expected to follow the departmental policy at that location. When unexpected issues arise, residents are required to contact their assigned attending or senior resident as soon as possible.

Wednesday lectures and other scheduled events will begin promptly at the designated time. Tardiness to lectures is considered to be disrespectful to presenters, and is disruptive to others participating in the program. Wednesday lectures and other designated educational events are scheduled to address curriculum requirements, and are considered a requirement for successfully completing your residency. Attendance and punctuality at all required scheduled events shall be
a part of the resident’s overall performance requirements, and shall be documented as part of the resident’s quarterly evaluation process. Absenteeism (unless officially excused by the program director), or excessive tardiness may result in disciplinary action. As covered in other sections, residents are required to be released from duty for Wednesday conference and MSOPTI lectures.

### Sick Leave

For reasons related to their own personal illness, residents are provided with twelve (12) days of sick leave per academic year. The intent of providing a sick leave benefit is to ensure uninterrupted salary income in the event of an illness. Sick leave will be paid in conjunction with worked time 14 day pay period regardless of the days in which the actual illness occurred. Therefore, weekend days are counted in sick leave calculations for residents. Any resident who is taking a day of sick leave must report this to the Chief resident as soon as possible so that coverage for your shift may be found. The resident is also responsible for reporting the missed shift to the residency coordinator as soon as possible but no more than 3 days after the shift. The AOA allows for a total of 20 days of leave each year. If you exceed these days with vacation, illness or personal leave, you are required to extend your residency.

If a resident is required to miss three (3) consecutive days of work due to illness, Employee Health must release the resident in order to return to work.

### Resident Responsibilities

#### Logs

All residents are required to maintain a log of all patient encounters during the training program. The logbook should include a unique patient identifier (e.g., medical record number or ED number), diagnosis/diagnoses, and procedures performed. These logs should be kept up-to-date for all rotations, and must be turned in to the program office on an every 28-day basis. In addition all residents are required to keep a log of all reading, conference/educational hours, and procedures performed (see procedure logs), also due every 28 days.

#### Completed Evaluations

It is the resident’s responsibility to ensure that all evaluations are returned to the program director at the end of every rotation. These include the evaluation of the resident for all off-service rotations, as well as the evaluation of the rotation by the resident.

#### Case Reports

Residents are also required to present a periodic case report. These are due by the date assigned by the program director or chief resident. The resident must be prepared to present this at any venue assigned by the program director.
Minimum Portfolio Documentation

It is the resident’s responsibility to ensure the portfolio is up-to-date. Current copies of the following items are to be kept in the residents “portfolio.”

- Medical School Diploma
- Internship training certificate
- Proof of AOA membership (copy of membership card)
- Copy of COM transcript
- Proof of any previous training
- Signed annual contract
- Proof of attendance and completion of ACLS, ATLS, PALS
- Proof of NIH Human Subjects Program
- Licensure

Schedule

The chief resident prepares the monthly emergency medicine (EM) rotation schedules, which will be posted on New Innovations. All schedule requests for emergency medicine rotations must be made by the first day of the month, two months prior to the beginning of the rotation. Schedule requests made afterwards may not be honored. Resident to resident changes are permitted, but must be made no later than two weeks prior to when the shift change occurs. The chief resident and program director must be notified of the switch in writing by both parties before the schedule change will be effected. Any changes made cannot alter the coverage originally scheduled by the chief resident and cannot violate duty hours. The chief resident is not responsible for arranging alternate coverage for EM shift changes made after the schedule has been placed on New Innovations.

PGL4 residents will average 16 shifts; PGL3 residents will average 18 shifts; PGL2 residents will average 19 shifts; and PGL1 interns will average 19 shifts each Emergency Medicine rotation. Residents will work a combination of day shifts at General and Women’s & Children’s (730am – 730pm), double coverage shifts at General and Women’s & Children’s (1pm - 1am), night shifts at General and Women’s & Children’s (730 – 730), day shifts at Memorial (7am - 5pm), midnight at Memorial (12am - 10 pm), evenings at Memorial (2pm – 12mn), nights at Memorial (10pm - 8am). The double coverage shifts and nights shifts on Tuesdays and Wednesdays are adjusted to allow for didactic activities on Wednesday mornings. The above shift times are subject to change. Scheduling will be done with concern for proper circadian rhythm adjustments. PGY4 residents will report to the regional poison control center 2 Wednesday afternoons for half-day shifts during their EM blocks.

All residents and interns will be assigned to an Emergency Medicine board certified attending for their shift. Should a resident or intern in this program report to work and find, for any reason, that the attending working with him/her for that shift is not a board certified attending, the resident MUST NOT ENGAGE IN ANY TYPE OF PATIENT CARE, AND MUST LEAVE THE EMERGENCY DEPARTMENT IMMEDIATELY. Every effort should be made to contact Dr. Turner, the Chief Resident or Ms. Mason at once, but inability to contact them must not delay your immediate departure from the Department.
Call Offs/ Missing Shifts

All residents will have “call months” throughout the year during which time they must be readily available to report to work in the event of a call off. These months will be determined by the program director at the beginning of the academic year.

If you are unable to cover a shift due to illness or other unforeseen circumstances, you must notify the chief resident as soon as you become aware of the situation. **The chief resident will make a determination on whether or not you need to report to work.** If the chief resident feels that you are incapable of working, he or she will then contact the EM resident on call via pager, unless the on call resident prefers to be contacted via phone. The on call resident has 15 minutes to respond to the page or call. The on call resident will then have 1 hour to report to the ED.

Any resident who calls off will make up a shift to the resident who worked for them on their next available EM block. This make up shift will be for the same hours as the shift called off. The resident who called off will have 1 month to make up the shift, or they will owe 2 shifts. Alternatively, the resident who called off can opt to use a vacation day, in which case the resident called in would be assigned to work 1 less shift on their next EM block. The chief resident may have to make discretionary decisions concerning make up shifts so as not to violate duty hours.

If you don’t show up for a shift, the on call policy will be implemented, and you will owe a shift to the resident called in, applying the aforementioned policy, plus an additional shift scheduled at the discretion of the chief resident.

Non Emergency Medicine Rotation Schedules:

One week prior to a non-Emergency Medicine rotation, the resident will contact the rotation preceptor to coordinate a meeting time and place, dress code, and schedule for that rotation. Some rotations may warrant a site visit with orientation a week prior to the rotation. The resident schedule for non-Emergency Medicine rotations will be at the discretion of the preceptor for that rotation. Overnight call and weekend service may be required of the resident on certain rotations. Any requests for days off during a non-Emergency Medicine rotation are to be directed to the preceptor’s office. The Emergency Medicine Residency Program Coordinator can assist with contacting the offices.

Arrangements have already been made to allow each resident rotating on a non-Emergency Medicine rotation to attend the Wednesday educational conferences. Wednesday Emergency Medicine conferences are mandatory, and you must be released from work to attend. You are expected to return to the clinical service after the end of the conference.
Research

The resident shall complete a research project during the course of the Emergency Medicine training program. The following is the minimum requirement, and must be followed or exceeded. Failure to follow this timeline will result in non-promotion.

The resident must submit an outline for the project in the first training year.

The resident must perform implementation and data collection methods with a second year interim report.

A final product suitable for publication must be completed in the third year of residency.

The completed research project must be submitted to the ACOEP with the annual report. A permanent copy will be retained in the resident’s file.

All research projects must be approved by the program director.

Other Research Requirements

- Each resident must do a combination of the following during the four years in the residency program.
- CPC competition at the fall ACOEP conference
- Yearly participation in the CAMC research day
- Other regional or national CPC competition
- ACOEP/ACEP abstract competition
- ACOEP/ACEP poster competition
- ACOEP/ACEP research paper competition
- Publication of original research, case presentation or review
- Any other scholarly activity approved by the Program Director

Conferences

The curriculum has been designed in a 2-year format to cover the Core Curriculum of the American College of Osteopathic Emergency Medicine, as well as a host of other topics of interest to the Emergency Medicine Resident. The Emergency Medicine Residency conducts weekly educational conferences at Charleston Area Medical Center every Wednesday from 7:00 am until 12:00 pm, except during the times when this would conflict with those conferences required by all Osteopathic Interns and Residents. Other conferences and times may occasionally be scheduled outside these guidelines, or even off-campus if appropriate opportunities present.

Attendance at the weekly conferences is MANDATORY. Residents are excused from Wednesday conferences ONLY as pre-approved by the Program Director. On rare occasions, excused absences may be arranged by calling the residency office before the conference. For
each unexcused hour of absence from an educational conference day, a review paper or educational presentation may be required from a topic(s) selected from that day’s conferences. The format of the assignment would be at the Program Director’s discretion.

Other educational conferences include, but are not limited to:

- Procedural Labs /Oral Board Simulations
- Medico-legal Conferences
- Morbidity and Mortality/Chart Peer Review
- Journal Club
- In-service Review Sessions /In-service Question Preparation Tests
- Case Presentation Conferences
- Radiology Rounds
- EKG Rounds
- Chapter Review of selected textbooks, with weekly quizzes

All Osteopathic interns and residents from all programs at CAMC participate in the following activities:

- Osteopathic Grand Rounds (6 lectures per year)
- Osteopathic Lunch and Learn Lecture (monthly)
- Osteopathic Manipulation Workshops (4 lectures per year)
- House Staff Day (an annual OPTI gathering of West Virginia interns & residents)

100% attendance is required for all MSOPTI lectures. If you are on vacation, or patient care prevents your release from duty to attend a lecture, you must watch the lecture online.

Annual Exam

The resident must participate in the ACOEP resident examination (In-service Examination/ Rise Exam) annually. Any resident unable to participate in the examination must notify the Program Director a minimum of 30 days in advance. Failure to participate may result in dismissal from the training program. As a benefit and incentive to residents to maintain high academic performance throughout the training period, CAMC will offer reimbursement of board exam fees to qualifying resident graduates. To qualify a resident must consistently perform at or above the national median or 50th percentile for residents in training at the comparable level until the completion of the program, with the exception of residents in the internship year(s). Reimbursement will only be available for the first applicable exam administration following a resident’s graduation, and application for reimbursement must be made prior to graduation. Every attempt will be made to ensure that the resident will be scheduled off at least eight hours prior to, and during the exam for ideal conditions conducive to enhancing the resident’s performance on the exam. Effective with exam dates after January 1, 2003, residents must demonstrate in-training exam scores at the national median or 50th percentile for residents in training at the comparable training level in order to be granted permission to moonlight.
Certifications

All residents/interns are required by CAMC to maintain a Basic Life Support (BLS) Certification as a condition of employment. All residents/interns are required by ACOEP-GME to maintain certification in Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and Advanced Trauma Life Support (ATLS) as a condition of participation in the residency. Residents are responsible for meeting and maintaining these requirements.

Resident as Teacher

This program provides the opportunity to develop teaching skills. The opportunities you will receive will include a combination of the following:

- Instructor for ACLS, PALS and/or other American Heart Association courses
- ATLS instructor
- Sepsis Instructor
- Instructor in the Orientation

Note that not every resident will be given these opportunities, as they must be earned, and are based on performance of the resident or intern.

Teaching time will be equivalent on an hour per hour basis to clinical time. This will be permitted to a maximum of 5 clinical days per academic year. “Teaching days” cannot be taken in combination with vacation or conference days. They also cannot be taken in the same month as vacation or conference days with the exception of PGY1 residents. These days can only be used on emergency medicine rotation blocks.

The “Great Case Day” is a series of cases presented by residents. Presentations are approximately 15 minutes in duration, and are based on a patient seen during the year. The following format should be used: Pertinent History/Pertinent PE/Pertinent Lab and X-rays/Case progression, and follow-up/Diagnosis. Case presentations that are deemed to be of particularly high quality may be used for Research Day presentations. Other brief lectures may be assigned throughout the year. Bedside instruction of others will be expected as described in the Resident Responsibility sections.

Elective Rotations

Emergency Medicine requires competency and experience in the evaluation and management of specialty areas of medicine. There is opportunity each year of residency to choose an elective rotation to enhance and/or develop an interest in these specialty areas. Requests for elective rotations must be turned in to the Program Director 30 days prior to the beginning of the rotation. A copy of the elective request form is enclosed in the appendix of this manual. Elective rotations
must be done at Charleston Area Medical Center unless previously arranged with the Program Director.

Examples of elective rotations include: Ultrasound, Pulmonary (ICU), Orthopedic Surgery, Radiology, Trauma ICU, and Management. Other selective rotation topic will be considered.

Failure to complete and return the selective request form will result in a mandatory Emergency Medicine rotation.

Residency Program Committees

**Standing Committees**: The Emergency Medicine Residency shall maintain the committees listed below. The Program Director shall be a member of each standing committee. A chair of each committee shall be selected from members of that committee. The Program Director may serve as a committee chair.

**Resident Selection Committee**: meets prior to the interview period to review and, if necessary, revise the standards for residency selection. These standards will be based on program, hospital, ACOEP and AOA criteria. During the interview period, this committee shall meet once monthly to rank order the prospective candidates for acceptance. The committee shall be comprised of at least three program faculty members. One or more Emergency Medicine resident representative shall also be a voting member of this committee.

**Faculty Committee**: comprised of all core faculty of the Emergency Medicine Residency; this committee shall meet quarterly to discuss progress of the Emergency Medicine Residency. Resident reviews, program changes, hospital, AOA and ACOEP program guidelines and requirements may be reviewed, as well as other matters related to the administration of the Emergency Medicine Residency. A PGL4 resident will be asked to be a voting member of this committee.

**EM-Research Committee**: Composed of faculty members; will meet at least annually to evaluate resident progression according to the above research time-line and to serve as a mentoring/guidance body to help best accomplish resident projects.

A peer-selected resident will be nominated for service on the MSOPTI Curriculum Committee, the MSOPTI OGME Committee and, if appointed by Dr. Pence, will serve.

A peer-selected resident will serve on the MSOPTI Chief Residents Committee.

The Chief residents will serve on the CAMC House Staff Committee.

A peer-selected resident will serve as the liaison to the Resident Affiliation of the ACOEP.

A peer-selected resident will serve as the liaison to the EMRA affiliation of the ACEP.

Other committee appointments may be made by the Program Director as needed.
Chief Resident Job Description

The Chief Resident(s)’s primary responsibility is to ensure that the resident component of the clinical operation of the Emergency Department and the educational activities of the residency are optimized and effective on a daily basis.

The Chief Resident(s) is responsible to, and will meet regularly with the Emergency Medicine Residency Program Director.

The Chief Resident(s) will serve Emergency Department committees including but not limited to:

Emergency Medicine Core Faculty Committee

Emergency Medicine Curriculum Committee

Resident/Intern Selection Committee

Chief Resident(s) will attend the CAMC House Staff Council held monthly. Chief Resident(s) will act as a liaison between other house staff and the Division of Emergency Medicine.

The Chief Resident(s) will assist the Emergency Medicine Residency Program Director, Core Faculty, and Residency Coordinator in curriculum development and evaluation for residents and interns.

The Chief Resident(s) will assist the Emergency Medicine Residency Program Director in designing and implementing educational programs for the Emergency Department including weekly didactic sessions.

The Chief Resident(s) will orient the students/interns prior to rotations in the Emergency Department as required.

The Chief Resident(s) will coordinate didactic presentations outside the defined Emergency Medicine curriculum, intended to enrich the educational experience of house staff.

The Chief Resident(s) will alert the Emergency Medicine Residency Program Director to any potential issues regarding house staff or faculty performance, and will assist the Emergency Medicine Residency Program Director (or his/her designee) in individual counseling sessions as necessary.

The Chief Resident(s) will assist in the recruitment and selection of Emergency Medicine residents.
The Chief Resident(s) will prepare and distribute the monthly clinical schedule for residents, interns, and students assigned to the Emergency Medicine service in conjunction with the Program Coordinator and approved by the Emergency Medicine Residency Program Director.

The Chief Resident(s) will hold resident meetings as needed when issues/concerns arise.

The Chief Resident(s) will assist the Emergency Medicine Residency Program Director with the annual orientation of Emergency Medicine residents.

The Chief Resident(s) will assist with preparation for and will participate in inspections for the purpose of Emergency Medicine Residency, Emergency Department, or CAMC accreditation.

The Chief Resident(s) will assist the Emergency Medicine Residency Program Director in designing and implementing educational programs for the Emergency Department. Such areas of responsibility will include but not be limited to:

- Coordination and scheduling of guest lecturers and topics
- Coordination of academic education programs
- Focused/Detailed preparation of resident lectures and presentations.

The Chief Resident(s) will orient the students/interns prior to rotations in the Emergency Department as required.

Upon selection by the Emergency Medicine Core Faculty Committee and the Program Director, the Chief Resident(s) will participate in the training of his/her successor see selection process below.

**Qualification for the Position of Chief Resident**

The Chief Resident(s) will have many responsibilities as described above; therefore it is imperative that the applicant be deemed to be academically qualified for the position. Criteria will include performance on the Rise Exam, SPE’s and other didactic standards.

Chief Resident(s) will have demonstrated the desire to teach.

Chief Resident(s) will seek to enhance his/her credentials through additional training, committee work, continuing medical education, self-study, and participation in professional development seminars.

Chief Resident(s) will have facilitated team spirit and cohesiveness.

Chief Resident(s) will be able to work with the Program Director and the Core Faculty as described above.
Chief Resident(s) will be chosen from the PGL 3 class if such person can be identified as able, willing, and qualified to serve in the position. If no such person can be identified then a PGL2 may be nominated.

It is NOT a requirement that both chief resident positions be filled every year. Therefore, in the event a single chief can be identified the Program director in conjunction with the core faculty may elect to have a single chief resident.

**Appointment Process**

Chief Resident(s) are nominated by the Emergency Medicine Core Faculty Committee and appointed by the Program Director. Chief Resident(s) selection shall be made in the fall or early winter for the upcoming academic year beginning July 1\(^{st}\), and ending June 30\(^{th}\). The Chief Resident(s)-Elect will participate in a training period (approximately January-June) under the direction of the Emergency Medicine Residency Program Director, Residency Coordinator, and current Chief Resident(s), prior to officially taking office on July 1\(^{st}\).

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**Resident/Faculty Mentor Program**

Residents will be assigned a faculty mentor who is an Attending Emergency Physician at Charleston Area Medical Center. The faculty physician will remain as the resident’s mentor until graduation. It is expected that the resident and mentor meet on at least one occasion socially each year. The mentor shall maintain an ongoing dialog with the resident by phone, e-mail, and in person. The mentor will be present during at least one of the four formal evaluations of the resident with the Program Director, each year. The mentor will be encouraged to attend the certificate ceremony at the end of each year, especially on the year of their graduation, as well as the graduation dinner. The mentor will be available to the resident for consultation with regard to residency progress, including academic or interpersonal concerns.

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**Emergency Medicine Resident Objectives**

These training objectives provide a reasonable set of expectations for various levels of residents. They are not meant to be restrictive in the separation of responsibility. Residents who exceed the expectations for the training year are permitted to assume greater responsibility, provided that they are not competing with the senior resident’s responsibilities. Many of our residents can perform at levels higher than those dictated by the training objectives for the year. This well-defined responsibility, based on year of training serves to provide organization and direction to the Emergency Department and makes optimal use of skills previously acquired by the resident.

**PGL-1:**

The first year of the Emergency Medicine training concentrates on developing skills in individual patient evaluation. The resident should begin to go from novice to advanced beginner. Focusing on the basic principles of decision making in Emergency Medicine, and acquiring the
central knowledge base are the primary educational objectives. The resident should become thorough and efficient in the performance of the history and physical exam, and should begin to develop skills in the use of diagnostic tests, initiating treatment, requesting consultation, developing a treatment plan and arranging appropriate follow-up. The focus is on providing high quality care, with an Emergency Medicine approach to patient complaints to avoid the misdiagnosis, or delayed diagnosis of life threatening conditions. The residents are expected to see a reasonable number of patients, and begin to develop efficiency as they acquire the basic familiarity with common Emergency Department presentation. The first year residents are not primarily responsible for the care of critically ill patients. The focus of their effort is not on the volume of patients, but the efficacy and accuracy of patient evaluation. They are expected to learn appropriate medical record keeping and documentation. Basic procedural skills are acquired with encouragement to use the resources available in the simulation lab, as well as from direct bedside supervision.

PGL2:

As residents progress into the second year of residency it is expected that an increasing level of independence will be warranted. It is at this level that the resident is expected to go from advanced beginner to competent. The PGL2 resident will be expected to not only increase in medical knowledge, but also in procedural expertise. Continued use of the simulation lab is encouraged as new skills and procedures are added to your knowledge base. The PGL2 is also encouraged to use this resource to review and practice those skills learned in the PGY1 year. Advancing to this level also carries with it added responsibilities. The resident will be assigned increasing duties to teach. These will include presentations in the new resident orientation and, if selected, instructorship in the American Heart Association courses, as well as ATLS. Other opportunities will present, and should be welcomed as a means to develop these important skills, not the least of which will include the opportunity to assist, (while not supervising), the intern class.

PGL2 level residents will participate on an ICU and Trauma month at Memorial Hospital in order to gain exposure to critically ill and injured patients. This is also an opportunity to gain some procedural expertise. PGL2 residents will also be tracked as to their proficiency in managing patients. Progress in the number of patients seen will be monitored through the patient logs and Team Health (ED) statistics. It is at this level that life-long skills in communication and disposition are beginning to be developed.

PGL-3:

The third year Emergency Medicine Resident concentrates on expanding and refining patient care skills. It is at this level that the resident is expected to go from competent to proficient. The resident begins to focus on developing an efficient approach to patient care, and learns the skills needed to manage several patients simultaneously. He/she is expected to see a larger number of patients to broaden the base of experience. Participation in major medical and trauma resuscitations is expected. The third year resident is introduced to advanced procedural skills and encouraged not only to avail themselves of the simulation lab for review and development of these skills, but also to teach and assist junior residents to develop their skills. Residents will participate on an EMS/AIR AMBULANCE rotation to gain exposure to the vital role played by
EMS in the field in emergency situations. PGL3 residents will also participate on an ICU service at Memorial Hospital. As they have now begun to gain increased autonomy and knowledge, it is expected that the resident at this level will assume increasing responsibility while on service. The residents develop skills in problem-solving, patient disposition, efficient delivery of emergency medical care and teaching. Increasing teaching responsibilities occur at this level and include presenting lectures, supervising junior residents, and assisting with procedures and medical management of emergency cases. Leadership abilities should be developed at or before this level. It is expected by the third year of post-graduate training the resident will have become a model for more junior residents, exemplifying those qualities so sought after in our profession.

PGL-4:

The fourth year Emergency Medicine Resident concentrates on broadening exposure and developing efficiency. It is at this level that the resident is expected to concentrate on those skills lacking proficiency and begin to develop expert standing. Life-long learning practices and habits, which will have been introduced earlier in training, now become individually resident-driven. The resident will increasingly share experience and knowledge with junior residents and medical students. The resident is primarily responsible for the most critically ill patients in the Emergency Department, and directs and assists junior residents with medical resuscitations. This should include demonstrations of mastery in clinical procedures, as well as the ability and willingness to teach those that follow, both at the bedside and in the lab. The PGL4 resident functions as an integral member of the ICU and Trauma resuscitation team. The PGL4 residents assume ever-increasing academic responsibilities, providing lectures and conferences as part of their regular academic activities. The resident continues to develop skills and confidence in problem-solving, patient disposition, efficient delivery of emergency medical care and teaching. Overseeing the operation of the Emergency Department and ensuring that all patients receive appropriate care are of paramount importance. The PGL4 residents will be afforded greater opportunity to provide lectures, presentations, and conferences to the faculty and junior residents as part of their regular academic activities. Leadership roles are expanded to include scheduling of resident shifts and lectures.

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**Emergency Medicine Resident Privileges**

PGL-1 and 2:

Senior level residents or faculty will closely supervise individuals in the PGL1 and 2 years. Residents entering this level of training are expected to present each patient case directly to the attending emergency physician or senior emergency medicine resident prior to the initiation of any diagnostic and/or therapeutic orders. The benefit of this immediate discussion of the patient management plan (including differential diagnoses, ancillary testing required and potential disposition) to the resident is real-time medical education. The patient benefits as the attending physician is made aware of his/her presenting complaint soon after the resident takes the history and physical. Therefore, the attending physician actively participates in the patient management
from the onset. The emergency department and ancillary departments benefit as the patient workup is ordered with the knowledge and assent of the attending physician.

PGL-3:

Individuals in the third postgraduate year are expected to perform independently the duties learned in the first two years and may supervise the routine activities of the PGL 1 and 2 year residents. Residents at this level of training should have progressed in independent responsibility as outlined and approved by the emergency medicine residency faculty. The resident should take a leadership role in teaching the more junior residents and medical students the practical aspects of patient care, and be able to explain complex diagnostic and therapeutic procedures to the patient and family. The PGL3 resident should be able to incorporate ethical concepts into patient care, and discuss these with the patient, family, and other members of the health care team.

PGL-4:

In the fourth emergency medicine training year, the resident should be capable of managing patients with virtually any routine or complicated condition, and of supervising junior residents, practitioners, and medical students in their daily activities. The resident is responsible for coordinating the care of multiple patients on the assigned team.

The delineation of privileges is designed as an outline for the purpose of determining the appropriate level of individual resident supervision. As with any group learning process, individuals may exceed or fall below the expected level of independence. Those residents who exceed the learning and procedural expectations for their given year may be approved by faculty consensus to increase their independent level of responsibility ahead of their peers. Those residents not meeting the determined level of independent responsibility as decided by faculty consensus will not be approved to increase their level of responsibility until such time as the faculty believes these educational requirements are met.

### Procedures

Procedures are to be recorded in New Innovations. Using this instrument, the resident can document proficiency in the 77 procedures necessary to become a competent, residency-trained emergency physician, as defined by the ACOEP-GME and the AOA.

The emergency medicine resident is expected to have accomplished the following minimum number of procedures prior to the completion of the emergency medicine residency. Although this list represents a minimum number, it is expected that all procedures performed shall be logged. It is understood that numerous critical procedures in emergency medicine are infrequent/rare. In consideration of this some procedures may be completed after demonstrating proficiency in an animal lab setting, or simulation lab. Such procedure requirements shall be allowed with the approval and at the discretion of the program director.
5.1.1 Cardioversion / Defibrillation – 10 procedures
5.1.2 Central Venous Access – 20 procedures
5.1.3 Chest Tube Insertion – 10 procedures
5.1.4 Closed Fraction Reduction – 20 procedures
5.1.5 Dislocation Reduction – 10 procedures
5.1.6 Splinting – 20 procedures
5.1.7 Procedural Sedation – 15 procedures
5.1.8 Cricothyroidotomy – 3 procedures
5.1.9 Intraosseous Line – 3 procedures
5.1.10 Intubation – 35 procedures
5.1.11 Laceration Repair – 50 procedures
5.1.12 Lumbar Puncture – 15 procedures
5.1.13 Osteopathic Manipulative Therapy – 30 procedures
5.1.14 Pediatric Medical Stabilization – 15 procedures
5.1.15 Pediatric Trauma Stabilization – 10 procedures
5.1.16 Thoracotomy – 1 procedure
5.1.17 Transvenous Cardiac Pacing - 2 procedures
5.1.18 Pericardiocentesis – 3 procedures
5.1.19 Ultrasound, Bedside – 40 procedures
5.1.20 Vaginal Deliveries – 10 procedures

The aforementioned minimum numbers were set forth by the AOA in August, 2010, and will be used as a guideline for emergency medicine residency training requirements for those beginning residency after that date.
The following is a list of all procedures Emergency Medicine Residents should be familiar with by the time of graduation. These additional procedures as well as the required ones above are listed on the New Innovations site. It is not expected that you will have the opportunity to perform every procedure, but it is expected you will have preformed, observed, and practiced in the simulation lab, and/or have received instruction on every procedure by graduation.

23.1 Airway Techniques
23.1.1 Cricothyrotomy
23.1.2 Heimlich maneuver
23.1.3 Intubation
23.1.3.1 Nasotracheal
23.1.3.2 Orotracheal
23.1.3.3 Rapid sequence
23.1.3.4 Fiberoptic
23.1.4 Mechanical ventilation
23.1.5 Percutaneous transtracheal ventilation
23.1.6 Airway adjuncts
23.2 Anesthesia
23.2.1 Local
23.2.2 Regional intravenous anesthesia
23.2.3 Regional nerve blocks
23.3 Diagnostic Procedures
23.3.1 Arthrocentesis.
23.3.2 Cystourethrogram
23.3.3 Lumbar puncture
23.3.4 Nasogastric intubation
23.3.5 Pericardiocentesis
23.3.6 Peritoneal lavage
23.3.7 Bedside ultrasonography (SEE 18.2.6)
23.3.7.1 Cardiac
23.3.7.2 Abdominal
23.3.7.3 Traumatic
23.3.7.4 Pelvic
23.3.8 Anoscopy
23.3.9 Thoracentesis
23.3.10 Tonometry
23.3.11 Slit lamp examination
23.3.12 Electrocardiogram interpretation
23.3.13 Radiographic interpretation
23.4 Genital/Urinary
23.4.1 Bladder catheterization
23.4.1.1 Foley catheters
23.4.1.2 Suprapubic catheterization
23.4.2 Delivery of newborn
23.4.2.1 Breech delivery
23.4.2.2 Normal delivery
23.4.2.3 Perimortem cesarean section
(SEE 12.7.8 and 18.5.2.3)
23.5 Head and Neck
23.5.1 Control of epistaxis
23.5.1.1 Anterior packing
23.5.1.2 Posterior packing/balloon placement
23.5.1.3 Cautery
23.5.2 Laryngoscopy
23.5.3 Nasopharyngeal endoscopy
23.6 Hemodynamic Techniques
23.6.1 Arterial catheter insertion
23.6.2 Central venous access
23.6.2.1 Femoral
23.6.2.2 Jugular
23.6.2.3 Subclavian
23.6.2.4 Umbilical
23.6.2.5 Venous cutdown (SEE 23.6.4)
23.6.2.6 Intraosseous infusion
23.6.3 Peripheral venous cutdown (SEE 23.6.2.5)
23.6.4 Pulmonary artery catheter insertion
23.7 Skeletal Procedures
23.7.1 Fracture/dislocation immobilization techniques
23.7.2 Fracture/dislocation reduction techniques
23.7.3 Spine
23.7.3.1 Cervical traction techniques
23.7.3.2 Immobilization techniques
23.7.3.2.1 Backboard techniques
23.8 Thoracic
23.8.1 Cardiac pacing
23.8.1.1 Cutaneous
23.8.1.2 Transvenous
23.8.2 Defibrillation/cardioversion
23.8.3 Cardiorrhaphy
23.8.4 Pericardiotomy
23.8.5 Thoracotomy
23.8.6 Thoracotomy
23.9 Other Techniques
23.9.1 End-tidal CO 2 monitoring
23.9.2 Gastric lavage
23.9.3 Incision - drainage
23.9.4 Intestinal tube insertion
23.9.5 Pulse oximetry
23.9.6 Sengstaken-Blakemore tube insertion
23.9.7 Wound closure techniques (SEE 18.4.17.1)
23.9.8 Trephination nails
23.9.9 Peak expiratory flow rate measurement
23.9.10 Excision of thrombosed hemorrhoids
23.9.11 Foreign body removal
23.9.12 Conscious sedation
Curriculum: the following will guide the curriculum of emergency medicine residents at CAMC.

5.1 Each resident shall complete a minimum of 52 four-week rotation for 224 week program.
5.1.1 Emergency medicine for a minimum of 24 rotations with a minimum of four (4) rotations training per year.
5.1.2 Critical care for a minimum of two (2) rotations.
5.1.3 General medicine that may include training in general internal medicine, medical subspecialties, or hospital based family practice in any combination for two (2) rotations.
5.1.4 Subspecialty surgery, e.g., surgery, anesthesiology, radiology, ophthalmology, ENT, hand or plastic surgery for a minimum of two (2) rotations.
5.1.5 Orthopedics for a minimum of one (1) rotation.
5.1.6 Pediatrics for a minimum of two (2) rotations. Strong consideration should be given to a pediatric emergency medicine or pediatric intensive care unit rotation.
5.1.7 Trauma for a minimum of one (1) rotation.
5.1.8 Emergency medical services for a minimum of one (1) rotation.
5.1.9 Administration/related activities, e.g., research, medical legal, quality assurance, etc., for a minimum of one (1) rotation.
5.1.10 Female reproductive medicine for a minimum of one (1) rotation; a minimum of 50% of this time spent in obstetrics.
5.1.11 Selective rotations for a minimum of six (6) rotations that will be at the discretion of the program director. These rotations shall be used to strengthen academic competence.
5.1.12 Elective rotations for a minimum of two (2) rotations.
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<thead>
<tr>
<th>Year</th>
<th>Rotation</th>
<th>28-day block</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>PGL 1</td>
<td>Introduction to Emergency Medicine</td>
<td>1</td>
<td>General</td>
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<tr>
<td></td>
<td>Emergency Medicine</td>
<td>3</td>
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<tr>
<td></td>
<td>Pediatric Emergency Medicine</td>
<td>1</td>
<td>WAC</td>
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<tr>
<td></td>
<td>Anesthesia</td>
<td>1</td>
<td>General/Memorial</td>
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<tr>
<td></td>
<td>Cardiology</td>
<td>1</td>
<td>Memorial</td>
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<tr>
<td></td>
<td>General Surgery</td>
<td>1</td>
<td>General/Memorial</td>
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<tr>
<td></td>
<td>Inpatient Medicine</td>
<td>1</td>
<td>General/Memorial</td>
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<td>Inpatient Family Practice</td>
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<td></td>
<td>Orthopedics</td>
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<td>General</td>
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<td></td>
<td>OB GYN</td>
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<td></td>
<td>Trauma Surgery</td>
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<td>Intensive Care Unit</td>
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<td>Intensive Care Unit</td>
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<td>Memorial</td>
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<td></td>
<td>Pediatric Intensive Care Unit</td>
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<td>Toxicology/ Poison Control</td>
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Clinical Rotation Summaries

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<tr>
<th>Rotation</th>
<th>Internal Medicine In-patient Service</th>
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<tr>
<td>Institution</td>
<td>FACILITY of the Internal Medicine Department</td>
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<tr>
<td>Year of training</td>
<td>EM1 1 month EM2 EM3 EM4</td>
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Goals:
Patient Care Goals: Residents must be able to provide patient care to the Internal Medicine patient that is compassionate, appropriate, and effective for the treatment of health problems and advocate for the promotion of health.

Medical Knowledge Goals: Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to Internal Medicine patients.

Practice-Based Learning Goals: Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire on the Internal Medicine in-patient service/unit.

Interpersonal and Communication Skills Goals: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates, all with diverse backgrounds.

Professionalism Goals: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Systems-Based Practice Goals: Residents must demonstrate an awareness of and responsiveness to the unique aspects of the healthcare system and be able to effectively call on system resources to provide care and patient follow-up that is of optimal value.

Osteopathic Principles and Practices: Residents must demonstrate an awareness of the basic tenets of osteopathic philosophy and ability in basic manipulative medicine.

Objectives:
It is expected that each intern’s rotation will vary greatly. The outcomes listed below are therefore a guide and it is unlikely that every intern will be exposed to every topic completely. The areas of abdominal and gastrointestinal disorders, cardiovascular disorders, cutaneous disorders, endocrine, metabolic, and nutritional disorders, head, ear, eye, nose, throat disorders, hematologic disorders, immune system disorders, systemic infectious disorders, musculoskeletal disorders (nontraumatic), nervous system disorders, psycho behavioral disorders, renal disorders, thoracic-respiratory disorders and clinical pharmacology should be reviewed in the core curriculum document prior to the start of service. As appropriate patients present, these topics should be expanded upon. Through day to day patient contact with Internal Medicine patients on the Internal Medicine in-patients service/unit, with direct supervision from nurse practitioners, senior residents and attending faculty, the Emergency Medicine resident will achieve the following outcomes.

Outcomes:
By the completion of this rotation, residents will be able to:

Patient Care Outcomes:
Gather accurate, essential information in a timely manner.
Generate an appropriate differential diagnosis for the Internal Medicine in-patient.
Implement an effective patient management plan for the adult and geriatric patient with attention to effect of age on various treatment modalities.
Patient Care Outcomes:
Competently perform the diagnostic and therapeutic procedures specific to the Internal Medicine in-patient. Special attention and effort should be made to attend or perform any of the following skills that opportunity may present:
Airway Techniques: Cricothyrotomy, Heimlich maneuver, Intubation, Nasotracheal, Orotracheal, Rapid sequence, Fiberoptic, Mechanical ventilation, Percutaneous transtracheal ventilation, Airway adjuncts.
Competently perform the diagnostic and therapeutic procedures specific to the Internal Medicine in-patient. Special attention and effort should be made to attend or perform any of the following skills that opportunity may present:
Anesthesia (Local, Regional intravenous anesthesia, Regional nerve blocks), Diagnostic Procedures (Arthrocentesis, Cystourethrogram, Lumbar puncture, Nasogastric intubation, Pericardiocentesis, Peritoneal lavage, Bedside ultrasonography (Cardiac, Abdominal, Traumatic, Pelvic), Anoscopy, Thoracentesis, Tonometry, Slit lamp examination, Electrocardiogram interpretation and Radiographic interpretation.

Competently perform the diagnostic and therapeutic procedures specific to the Internal Medicine in-patient. Special attention and effort should be made to attend or perform any of the following skills that opportunity may present:
Genital/Urinary, Bladder catheterization, Foley catheters and Suprapubic catheterization.

Competently perform the diagnostic and therapeutic procedures specific to the Internal Medicine in-patient. Special attention and effort should be made to attend or perform any of the following skills that opportunity may present:
Hemodynamic Techniques: Arterial catheter insertion, Central venous access (Femoral, Jugular, Subclavian, and Umbilical), Venous cutdown, Intraosseous infusion, Peripheral venous cutdown and Pulmonary artery catheter insertion.

Competently perform the diagnostic and therapeutic procedures specific to the Internal Medicine in-patient. Special attention and effort should be made to attend or perform any of the following skills that opportunity may present:
Thoracic: cardiac pacing (Cutaneous, Transvenous), Defibrillation/cardioversion, Cardiorrhaphy.

Competently perform the diagnostic and therapeutic procedures specific to the Internal Medicine in-patient. Special attention and effort should be made to attend or perform any of the following skills that opportunity may present:
Skeletal Procedures: Fracture/dislocation immobilization techniques, Fracture/dislocation reduction techniques, Spine (cervical traction techniques, Immobilization techniques and Backboard techniques.

Competently perform the diagnostic and therapeutic procedures specific to the Internal Medicine in-patient. Special attention and effort should be made to attend or perform any of the following skills that opportunity may present:
End-tidal CO 2 monitoring, Gastric lavage, Intestinal tube insertion, Pulse oximetry, and Peak expiratory flow rate measurement.

Prioritize and stabilize multiple patients and perform other responsibilities simultaneously
Demonstrate the ability to perform and interpret focused (goal directed) care of the septic patient.
Provide health care services aimed at preventing health problems or maintaining health during and after hospitalization.
Work with health care professionals to provide patient-focused care.

Medical Knowledge Outcomes:
- Identify life-threatening conditions that affect the hospitalized patient, identify the most likely diagnoses, synthesize acquired patient data, and identify how and when to access current medical information
- Discuss treatment options in abdominal and gastrointestinal disorders (Esophagus, Liver, Gall Bladder and Biliary Tract, Pancreas, Stomach, Small Bowel, Large Bowel, Rectum and Anus, Abdominal Wall.
- Discuss the signs, symptoms and treatment of the cardiovascular disorders (pathophysiology, cardiac failure.
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- Describe the management of head, ear, eye, nose, and throat disorders.
Describe the critical actions in the diagnosis and treatment of endocrine, metabolic, and nutritional disorders
Acid-Base Disturbances, Adrenal Disease, Fluid and Electrolyte Disturbances, Glucose Metabolism, Nutritional Disorders, Parathyroid Disease, Pheochromocytoma, Pituitary Disorders, Thyroid Disorders and Endocrine Manifestations of Neoplasia.


Describe the relative effectiveness and complications of various IMMUNE SYSTEM DISORDERS: Humeral Immunity, Cellular Immunity, Chemical Mediators, Complement, Autoimmune Diseases, Immune Deficiency Syndromes, Rejection and Hypersensitivity.

Discuss treatment options in RENAL DISORDERS: Structural Disorders, Infection, Glomerular Disorders, Acute and Chronic Renal Failure, Interstitial Tubular Necrosis, Interstitial Nephritis, Tumors, Complications of Dialysis.

Discuss treatment options in UROGENITAL/GYNECOLOGIC DISORDERS: Genital Tract – Female (Vagina and vulva, Uterus, Cervix, Infectious disorders); Genital Tract – Male (Congenital, Structural, Priapism, Testicular torsion Urethral strictures, Urethral foreign bodies, Prostatic hypertrophy); Inflammation/infection, Tumors, Sexual Assault and Genital Lesions.

Discuss the signs, symptoms and treatment including Prevention of the SYSTEMIC INFECTIOUS DISORDERS: Bacterial, Fungal, Protozoan B Parasites, Rickettsial, Viral and Travel-Related.


Describe the critical actions in the diagnosis and treatment of NERVOUS SYSTEM DISORDERS: Stroke, Cranial Nerve Disorders, Demyelinating Disorders, Abscess, Neuromuscular Disorders, Peripheral Neuropathy, Spinal Cord Compression, Hydrocephalus, Seizure Disorders, Headache, Pseudotumor, Cerebri/Benign Intracranial Hypertension, Tumors and Movement Disorders.

Describe the classification scheme for, the relative effectiveness and complications of various treatments in CLINICAL PHARMACOLOGY: Principles, Drug interactions, Adverse reactions, Drugs in pregnancy/breast-feeding, Effect of age, Withdrawal syndromes, and Drug Classes.

Describe the critical actions in the diagnosis and treatment of THORACIC-RESPIRATORY DISORDERS: Acute Upper Airway Obstruction, Breast Disorders, Disorders of Pleura, Mediastinum, and Chest Wall, Hyperventilation Syndrome, Non-cardiogenic Pulmonary Edema (Adult Respiratory Distress Syndrome), Obstructive/Restrictive Lung Disease, Physical and Chemical Irritants/Insults, Primary Pulmonary Hypertension, Pulmonary Embolism/Infarct, Pulmonary Infections, Thoracic Outlet Syndrome (OM considerations), Pulmonary Tumors, Sarcoidosis and Sleep Apnea Syndromes.

Complete disposition of patients using available resources.

Practice Based Learning Outcomes:
Analyze and assess their practice experience and perform practice-based improvement and patient safety.
Locate, appraise and utilize scientific evidence related to their patient’s health problems.
Apply knowledge of study design and statistical methods to critically appraise the medical literature as it relates to the hospitalized patient.
Utilize information technology to enhance their education and improve patient care.
Facilitate the learning of students and other health care professionals.

Interpersonal and Communication Skills Outcomes:
Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences.
Demonstrate effective participation in and leadership of the health care team.
Develop effective written communication skills including, but not limited to, writing of admission orders, history and physical exams, daily progress notes and discharge summaries.
Demonstrate the ability to handle situations unique to the in-patient setting.
Effectively communicate with medical as well non-medical personnel.
Professionalism Outcomes:
Treats patients/family/staff/paraprofessional personnel with respect.
Protects staff/family/patient’s interests/confidentiality.
Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues.
Be able to discuss death honestly, sensitively, patiently, and compassionately.
Demonstrates unconditional positive regard for the patient, family, staff, and consultants.
Accept responsibility/accountability for the team’s as well as your actions.
Demonstrate openness and responsiveness to the comments of other team members, patients, families, and peers.

System-Based Practice Outcomes:
Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal care to the hospitalized patient.
Practice cost-effective health care and resource allocation that does not compromise quality of care for the in-patient during and after hospitalization.
Provide advocate position for and facilitate their patients’ advancement through the health care system.

Osteopathic Principles and Practices:
Understand the interdependence of the musculoskeletal/lymphatic system and other organ systems as they relate to the unique situation of the hospitalized patient.
Understand that the mind, body and spirit all interact in the promotion of health and well-being. Demonstrate the ability to utilize osteopathic manipulative medicine as a part of their patient care regimen.
Discuss and demonstrate the practice and principals of Osteopathic Manipulative Treatment for various body systems as it relates to the hospitalized patient.

Description of clinical experiences:
The EM resident will see patients that present to the service/ward under the direct supervision of the attending physician, senior residents and allied health providers. The EM resident will take call and manage these patients as required by the service policy. While on call, the EM resident will see patients referred to medical service.

The EM resident will also gain experience in the ED while rotating on the in-patient Internal Medicine service by presenting to the ED as opportunities permit. The resident will explore the relationship between these services to help ensure future effective patient center care.

Description of didactic experiences:
EM residents will attend Internal Medicine Department conferences appropriate for their education as well as weekly Emergency Medicine conferences and monthly Journal Club. The residents will participate in additional Internal Medicine didactics, as that department requires.

Duty Hours:
The EM resident will conform to AOA and CAMC duty hours which include:
Not exceeding 80 hours per week averaged over 4 weeks.
Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At home call cannot be assigned on these free days. Residents must not be scheduled for more than six consecutive nights of night float/call. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
Duty periods of PGY1 residents must not exceed 16 hours in duration.
It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
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.
Under those circumstances, the resident must: 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.

**Duty Hours:**
The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty. Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods and after in house call. Residents are permitted to return to the hospital while on at home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off duty period”.

**Evaluation process:**
Evaluation of the resident’s knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACGME/AOA defined core competencies. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident’s confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.

The EM resident will receive verbal and written feedback about their performance. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM faculty and EM resident will communicate the concern immediately to the other party and develop a plan to resolve the issue.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?  yes

If no, please explain:
Patient Care Goals: Residents must be able to provide patient care to the family practice patient that is compassionate, appropriate, and effective for the treatment of health problems and advocate for the promotion of health.

Medical Knowledge Goals: Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to family practice patients.

Practice-Based Learning Goals: Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed, based on the knowledge and experience they acquire on the family practice in-patient service/unit.

Interpersonal and Communication Skills Goals: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates, all with diverse backgrounds.

Professionalism Goals: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Systems-Based Practice Goals: Residents must demonstrate an awareness of and responsiveness to the unique aspects of the healthcare system and be able to effectively call on system resources to provide care and patient follow-up that is of optimal value.

Osteopathic Principles and Practices: Residents must demonstrate an awareness of the basic tenets of osteopathic philosophy and ability in basic manipulative medicine as it applies to the Family Medicine patient.

Objectives:

It is expected that each intern’s rotation will vary greatly. The outcomes listed below are therefore a guide and it is unlikely that every intern will be exposed to every topic completely. The areas of abdominal and gastrointestinal disorders, cardiovascular disorders, cutaneous disorders, endocrine, metabolic, and nutritional disorders, head, ear, eye, nose, throat disorders, hematologic disorders, immune system disorders, systemic infectious disorders, musculoskeletal disorders (nontraumatic), nervous system disorders, obstetrics and disorders of pregnancy, urogenital/gynecologic disorders, pediatric disorders, psycho behavioral disorders, renal disorders, thoracic-respiratory disorders and clinical pharmacology should be reviewed in the core curriculum document prior to the start of service. As appropriate patients present, these topics should be expanded upon. Through day to day patient contact with family practice patients on the family practice in-patients service/ unit, with direct supervision from senior residents and attending faculty, the emergency medicine resident will achieve the following outcomes.
Outcomes:

By the completion of this rotation, residents will be able to:

Patient Care Outcomes:

Gather accurate, essential information in a timely manner.

Generate an appropriate differential diagnosis for the family practice in-patient.

Implement an effective patient management plan for the Pediatric, Adult and Geriatric patient with attention to effect of age on various treatment modalities.

Competently perform the diagnostic and therapeutic procedures specific to the family practice in-patient. Special attention and effort should be made to attend or perform any of the following skills that opportunity may present: Airway Techniques (Cricothyrotomy, Heimlich maneuver, Intubation, Nasotracheal, Orotracheal, Rapid sequence, Fiberoptic ), Mechanical ventilation, Percutaneous transtracheal ventilation, Airway adjuncts.

Competently perform the diagnostic and therapeutic procedures specific to the family practice in-patient. Special attention and effort should be made to attend or perform any of the following skills that opportunity may present: Anesthesia ( Local, Regional intravenous anesthesia, Regional nerve blocks), Diagnostic Procedures ( Arthrocentesis, Cystourethrogram, Lumbar puncture, Nasogastric intubation, Pericardiocentesis, Peritoneal lavage, Bedside ultrasonography ( Cardiac, Abdominal, Traumatic, Pelvic), Anoscopy, Thoracentesis, Tonometry, Slit lamp examination, Electrocardiogram interpretation and Radiographic interpretation.

Competently perform the diagnostic and therapeutic procedures specific to the family practice in-patient. Special attention and effort should be made to attend or perform any of the following skills that opportunity may present: Genital/Urinary ( Bladder catheterization, Foley catheters, Suprapubic catheterization), Delivery of newborn (Breech delivery, Normal delivery, Perimortem cesarean section).

Competently perform the diagnostic and therapeutic procedures specific to the family practice in-patient. Special attention and effort should be made to attend or perform any of the following skills that opportunity may present: Head and Neck (Control of epistaxis, Anterior packing, Posterior packing/balloon placement, Cautery, Laryngoscopy, Nasopharyngeal endoscopy)

Competently perform the diagnostic and therapeutic procedures specific to the family practice in-patient. Special attention and effort should be made to attend or perform any of the following skills that opportunity may present: Hemodynamic Techniques: Arterial catheter insertion, Central venous access ( Femoral, Jugular, Subclavian, Umbilical), Venous cutdown , Intraosseous infusion, Peripheral venous cutdown and Pulmonary artery catheter insertion.

Competently perform the diagnostic and therapeutic procedures specific to the family practice in-patient. Special attention and effort should be made to attend or perform any of the following skills that opportunity may present: Skeletal Procedures: Fracture/dislocation immobilization techniques, Fracture/dislocation reduction techniques, Spine (Cervical traction techniques,Immobilization techniques and Backboard techniques.

Competently perform the diagnostic and therapeutic procedures specific to the family practice in-patient. Special attention and effort should be made to attend or perform any of the following skills that opportunity may present: Thoracic: Cardiac pacing (Cutaneous, Transvenous), Defibrillation/cardioversion, Cardiorrhaphy, Pericardiotomy, Thoracostomy, and Thoracotomy.

Competently perform the diagnostic and therapeutic procedures specific to the family practice in-patient. Special attention and effort should be made to attend or perform any of the following skills that opportunity may present: Other Techniques: End-tidal CO 2 monitoring, Gastric lavage, Incision – drainage, Intestinal tube insertion, Pulse oximetry, Wound closure techniques, Peak expiratory flow rate measurement

Demonstrate the ability to perform and interpret focused (goal directed) care of the septic patient.

Provide health care services aimed at preventing health problems or maintaining health during and after hospitalization. Work with health care professionals to provide patient-focused care.

Medical Knowledge Outcomes:

Identify life-threatening conditions that affect the hospitalized patient, identify the most likely diagnoses, synthesize acquired patient data, and identify how and when to access current medical information.

Discuss treatment options in ABDOMINAL AND GASTROINTESTINAL DISORDERS (Esophagus, Liver, Gall Bladder and Biliary Tract, Pancreas, Stomach, Small Bowel, Large Bowel, Rectum and Anus, Abdominal Wall.

Discuss the signs, symptoms and treatment of the CARDIOVASCULAR DISORDERS (Pathophysiology, Cardiac failure, Diseases of the Pericardium, Diseases of the Conduction System /Disturbances of Cardiac Rhythm, Acquired
Diseases of the Circulation, Congenital Abnormalities of the Cardiovascular System, Cardiac Transplant Patient,
Medical Knowledge Outcomes:
Hypertension, Primary Tumors of the Heart, Myocardial Manifestations of Systemic Disease, and Treatment Modalities.
Describe the management of HEAD, EAR, EYE, NOSE, and THROAT DISORDER.
Describe the critical actions in the diagnosis and treatment of ENDOCRINE, METABOLIC, AND NUTRITIONAL DISORDERS Acid-Base Disturbances, Adrenal Disease, Fluid and Electrolyte Disturbances, Glucose Metabolism, Nutritional Disorders Parathyroid Disease, Pheochromocytoma, Pituitary Disorders, Thyroid Disorders and Endocrine Manifestations of Neoplasia.
Describe the relative effectiveness and complications of various 8.0 IMMUNE SYSTEM DISORDERS: Humoral Immunity, Cellular Immunity, Chemical Mediators, Complement, Autoimmune Diseases, Immune Deficiency Syndromes, Rejection and Hypersensitivity.
Discuss treatment options in OBSTETRICS AND DISORDERS OF PREGNANCY: Contraception, Pregnancy, Uncomplicated, Pregnancy, Complicated, Labor, Uncomplicated, Labor, Complicated, Delivery, Uncomplicated, Delivery, Complicated and Postpartum Complications.
Discuss treatment options in RENAL DISORDERS: Structural Disorders, Infection, Glomerular Disorders, Acute and Chronic Renal Failure, Interstitial Tubular Necrosis, Interstitial Nephritis, Tumors, Complications of Dialysis.
Discuss treatment options in UROGENITAL/GYNECOLOGIC DISORDERS: Genital Tract – Female (Vagina and vulva, Uterus, Cervix, Infectious disorders); Genital Tract – Male (Congenital, Structural, Priapism, Testicular torsion, Urethral strictures, Urethral foreign bodies, Prostatic hypertrophy); Inflammation/infection, Tumors, Sexual Assault, and Genital Lesions.
Discuss the signs, symptoms and treatment including Prevention of the SYSTEMIC INFECTIOUS DISORDERS: Bacterial, Fungal, Protozoan B Parasites, Rickettsial, Viral and Travel-Related.
Describe the critical actions in the diagnosis and treatment of NERVOUS SYSTEM DISORDERS: Stroke, Cranial Nerve Disorders, Demyelinating Disorders, Abscess, Neuromuscular Disorders, Peripheral Neuropathy, Spinal Cord Compression, Hydrocephalus, Seizure Disorders, Headache, Pseudotumor, Cerebri/Benign Intracranial Hypertension, Tumors and Movement Disorders.
Describe the classification scheme for, the relative effectiveness and complications of various treatments in CLINICAL PHARMACOLOGY: Principles, Drug interactions, Adverse reactions, Drugs in pregnancy/breast-feeding, Effect of age, Withdrawal syndromes, Neonatal/pediatric considerations and Drug Classes.
Describe the critical actions in the diagnosis and treatment of THORACIC-RESPIRATORY DISORDERS: Acute Upper Airway Obstruction, Breast Disorders, Disorders of Pleura, Mediastinum, and Chest Wall, Hyperventilation Syndrome, Non-cardiogenic Pulmonary Edema (Adult Respiratory Distress Syndrome), Obstructive/Restrictive Lung Disease, Physical and Chemical Irritants/Insults, Primary Pulmonary Hypertension, Pulmonary Embolism/Infarct, Pulmonary Infections, Thoracic Outlet Syndrome (OM considerations), Pulmonary Tumors, Sarcoïdosis and Sleep Apnea Syndromes.

Practice Based Learning Outcomes:
Analyze and assess their practice experience and perform practice-based improvement and patient safety.
Locate, appraise and utilize scientific evidence related to their patient’s health problems.
Apply knowledge of study design and statistical methods to critically appraise the medical literature as it relates to the hospitalized patient.
Utilize information technology to enhance their education and improve patient care.
Facilitate the learning of students and other health care professionals.

Interpersonal and Communication Skills Outcomes:
Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences.
Demonstrate effective participation in and leadership of the health care team.
Develop effective written communication skills including, but not limited to, writing of admission orders, history and physical exams, daily progress notes and discharge summaries.
Demonstrate the ability to handle situations unique to the in-patient setting.
Effectively communicate with medical as well non-medical personnel.

**Professionalism Outcomes:**
- Treats patients/family/staff/paraprofessional personnel with respect.
- Protects staff/family/patient’s interests/confidentiality.
- Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues.
- Be able to discuss death honestly, sensitively, patiently, and compassionately.
- Demonstrates unconditional positive regard for the patient, family, staff, and consultants.
- Accept responsibility/accountability for the team’s as well as your actions.
- Demonstrate openness and responsiveness to the comments of other team members, patients, families, and peers.

**System-Based Practice Outcomes:**
- Understand access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal care to the hospitalized patient.
- Practice cost-effective health care and resource allocation that does not compromise quality of care for the in-patient during and after hospitalization.
- Provide advocate position for and facilitate their patients’ advancement through the health care system.

**Osteopathic Principles and Practices:**
- Understand the interdependence of the musculoskeletal/lymphatic system and other organ systems as they relate to the unique situation of the hospitalized patient.
- Understand that the mind, body and spirit all interact in the promotion of health and well-being.
- Demonstrate the ability to utilize osteopathic manipulative medicine as a part of their patient care regimen.
- Discuss and demonstrate the practice and principals of osteopathic manipulative treatment for various body systems as it relates to the hospitalized patient.

**Description of clinical experiences:**

The EM resident will see patients that present to the Family Practice service/ward under the direct supervision of the Family Practice attending, Family Practice senior residents and allied health providers. The EM resident will take call and manage these patients as required by the service policy. While on call, the EM resident will see patients referred to Emergency Department for the Family Practice service as well as other patients on the Family Practice service.

The EM resident will also gain experience in the ED while rotating on the in-patient family practice service by presenting to the ED as opportunities permit. The resident will explore the relationship between these services to help ensure future effective patient center care.

**Description of didactic experiences:**

EM residents will attend Family Practice Department conferences appropriate for their education as well as weekly Emergency Medicine conferences and monthly Journal Club. The residents will participate in additional Family Practice didactics, as that department requires.

**Duty Hours:**

The EM resident will conform to AOA and CAMC duty hours which include:

- Not exceeding 80 hours per week *averaged over 4 weeks*.
- Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At home call cannot be assigned on these free days. Residents must not be scheduled for more than six consecutive nights of night float/call. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
- Duty periods of PGY1 residents must not exceed 16 hours in duration.
- It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
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.

Under those circumstances, the resident must: 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. The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty. Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods and after in house call. Residents are permitted to return to the hospital while on at home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off duty period”.

**Evaluation process:**

Evaluation of the resident’s knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACGME/AOA defined core competencies. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident’s confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.

**Feedback mechanisms:**

The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the Family Practice In-patient rotation and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Rotation Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described? **YES**

If no, please explain:
Rotation | Anesthesiology
---|---
Institution | All CAMC Facilities
Year of training | EM1 1 month | EM2 | EM3 | EM4

**Goals:**

**Patient Care Goals:** Residents must be able to provide patient care to the anesthesia and surgical patient that is compassionate, appropriate, and effective for the treatment of health problems and advocate for the promotion of health. Includes the pediatric patients and their families.

**Medical Knowledge Goals:** Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to the anesthesia and surgical patient both adult and pediatric.

**Practice-Based Learning Goals:** Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed, based on the knowledge and experience they acquire on the anesthesia service/unit.

**Interpersonal and Communication Skills Goals:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates all with diverse backgrounds.

**Professionalism Goals:** Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

**Systems-Based Practice Goals:** Residents must demonstrate an awareness of and responsiveness to the unique aspects of the healthcare system and be able to effectively call on system resources to provide care and patient follow up that is of optimal value.

**Osteopathic Principles and Practices:** Residents must demonstrate an awareness of the basic tenets of osteopathic philosophy and ability in basic manipulative medicine.

**Objectives:**

Through day to day patient contact with surgical patients on the anesthesia patients service/unit, with direct supervision from nurse practitioners, senior residents and attending faculty, the emergency medicine resident will achieve the following outcomes.

**Outcomes:**

By the completion of this rotation, residents will be able to:

**Patient Care Outcomes:**

Gather accurate, essential information in a timely manner
Generate an appropriate differential diagnosis for the difficult airway patient
Implement an effective patient management plan for acute upper airway obstruction patient
Competently perform the diagnostic and therapeutic procedures specific to intubations
Perform emergency airway stabilization for the acutely ill patient
Demonstrate ability to determine proper indications for pharyngeal-tracheal lumen airway
Demonstrate ability to perform nasotracheal intubation
Demonstrate the ability to assess a patient using the anesthesia association guidelines
Demonstrate ability to evaluate and manage the care of patients requiring the use of paralytic agents
Discuss the indications for orotracheal intubation and demonstrate various techniques
Demonstrate ability to diagnose and manage mechanical ventilation
Prioritize and stabilize multiple patients and perform other responsibilities simultaneously
**Patient Care Outcomes:**
Demonstrate the ability to perform and interpret end-tidal CO2 and pulse oximetry monitoring
Work with health care professionals to provide patient-focused care
Discuss the indications for and actions/adverse affects of the following medications: Fentanyl, Ketamine, Nitrous oxide,
Demonstrate and discuss the above outcomes as they relate to pediatric patients

**Medical Knowledge Outcomes:**
Identify life-threatening conditions that affect the acute upper airway obstruction patient, identify the most likely diagnoses, synthesize acquired patient data, and identify how and when to access current medical information
Discuss treatment options in local anesthetics
Describe the classification scheme for pre-intubation airway assessment
Describe the relative effectiveness and complications of various analgesics / anesthetics
Complete disposition of patients using available resources
Demonstrate proper use of local, regional IV anesthesia and regional nerve blocks
Discuss the anatomical differences of the adult VS pediatric airway and the impact of the differences they have on selections of equipment and medications
Demonstrate and discuss the above outcomes as they relate to pediatric patients

**Practice Based Learning Outcomes:**
Analyze and assess their practice experience and perform practice-based improvement
Locate, appraise and utilize scientific evidence related to their patient’s health problems
Apply knowledge of study design and statistical methods to critically appraise the medical literature
Utilize information technology to enhance their education and improve patient care
Facilitate the learning of students and other health care professionals
Demonstrate and discuss the above outcomes as they relate to pediatric patients

**Interpersonal and Communication Skills Outcomes:**
Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences
Demonstrate effective participation in and leadership of the health care team
Develop effective written communication skills
Demonstrate the ability to handle situations unique to the anesthetized patient
Effectively communicate with medical as well non-medical personnel
Demonstrate and discuss the above outcomes as they relate to pediatric patients

**Professionalism Outcomes:**
Treats patients/family/staff/paraprofessional personnel with respect
Protects staff/family/patient’s interests/confidentiality
Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues
Able to discuss death honestly, sensitively, patiently, and compassionately
Unconditional positive regard for the patient, family, staff, and consultants
Accepts responsibility/accountability
Openness and responsiveness to the comments of other team members, patients, families, and peers
Demonstrate and discuss the above outcomes as they relate to pediatric patients

**System-Based Practice Outcomes:**
Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal care to the preoperative patient and emergency airway and those patients requiring emergency airway stabilization
Practice cost-effective health care and resource allocation that does not compromise quality of care
Advocate for and facilitate their patients’ advancement through the health care system
Demonstrate and discuss the above outcomes as they relate to pediatric patients
Osteopathic Principles and Practices:
Understand the interdependence of the musculoskeletal/lymphatic system and other organ systems as they relate to the pre and post intubation patient
Understand that the mind, body and spirit all interact in the promotion of health and well being and demonstrate the ability to utilize osteopathic manipulative medicine as a part of their patient care regimen
Demonstrate and discuss the above outcomes as they relate to pediatric patients

Description of clinical experiences:
The EM resident will see patients that present to the anesthesia/surgery service under the direct supervision of the anesthesiologist and allied health providers. The EM resident will take call and manage these patients as required by the service policy. While on call, the EM resident will see patients referred to CAMC Emergency Services and on the emergency service. A portion of this rotation is to be spent in the pediatric surgical unit to familiarize the resident with airway management of the younger patient.

Description of didactic experiences:
EM residents will attend Anesthesia Department conferences appropriate for their education as well as weekly Emergency Medicine conferences and monthly Journal Club. The residents will complete courses presented through the American Heart Association to augment the didactic experience.

Duty Hours:
The EM resident will conform to AOA and CAMC duty hours which include:
Not exceeding 80 hours per week averaged over 4 weeks.
Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks).
At home call cannot be assigned on these free days. Residents must not be scheduled for more than six consecutive nights of night float/call. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
Duty periods of PGY1 residents must not exceed 16 hours in duration.
It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
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.
Under those circumstances, the resident must: 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. The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty. Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods and after in house call. Residents are permitted to return to the hospital while on at home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off duty period”.

Evaluation process:
Evaluation of the resident’s knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACGME/AAOA defined core competencies. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident’s confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.
Evaluation process:

Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.

Feedback mechanisms:

The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the anesthesia rotation and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Rotation Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

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<tr>
<th>Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?</th>
<th>YES</th>
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</table>

If no, please explain:
Goals:

**Patient Care Goals:** Residents must be able to provide patient care to the pregnant and postpartum patient that is compassionate, appropriate, and effective for the treatment of health problems and advocate for the promotion of health.

**Medical Knowledge Goals:** Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to pregnant woman and infant’s care.

**Practice-Based Learning Goals:** Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire on the Obstetrics ward and OB triage unit.

**Interpersonal and Communication Skills Goals:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates all with diverse backgrounds.

**Professionalism Goals:** Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

**Systems-Based Practice Goals:** Residents must demonstrate an awareness of and responsiveness to the unique aspects of the healthcare system and be able to effectively call on system resources to provide care and patient follow up that is of optimal value.

**Osteopathic Principles and Practices:** Residents must demonstrate an awareness of the basic tenets of osteopathic philosophy and ability in basic manipulative medicine.

**Objectives:**

Through day to day patient contact with a maternal-fetal health patients on the Obstetrics ward and OB triage unit with direct supervision from nurse-practioners, senior OB-GYN residents and attending OB-GYN faculty, the emergency medicine resident will achieve the following outcomes.

**Outcomes:**

By the end of the rotation, residents will be able to:

**Patient Care Outcomes:**
Gather accurate, essential information in a timely manner
Generate an appropriate differential diagnosis for the maternal-fetal health patient
Implement an effective patient management plan for the OB patient
Competently perform the diagnostic and therapeutic procedures specific to the OB patient and her child
Perform emergency stabilization for the ill pregnant patient and/or neonate
Demonstrate ability to determine the APGAR score and discuss the significance of different values
Demonstrate ability to perform peri-natal and neonatal resuscitations
Demonstrate the ability to assess a pregnant patient and perform an uncomplicated vaginal delivery
Demonstrate ability to evaluate and manage the care of patients with suspected ectopic pregnancy
Discuss the indications for peri-mortem caesarian section and describe the technique
Demonstrate ability to diagnose and manage postpartum complications including retained products, endometritis, retained placenta and mastitis
Prioritize and stabilize multiple patients and perform other responsibilities simultaneously
Demonstrate the ability to perform and interpret focused (goal directed) bedside trans-abdominal and pelvic ultrasounds
Provide health care services aimed at preventing health problems or maintaining health during and after pregnancy
Work with health care professionals to provide patient-focused care

Medical Knowledge Outcomes:
- Identify life-threatening conditions that affect the pregnant/postpartum patient and her baby, identify the most likely diagnoses, synthesize acquired patient data, and identify how and when to access current medical information
- Discuss treatment options in hyperemesis gravidarum
- Discuss the signs, symptoms and treatment of the female genital tract to include: ovarian disorders (ovarian cyst, ovarian torsion); vagina and vulva (vaginitis, foreign bodies); vaginal bleeding; infectious disorders (bartholin abscess, cervicitis, endometritis, Fitz-Hugh-Curtiss syndrome, pelvic inflammatory disease, salpingitis, tubo-ovarian abscess); vulvovaginitis
- Discuss the signs, symptoms and treatment of uncomplicated delivery including: presentation, position, lie
- Describe the management of complicated deliveries including: presentation, dystocia, prolapsed cord, retained placenta, 12.4.5 uterine inversion, multiple births, stillbirth,
- Discuss RH incompatibility
- Describe the critical actions in the diagnosis and treatment of ectopic pregnancy
- Describe the classification scheme for abortion and differentiate types including threatened, inevitable, incomplete, complete, septic, missed
- 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
Complete disposition of patients using available resources

Practice Based Learning Outcomes:
- Analyze and assess their practice experience and perform practice-based improvement
- Locate, appraise and utilize scientific evidence related to their patient’s health problems
- Apply knowledge of study design and statistical methods to critically appraise the medical literature
- Utilize information technology to enhance their education and improve patient care
- Facilitate the learning of students and other health care professionals

Interpersonal and Communication Skills Outcomes:
- Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences
- Demonstrate effective participation in and leadership of the health care team
- Develop effective written communication skills
- Demonstrate the ability to handle situations unique to pregnant and postpartum patients
- Effectively communicate with medical as well non-medical personnel

Professionalism Outcomes:
- Treats patients/family/staff/paraprofessional personnel with respect
- Protects staff/family/patient’s interests/confidentiality
- Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues
- Able to discuss death honestly, sensitively, patiently, and compassionately
- Unconditional positive regard for the patient, family, staff, and consultants
- Accepts responsibility/accountability
- Openness and responsiveness to the comments of other team members, patients, families, and peers

System-Based Practice Outcomes:
- Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal care to the maternal health patient
- Practice cost-effective health care and resource allocation that does not compromise quality of care
- Advocate for and facilitate their patients’ advancement through the health care system
Osteopathic Principles and Practices:
Among other understand the interdependence of the musculoskeletal /lymphatic system and other organ systems as they relate to the obstetrical patient
Understand that the mind, body and spirit all interact in the promotion of health and well being and demonstrate the ability to utilize osteopathic manipulative medicine as a part of their patient care regimen

Description of clinical experiences:
The EM resident will see patients that present to the OB ward under the direct supervision of the OB/GYN attending, OB/GYN senior residents and midwives. The EM resident will take call and manage OB/GYN inpatients while on call. While on call, the EM resident will see patient referred to OB triage and on the OB service.
The EM resident will also gain OB experience in the ED and neonatal resuscitation while rotating on the obstetrical service.

Description of didactic experiences:
EM residents will attend OB/GYN Department conferences appropriate for their education as well as weekly Emergency Medicine conferences and monthly Journal Club. The residents will participate in an Emergency Medicine ultrasound course and clinical practicum during their training that will cover indications and proper technique for ED goal directed bedside ultrasound.

Duty Hours:
The EM resident will conform to AOA and CAMC duty hours which include:
Not exceeding 80 hours per week averaged over 4 weeks.
Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks).
At home call cannot be assigned on these free days. Residents must not be scheduled for more than six consecutive nights of night float/ call. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
Duty periods of PGY1 residents must not exceed 16 hours in duration.
It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
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.
Under those circumstances, the resident must: 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. The program director must review each submission of additional duty, and track both individual resident and program wide episodes of additional duty. Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods and after in house call. Residents are permitted to return to the hospital while on at home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off duty period”.

Evaluation process:
Evaluation of the resident’s knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACGME/AOA defined core competencies. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident’s confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination. Any deficiencies noted are corrected with a focused remediation program designed by
the EM Residency Program Director, EM Faculty and EM resident.

**Evaluation process:**
At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.
Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination, PALS and ATLS course. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

The resident tracks all procedures and completes a rotation evaluation. The EM Residency Program Director will discuss rotation evaluations with the OB/GYN rotation director.

**Feedback mechanisms:**
The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the OB rotation and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and OB Rotation Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

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</table>

If no, please explain:
<table>
<thead>
<tr>
<th>Rotation</th>
<th>Orthopedics</th>
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<tbody>
<tr>
<td>Institution</td>
<td>Charleston Area Medical Center</td>
</tr>
<tr>
<td>Year of training</td>
<td>EM1</td>
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<tr>
<td>Goals:</td>
<td></td>
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<tr>
<td>Patient Care Goals:</td>
<td>Residents must be able to provide patient care to patients with orthopedic complaints that are compassionate, appropriate and effective for the treatment of inflammatory and infectious disorders of the musculoskeletal system, and advocate for the promotion of health in the hospital system.</td>
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<tr>
<td>Medical Knowledge Goals:</td>
<td>Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences associated with orthopedic surgery and must apply this knowledge to the care of patients with acute and chronic pain from musculoskeletal disorders.</td>
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<tr>
<td>Practice-Based Learning Goals:</td>
<td>Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire on the Orthopedic service.</td>
</tr>
<tr>
<td>Interpersonal and Communication Skills Goals:</td>
<td>residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates all with diverse backgrounds.</td>
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<td>Professionalism Goals:</td>
<td>residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.</td>
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<tr>
<td>Systems-Based Practice Goals:</td>
<td>residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.</td>
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<tr>
<td>Osteopathic Principles and Practices:</td>
<td>residents must demonstrate an awareness of the basic tenets of osteopathic philosophy and ability in basic manipulative medicine.</td>
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<tr>
<td>Objectives:</td>
<td></td>
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<tr>
<td>Patient Care Outcomes:</td>
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<tr>
<td>Gather accurate, essential information from the patient's history and physical examination in a timely manner.</td>
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<tr>
<td>Implement a timely, effective patient management plans.</td>
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<tr>
<td>Competently perform diagnostic and therapeutic procedures, including: fracture/dislocation immobilization and reduction, arthrocentesis and tendon repair.</td>
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<tr>
<td>Demonstrate the ability to diagnose and treat orthopedic injuries in multiple trauma patients, including inflammatory and infectious disorders, soft tissue foreign bodies.</td>
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<tr>
<td>Demonstrate stability of critical patients with orthopedic trauma.</td>
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<tr>
<td>Outcomes: By the completion of this rotation, residents will be able to:</td>
<td></td>
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<tr>
<td>Patient Care Outcomes:</td>
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<tr>
<td>Demonstrate ability to correctly order and interpret radiographs in patients with orthopedic injuries.</td>
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<tr>
<td>Demonstrate knowledge of standard orthopedic nomenclature.</td>
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<tr>
<td>Demonstrate knowledge of appropriate aftercare of orthopedic injuries.</td>
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<tr>
<td>Demonstrate knowledge of the differences in pediatric and adult skeletal anatomy and indicate how those differences are manifest in clinical and radiographic presentations.</td>
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<tr>
<td>Demonstrate ability to apply orthopedic devices, including compressive dressings, splints and immobilizer.</td>
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<tr>
<td>Describe the presentation of patients with inflammatory and infectious disorders and demonstrate ability to diagnose and treat them.</td>
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</table>
Patient Care Outcomes:
Demonstrate ability to diagnose and treat soft tissue foreign bodies.
Describe the presentations, complications, diagnosis, management and prognosis of patients with human and animal bites.
Describe the presentations, complications, diagnosis and management of compartment syndromes.
Work with health care professionals to provide patient-focused care.

Medical Knowledge Outcomes:
Demonstrate ability to provide regional anesthesia, including hematoma blocks, Bier blocks and regional, nerve blocks.
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.
Discuss the differential diagnosis, historical features, physical and examination findings of patients with low back pain.
Demonstrate ability to recognize and treat soft tissue infections involving muscle, fascia, and tendons.
Describe diagnosis and treatment of overuse syndrome.
Describe how to evaluate and preserve amputated limb parts.
Demonstrate knowledge of joint injuries, their appropriate treatment and prognosis.
Discuss evaluation and treatment of soft tissue injuries such as strains, penetrating soft tissue injuries, crush injuries, and high-pressure injection injuries.

Practice Based Learning Outcomes:
Analyze and assess their practice experience and perform practice-based improvement.
Locate, appraise and utilize scientific evidence related to their patient’s health problems.
Apply knowledge of study design and statistical methods to critically appraise the literature.
Utilize information technology to enhance their education and improve patient care.
Facilitate the learning of students and other health care professionals.

Interpersonal and Communication Skills Outcomes:
Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences.
Demonstrate effective participation in and leadership of the health care team.
Develop effective written communication skills.
Demonstrate the ability to handle situations unique to the Orthopedic patient.
Effectively communicate with medical as well non-medical personnel.

Professionalism Outcomes:
Treats patients, family, staff, and ancillary personnel with respect.
Protects staff, family, and patient’s interests and confidentiality.
Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues.
Discuss death honestly, sensitively, patiently, and compassionately.
Unconditional positive regard for the patient, family, staff, and consultants.
Accepts responsibility and demonstrates accountability.
Exhibit openness and responsiveness to the comments of other team members, patients, families, and peers.
Demonstrate an understanding of the ethical and legal principles applicable to the care of orthopedic patients.
Demonstrate an understanding of “Do not resuscitate” orders, advance directives, living wills, and brain death criteria.

System-Based Practice Outcomes:
Demonstrate an understanding of the appropriate use of consultants with orthopedic injuries patients.
Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal patient care.
Practice cost-effective health care and resource allocation that does not compromise quality of care.
Advocate for and facilitate patient’s advancement through the health care system.

Osteopathic Principles and Practices:
Among other Understand the interdependence of the musculoskeletal lymphatic system and other organ systems as they relate to the Orthopedic patient.
Understand that the mind, body and spirit all interact in the promotion of health and well being and demonstrate the
ability to utilize osteopathic manipulative medicine as a part of their patient care regimen

### Description of clinical experiences:
The EM resident will see patients that present to the Orthopedic service/ward under the direct supervision of the assigned attending, and allied health providers. The EM resident will take call and manage these patients as required by the service policy.
The EM resident will also gain experience in the ED while rotating on the Orthopedic service.

### Description of didactic experiences:
EM residents will attend Orthopedic and Surgery Department conferences appropriate for their education as well as weekly Emergency Medicine conferences and monthly Journal Club. The residents will participate in required OPTI conferences.

### Duty Hours:
The EM resident will conform to AOA and CAMC duty hours which include:
Not exceeding **80 hours per week averaged over 4 weeks**.
Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At home call cannot be assigned on these free days. Residents must not be scheduled for more than six consecutive nights of night float/call. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
Duty periods of PGY1 residents must not exceed 16 hours in duration.
It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
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.
Under those circumstances, the resident must: 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. The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty. Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods and after in house call. Residents are permitted to return to the hospital while on at home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off duty period”.

### Evaluation process:
Evaluation of the resident’s knowledge and skills by direct supervision of the care given to patients on this rotation.
Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACGME/OA defined core competencies. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident’s confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination, ACLS and ATLS course. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.

The resident tracks all procedures and completes a rotation evaluation. The EM Residency Program Director will discuss rotation evaluations with the Orthopedic rotation director.
Feedback mechanisms:
The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the Orthopedic rotation and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Rotation Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

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If no, please explain:
### Goals:

**Patient Care Goals:** Residents must be able to provide patient care to intensive care patient that is compassionate, appropriate, and effective for the treatment of health problems and advocate for the promotion of health in the CAMC medical system.

**Medical Knowledge Goals:** Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to patient care.

**Practice-Based Learning Goals:** Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire in the CAMC Medical, Neurological, Surgical or Cardiac Intensive Care Units.

**Interpersonal and Communication Skills Goals:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates all with diverse backgrounds.

**Professionalism Goals:** Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

**Systems-Based Practice Goals:** Residents must demonstrate an awareness of and responsiveness to the unique aspects of the CAMC system and be able to effectively call on system resources to provide care and patient follow up that is of optimal value.

**Osteopathic Principles and Practices:** Residents must demonstrate an awareness of the basic tenets of osteopathic philosophy and ability in basic manipulative medicine.

### Objectives:

Through day to day patient contact with patients in the Intensive Care Unit and attending supervision, the emergency medicine resident will achieve the following outcomes.

### Outcomes:

By the completion of this rotation, residents will be able to:

**Patient Care Outcomes:**
- Gather accurate, essential information from the patient’s history and physical examination in a timely manner
- Implement a timely, effective patient management plans
- Competently perform diagnostic and therapeutic procedures
- Demonstrate ability to diagnose and treat patients with the more common acute cardiac conditions including: cardiac failure (high output and low output), myocardial infarction, arrhythmias.
- Stabilize critical patients
- Prioritize and stabilize multiple patients and perform other responsibilities simultaneously
- Work with health care professionals to provide patient-focused care

**Medical Knowledge Outcomes:**
- Identify life-threatening conditions, the most likely diagnosis, synthesize acquired patient data, and identify how and when to access current medical information
- Demonstrate the ability to use and interpret data from electrocardiography (ECG monitors and 12 lead ECGs), cardiac outputs, hemodynamic monitoring, arterial blood gas sampling, pulse oximetry, end tidal CO2 monitors and respirators.
- Demonstrate the ability to manage a patient with an arterial catheterization including indications contraindications and complications of the treatment modality.
Medical Knowledge Outcomes:
Demonstrate the ability to manage a patient with central venous catheterization including indications and contraindications and complications of the treatment modality.
Discuss the critical steps in the implementation of a swan-ganz catheterization, cardiac pacing. Demonstrate the ability to manage a patient needing defibrillation/cardioversion including indications and contraindications and complications of the treatment modality.
Demonstrate the ability to manage a patient on mechanical ventilation including indications and contraindications and complications of the treatment modality.
Discuss the differential and preliminary work-up myocarditis, pericardial effusion/tamponade, pericarditis and endocarditis.
Discuss the differential and preliminary work-up cardiogenic shock.
Demonstrate knowledge of aortic insufficiency/stenosis, mitral insufficiency/stenosis, and pulmonary insufficiency/stenosis.
Demonstrate knowledge of the pathophysiology and manifestations arterial emboli, arterial spasm, arterial thrombosis, venous insufficiency/varicosities, venous thromboembolism, and venous thrombophlebitis.
Discuss the differential and correct treatment of acute hypertensive crisis, essential hypertension, and secondary hypertension.
Discuss the differential and preliminary work-up of and the appropriate management of: cardiovascular surgery, mechanical assistance, primary tumors of the heart, myocardial manifestations of systemic disease, and transplantation.
Demonstrate knowledge of the pathophysiology and manifestations of mitral valve prolapse, patent foramen ovale, congenital abnormalities, tricuspid insufficiency/stenosis and hypertrophic heart disease.
The resident will demonstrate knowledge of the indications and counter indications for thrombolytic therapy and other interventional techniques and experience their use.
Complete disposition of patients using available resources
Analyze and assess their practice experience and perform practice-based improvement
Locate, appraise and utilize scientific evidence related to their patient’s health problems
Apply knowledge of study design and statistical methods to critically appraise the medical literature
Utilize information technology to enhance their education and improve patient care
Facilitate the learning of students and other healthcare professionals

Interpersonal and Communication Skills Outcomes:
Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences
Demonstrate effective participation in and leadership of the healthcare team
Develop effective written communication skills
Demonstrate the ability to handle situations unique to the practice of emergency medicine
Effectively communicate with out-of-hospital personnel as well as non-medical personnel

Professionalism Outcomes:
Treats patients, family, staff, and ancillary personnel with respect
Protects staff, family, and patient’s interests and confidentiality
Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues
Able to discuss death honestly, sensitively, patiently, and compassionately
Unconditional positive regard for the patient, family, staff, and consultants
Accepts responsibility and demonstrates accountability
Openness and responsiveness to the comments of other team members, patients, families, and peers
Demonstrate an understanding of the ethical and legal principles applicable to the care of critically ill patients.
Demonstrate understanding of “Do not resuscitate” orders, advance directives, living wills, and brain dead criteria

System-Based Practice Outcomes:
Demonstrate an understanding of the appropriate use of consultants in critically ill patients
Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal patient care
Practice cost-effective health care and resource allocation that does not compromise quality of care
Advocate for and facilitate patient’s advancement through the health care system
Osteopathic Principles and Practices:
Among other understand the interdependence of the musculoskeletal /lymphatic system and other organ systems as they relate to the critically ill patient
Understand that the mind, body and spirit all interact in the promotion of health and well being and demonstrate the ability to utilize osteopathic manipulative medicine as a part of their patient care regimen

Description of clinical experiences:
The EM resident will see patients that present to the Intensive Care Unit under the direct supervision of the of the Intensive Care Unit attending. The EM resident will take call and manage Intensive Care Unit patients while on call.

Description of didactic experiences:
EM residents will attend ICU conferences appropriate for their education as well as weekly Emergency Medicine conferences and Journal Club as scheduled.

Duty Hours:
The EM resident will conform to AOA and CAMC duty hours which include:
Not exceeding 80 hours per week averaged over 4 weeks.
Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At home call cannot be assigned on these free days. Residents must not be scheduled for more than six consecutive nights of night float/ call. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
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It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
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.
Under those circumstances, the resident must: 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. The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty. Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods and after in house call. Residents are permitted to return to the hospital while on at home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off duty period”.

Evaluation process:
Evaluation of the resident’s knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACGME/AOA defined core competencies. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident’s confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.
Residents are also evaluated on their performance through the use of the ABOEM in training examination, CORD On-Line tests, Simulation scenarios and Emergency Medicine Residency Oral examination and ACLS. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.
The resident tracks all procedures and completes a rotation evaluation. The EM Residency Program Director will discuss rotation evaluations with the Intensive Care Unit Faculty.

<table>
<thead>
<tr>
<th>Feedback mechanisms:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the ICU rotation and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Intensive Care Unit Rotation Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.</td>
</tr>
</tbody>
</table>

| Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described? | √ |
| If no, please explain: |
Rotation | Toxicology
--- | ---
Institution | Regional Poison Control Center WVU building
Year of training | EM1 | EM2 | EM3 | EM4 | 1/2 day, 2 times per block

Goals:

**Patient Care Goals:** Residents must be able to provide patient care to the toxicology patient that is compassionate, appropriate, and effective for the treatment of health problems and advocate for the promotion of health.

**Medical Knowledge Goals:** Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to toxicology patients.

**Practice-Based Learning Goals:** Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire on the Toxicology service/unit.

**Interpersonal and Communication Skills Goals:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates all with diverse backgrounds. And must be able to do this through use of various electronic media as well as face to face.

**Professionalism Goals:** Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

**Systems-Based Practice Goals:** Residents must demonstrate an awareness of and responsiveness to the unique aspects of the healthcare system and be able to effectively call on system resources to provide care and patient follow up that is of optimal value.

**Osteopathic Principles and Practices:** Residents must demonstrate an awareness of the basic tenets of osteopathic philosophy and ability in basic manipulative medicine.

**Objectives:**

Through day to day patient contact with toxicology patients on the regional toxicology service/unit with direct supervision from toxicology technicians, senior residents and attending faculty, the emergency medicine resident will achieve the following outcomes.

**Outcomes:**

By the completion of this rotation, residents will be able to:

**Patient Care Outcomes:**
- Gather accurate, essential information in a timely manner
- Generate an appropriate differential diagnosis for the poisoned patient
- Implement an effective patient management plan for the toxicology patient including treatment modalities for Antidotes, Skin decontamination, Gastric decontamination, Emetics, Lavage, Enhanced elimination, Activated charcoal, Cathartics/whole bowel irrigation, Diuresis, Dialysis/hemoperfusion, Hyperbaric oxygen, and Withdrawal syndromes
- Prioritize and Manage Multiple Patients and perform other responsibilities simultaneously
- Demonstrate the ability to perform and interpret Toxicologic information, Toxicologic diagnostic modalities, Toxidromes
- Provide health care services aimed at preventing health problems or maintaining health during and after initial contact with such patients.
- Work with health care professionals to provide patient-focused care
Medical Knowledge Outcomes:
Identify life-threatening conditions that affect these patients, identify the most likely diagnoses, synthesize acquired patient data, and identify how and when to access current medical information.

Discuss treatment options of various Drug and Chemical Classes
Complete disposition of patients using available resources

Practice Based Learning Outcomes:
Analyze and assess their practice experience and perform practice-based improvement
Locate, appraise and utilize scientific evidence related to their patient’s health problems
Apply knowledge of study design and statistical methods to critically appraise the medical literature
Utilize information technology to enhance their education and improve patient care
Facilitate the learning of students and other health care professionals

Interpersonal and Communication Skills Outcomes:
Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences
Demonstrate effective participation in and leadership of the health care team
Develop effective written communication skills
Demonstrate the ability to handle situations unique to patients contacting a regional poison control center.
Effectively communicate with medical as well non-medical personnel

Professionalism Outcomes:
Treats patients/family/staff/paraprofessional personnel with respect
Protects staff/family/patient’s interests/confidentiality
Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues
Able to discuss death honestly, sensitively, patiently, and compassionately
Unconditional positive regard for the patient, family, staff, and consultants
Accepts responsibility/accountability
Openness and responsiveness to the comments of other team members, patients, families, and peers

System-Based Practice Outcomes:
Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal care to these patients
Practice cost-effective health care and resource allocation that does not compromise quality of care
Advocate for and facilitate their patients’ advancement through the health care system

Osteopathic Principles and Practices:
Among other Understand the interdependence of the musculoskeletal/lymphatic system and other organ systems as they relate to the toxicologically exposed patient
Understand that the mind, body and spirit all interact in the promotion of health and well being and demonstrate the ability to utilize osteopathic manipulative medicine as a part of their patient care regimen
Description of clinical experiences:
PGL-4 EM residents will report to the regional poison center 2 half days in each 4 week block during their EM rotations. The EM resident will see patients that present to the Regional Poison Control Center under the direct supervision of the toxicologist and allied health providers. The EM resident will take call and manage these patients as required by the service policy. While on call, the EM resident will see patient referred to Poison Control Center and those patients exposed and presenting to any CAMC emergency department.

Description of didactic experiences:
EM residents will attend Toxicology Department conferences appropriate for their education as well as weekly Emergency Medicine conferences and Journal Club as scheduled. The residents will participate in any additional educational experiences afforded by the Poison Control Service.

Duty Hours:
The EM resident will conform to AOA and CAMC duty hours which include:
Not exceeding 80 hours per week averaged over 4 weeks.
Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At home call cannot be assigned on these free days. Residents must not be scheduled for more than six consecutive nights of night float/call. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
Duty periods of PGY1 residents must not exceed 16 hours in duration.
It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
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.
Under those circumstances, the resident must: 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. The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty. Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods and after in house call. Residents are permitted to return to the hospital while on at home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off duty period”.

Evaluation process:
Residents will receive concurrent feedback from the faculty, residents and allied health personal on rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACOGME defined core competencies. The overall evaluation is reviewed by the EM Residency Program Director and placed the resident’s confidential file. A copy of the written rotation evaluation is given to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination, weekly department testing. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

The resident tracks all procedures and completes a rotation evaluation. The EM Residency Program Director will discuss rotation evaluations with the Poison Control Director. At the annual program review, the residents and EM faculty will also discuss the rotation.
Feedback mechanisms:
The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the Toxicology rotation and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Rotation Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

| Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described? | YES |
| If no, please explain: |

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Emergency Medicine Resident Manual

Page 66
Rotation | Trauma/Surgical Intensive Care Unit
---|---
Institution | Charleston Area Medical Center - Memorial

<table>
<thead>
<tr>
<th>Year of training</th>
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<th>OEM2</th>
<th>OEM3</th>
<th>Elective</th>
<th>OEM4</th>
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Goals:

**Patient Care Goals:** Residents must be able to provide patient care to intensive care patient that is compassionate, appropriate, and effective for the treatment of health problems and advocate for the promotion of health in the medical system.

**Medical Knowledge Goals:** Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to patient care.

**Practice-Based Learning Goals:** Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire in the Trauma/Surgical Intensive Care Unit.

**Interpersonal and Communication Skills Goals:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates all with diverse backgrounds.

**Professionalism Goals:** Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

**Systems-Based Practice Goals:** Residents must demonstrate an awareness of and responsiveness to the unique aspects of the CAMC system and be able to effectively call on system resources to provide care and patient follow up that is of optimal value.

Objectives:

Through day to day patient contact with patients in the Trauma/Surgical Intensive Care Unit and attending supervision, the emergency medicine resident will achieve the following outcomes.

Outcomes:

By the completion of this rotation, residents will be able to:

**Patient Care Outcomes:**
- Gather accurate, essential information from the patient’s history and physical examination in a timely manner
- Implement a timely, effective patient management plans for the preoperative and post operative patients as well as the trauma patient.
- Competently perform diagnostic and therapeutic procedures as required to care for the trauma or peri-operative patient
- Demonstrate ability to diagnose and treat shock, sepsis, fluid and electrolyte abnormalities, cardiac failure, cardiac dysrhythmia, renal failure, and hepatic failure in critically ill Trauma/ surgical patients.
- Stabilize critical patients
- Prioritize and stabilize multiple patients and perform other responsibilities simultaneously
- Work with health care professionals to provide patient-focused care

**Medical Knowledge Outcomes:**
Identify life-threatening conditions, the most likely diagnosis, synthesize acquired patient data, and identify how and when to access current medical information
- 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.
- Demonstrate the ability to manage a patient on a ventilator.
- Complete disposition of patients using available resources
### Practice Based Learning Outcomes:
- Analyze and assess their practice experience and perform practice-based improvement
- Locate, appraise and utilize scientific evidence related to their patient’s health problems
- Apply knowledge of study design and statistical methods to critically appraise the medical literature
- Utilize information technology to enhance their education and improve patient care
- Facilitate the learning of students and other healthcare professionals

### Interpersonal and Communication Skills Outcomes:
- Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences
- Demonstrate effective participation in and leadership of the healthcare team
- Develop effective written communication skills
- Demonstrate the ability to handle situations unique to the practice of emergency medicine
- Effectively communicate with out-of-hospital personnel as well as non-medical personnel

### Professionalism Outcomes:
- Treats patients, family, staff, and ancillary personnel with respect
- Protects staff, family, and patient’s interests and confidentiality
- Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues
- Able to discuss death honestly, sensitively, patiently, and compassionately
- Unconditional positive regard for the patient, family, staff, and consultants
- Accepts responsibility and demonstrates accountability
- Openness and responsiveness to the comments of other team members, patients, families, and peers
- Demonstrate an understanding of the ethical and legal principles applicable to the care of critically ill patients.
- Demonstrate understanding of “Do not resuscitate” orders, advance directives, living wills, and brain dead criteria

### System-Based Practice Outcomes:
- Demonstrate an understanding of the appropriate use of consultants in critically ill patients
- Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal patient care
- Practice cost-effective health care and resource allocation that does not compromise quality of care
- Advocate for and facilitate patient’s advancement through the health care system

### Description of clinical experiences:
The EM resident will see patients that present to the Trauma/Surgical Intensive Care Unit under the direct supervision of the of the Trauma/Surgical Intensive Care Unit attending. The EM resident will take call and manage Trauma/Surgical Intensive Care Unit patients while on call.

### Description of didactic experiences:
EM residents will attend Trauma/Surgical ICU conferences appropriate for their education as well as weekly Emergency Medicine conferences and monthly Journal Club.

### Duty Hours:
The EM resident will conform to AOA and CAMC duty hours which include:
- Not exceeding 80 hours per week averaged over 4 weeks.
- Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At home call cannot be assigned on these free days. Residents must not be scheduled for more than six consecutive nights of night float/ call. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
- Duty periods of PGY1 residents must not exceed 16 hours in duration.
- It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
- 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.

Duty Hours Cont.: Under those circumstances, the resident must: 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. The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty. Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods and after in house call. Residents are permitted to return to the hospital while on at home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off duty period".

Evaluation process:

Evaluation of the resident's knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident's clinical performance during their rotation and their progress in achieving ACGME/AOA defined core competencies. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident's confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination, ACLS and ATLS. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.

The resident tracks all procedures and completes a rotation evaluation. The EM Residency Program Director will discuss rotation evaluations with the Trauma/Surgical Intensive Care Unit Coordinator.

Feedback mechanisms:

The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the Trauma/Surgical ICU rotation and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Trauma/Surgical Intensive Care Unit Rotation Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?  

If no, please explain: 

- [ ]
### Emergency Medicine Resident Manual

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institution</td>
<td>Charleston Area Medical Center- General Hospital</td>
</tr>
<tr>
<td>Year of training</td>
<td>OEM1 During ED rotations ✓ 1 month OEM3 During ED rotations ✓</td>
</tr>
<tr>
<td></td>
<td>OEM2 1 month OEM4 During ED rotations ✓</td>
</tr>
</tbody>
</table>

#### Goals:
- **Patient Care Goals:** Residents must be able to provide patient care to trauma patient that is compassionate, appropriate, and effective for the treatment of health problems and advocate for the promotion of health in the medical system.

- **Medical Knowledge Goals:** Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to patient care.

- **Practice-Based Learning Goals:** Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire on the trauma service.

- **Interpersonal and Communication Skills Goals:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates all with diverse backgrounds.

- **Professionalism Goals:** Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

- **Systems-Based Practice Goals:** Residents must demonstrate an awareness of and responsiveness to the unique aspects of the CAMC system and be able to effectively call on system resources to provide care and patient follow up that is of optimal value.

#### Objectives:
Through day to day patient contact with patients on the trauma service and attending supervision, the emergency medicine resident will achieve the following outcomes.

- **Patient Care Outcomes:**
  - Demonstrate ability to rapidly and thoroughly assess victims of major and minor trauma.
  - Demonstrate ability to establish priorities in the initial management of victims of life-threatening trauma.
  - Demonstrate ability to manage fluid resuscitation of trauma victims.
  - Demonstrate ability to manage the airway of trauma victims.
  - Demonstrate ability to perform the following procedures: oral and nasogastric intubation, venous cutdown, 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, pericardiotomy, cardiography, aortic cross-clamping, and extensor tendon repair and FAST exam.

- **Medical Knowledge Outcomes:**
  - Demonstrate ability to interpret radiographs on trauma patients, including chest, cervical, thoracic and lumbar spine, pelvis and extremity films.
  - Discuss the importance of mechanism of injury in the evaluation and treatment of the trauma victim.
  - Demonstrate ability to calculate the Glasgow Coma Score and discuss its role in the evaluation and treatment of head injured patients.
  - Demonstrate ability to use spine immobilization techniques in trauma victims.
  - Demonstrate ability to diagnose and manage trauma victims with extremity fractures, dislocations and subluxations.
  - Demonstrate ability to manage soft tissue injuries including lacerations, avulsions and high-pressure injection injuries.
Discuss the continuing care of the trauma victim, including operative, post-operative and rehabilitative phases of care.

Medical Knowledge Outcomes:
Discuss the diagnosis and management of compartment syndromes.
Discuss the diagnosis and management of urogenital injuries.
Demonstrate appropriate use of analgesics and sedatives in trauma patients.
Demonstrate appropriate use of antibiotics in trauma patients.
Demonstrate ability to direct a trauma team during complex resuscitations.
Demonstrate ability to coordinate consultants involved in the care of multiple trauma patients.
Demonstrate ability to use and interpret imaging modalities in the evaluation of trauma patients.
Demonstrate ability to arrange appropriate consultation and disposition of trauma patients.
Demonstrate ability to direct the care of trauma victims in the pre-hospital setting.
Discuss principle of disaster management and participate in disaster drills.
Discuss factors unique to the evaluation and management of pediatric trauma.
Demonstrate ability to direct pediatric trauma resuscitations.
Discuss factors unique to the evaluation and management of geriatric trauma.
Demonstrate ability to direct geriatric trauma resuscitations.
Discuss factors unique to the evaluation and management of trauma in pregnancy.
Discuss the evaluation and management of spinal cord injuries.
Demonstrate ability to diagnose and manage tendon injuries.
Demonstrate ability to manage amputation injuries and discuss the potential for reimplantation.
Demonstrate the ability to manage the acutely burned patient, including minor and major injuries.
Demonstrate the ability to diagnose and treat smoke inhalation.
Discuss indications and procedures for transfer of an injured patient to a specialty center if indicated.
Demonstrate the ability to assess and manage facial trauma.
Demonstrate the ability to evaluate and manage anterior neck injuries.
Demonstrate the ability to assess and manage penetrating and blunt chest trauma.
Demonstrate the ability to evaluate and manage blunt and penetrating abdominal trauma.
Demonstrate the ability to diagnose and treat pelvic fractures.

Practice Based Learning Outcomes:
Analyze and assess their practice experience and perform practice-based improvement.
Locate, appraise and utilize scientific evidence related to their patient's health problems.
Apply knowledge of study design and statistical methods to critically appraise the medical literature.
Utilize information technology to enhance their education and improve patient care.
Facilitate the learning of students and other healthcare professionals.

Interpersonal and Communication Skills Outcomes:
Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences.
Demonstrate effective participation in and leadership of the healthcare team.
Develop effective written communication skills.
Demonstrate the ability to handle situations unique to the practice of emergency medicine.
Effectively communicate with out-of-hospital personnel as well as non-medical personnel.

Professionalism Outcomes:
Treats patients, family, staff, and ancillary personnel with respect.
Protects staff, family, and patient's interests and confidentiality.
Demonstrates sensitivity to patient's pain, emotional state, and gender/ethnicity issues.
Able to discuss death honestly, sensitively, patiently, and compassionately.
Unconditional positive regard for the patient, family, staff, and consultants.
Accepts responsibility and demonstrates accountability.
Openness and responsiveness to the comments of other team members, patients, families, and peers.
Demonstrate an understanding of the ethical and legal principles applicable to the care of critically ill patients.
Demonstrate understanding of "Do not resuscitate" orders, advance directives, living wills, and brain dead criteria.
System-Based Practice Outcomes:
Demonstrate an understanding of the appropriate use of consultants in trauma patients
Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal patient care
Practice cost-effective health care and resource allocation that does not compromise quality of care
Advocate for and facilitate patient’s advancement through the health care system

Description of clinical experiences:
The EM residents will see patients that present to Emergency Department and under the direct supervision of the Trauma senior resident, fellow and attending and Emergency Medicine attending. The EM resident will take call and manage the trauma inpatient service while on call as a second year resident. While on call, the EM resident will see patient referred to the Trauma service from the Emergency Department. During the inpatient Trauma rotation the EM resident will be supervised by the Trauma service senior and attending.

Description of didactic experiences:
EM residents will attend Trauma Department conferences as well as weekly Emergency Medicine conferences and monthly Journal Club. The EM resident will participate in an ATLS course during their residency training.

Evaluation process:
Duty Hours:
The EM resident will conform to AOA and CAMC duty hours which include:
Not exceeding 80 hours per week averaged over 4 weeks.
Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At home call cannot be assigned on these free days. Residents must not be scheduled for more than six consecutive nights of night float/call. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
Duty periods of PGY1 residents must not exceed 16 hours in duration.
It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
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.
Under those circumstances, the resident must: 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. The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty. Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods and after in house call. Residents are permitted to return to the hospital while on at home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off duty period”.

Evaluation process:
Evaluation of the resident’s knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACGME/AOA defined core competencies. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident’s confidential file. A copy of the written rotation
evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

**Evaluation process:**

Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination, ACLS and ATLS. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.

The resident tracks all procedures and completes a rotation evaluation. The EM Residency Program Director will discuss rotation evaluations with the Trauma rotation director.

**Feedback mechanisms:**

The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the Inpatient Trauma rotation annually and provide feedback to the rotation coordinator. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Trauma Rotation Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

<table>
<thead>
<tr>
<th>Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?</th>
<th>Yes</th>
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If no, please explain:
<table>
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<th>Rotation</th>
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<td>Year of training</td>
<td>EM1</td>
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<td></td>
<td>1 month</td>
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</table>

**General Goals:**
To become competent in the area of on-line medical command.
To understand the indications, contraindications and utility of air medical transport.
To understand the general principles of disaster medicine including planning and implementation of a disaster response.

**Patient Care Goals:** Residents must be able to provide patient care to pre-hospital/EMS patients that are compassionate, appropriate, and effective for the treatment of health problems and advocate for the promotion of health.

**Medical Knowledge Goals:** Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to the pre-hospital/EMS setting.

**Practice-Based Learning Goals:** Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire on the EMS service/ unit.

**Interpersonal and Communication Skills Goals:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates all with diverse backgrounds.

**Professionalism Goals:** Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

**Systems-Based Practice Goals:** Residents must demonstrate an awareness of and responsiveness to the unique aspects of the healthcare system and be able to effectively call on system resources to provide care and patient follow up that is of optimal value.

**Osteopathic Principles and Practices:** Residents must demonstrate an awareness of the basic tenets of osteopathic philosophy and ability in basic manipulative medicine.

**Objectives:**
Through day to day patient contact with pre-hospital/EMS personnel and patients on the pre-hospital/EMS service/unit with direct supervision from paramedics, senior residents and attending faculty, the emergency medicine resident will achieve the following outcomes.

**Outcomes:**
By the completion of this rotation, residents will be able to:

**Patient Care Outcomes:**
Gather accurate, essential information in a timely manner including in the area of: Disaster medical care) Rapid assessment of emergency health care needs, Medical care at mass casualties, Disaster specific medical problems, Mental health and behavioral Consequences, For disaster victims, For professionals, Critical incident stress, debriefing (CISD)
Generate an appropriate differential diagnosis for the Shock and its treatment in field Situations of the EMS/Trauma patient
Implement an effective patient management plan for the Crush syndrome/injury and Compartment syndrome patient.
Generate an appropriate differential diagnosis for Trauma casualties
Generate an appropriate differential diagnosis for Pulmonary casualties
Patient Care Outcomes continued:
Generate an appropriate differential diagnosis for Pediatric casualties
Perform emergency stabilization for the Mass burn care patient
Perform emergency stabilization for the patient Neuropsychiatric casualties
Demonstrate the ability to assess a: Toxic-chemical casualties, Radiation exposure casualties, Blast injuries patient.
Perform emergency stabilization for the ill pre-hospital/ EMS patient
Work with health care professionals to provide patient-focused care

Medical Knowledge Outcomes:
Demonstrate familiarity with research methodologies relating to EMS and disaster management including: (Disaster Medicine) Definition of disaster, Disaster assessment, Epidemiology of disasters, Philosophy of disaster management and the incident command system, Types of disaster/nomenclature, Explosions and fires, Mass crowd gathering events, Medical response to terrorist, incidents (conflict related), Natural, Transportation disasters, Technologic / industrial /HAZMAT.
Complete disposition of patients using available resources

Practice Based Learning Outcomes:
Participate in EMS continuous quality improvement.
Analyze and assess their practice experience and perform practice-based improvement
Locate, appraise and utilize scientific evidence related to their patient’s health problems
Apply knowledge of study design and statistical methods to critically appraise the medical literature and Research including Assessment of new methods and procedures, Testing of new equipment and technologic advances, Data collection/analysis.
Discuss the importance of EMS administration in: System monitoring & maintenance, Serving as a training resource, Resource allocation, Stress/burnout of EMS personnel, Scene violence, System overload
Utilize information technology to enhance their education and improve patient care for disaster information services, Local/national/international disaster, Information, Public relations, Media coordination.
Facilitate the learning of students and other health care professionals. Demonstrate ability to provide initial and continuing education to all levels of EMS personnel including: EMS Education) CPR, first aid, and EMS awareness training, First responders, General public, EMT training, EMS continuing education/skills maintenance, Injury prevention and safety, Assessment of environmental, biologic, and toxicologic hazards.
In addition to above describe the difference in training and legal limits applied to each of the following LEVEL of EMS education: Basic, Intermediate, Paramedic.

Interpersonal and Communication Skills Outcomes:
Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences.
Actively participate in EMS system with attention to the areas of Medical control, Medical director, Offline and online supervision.
Demonstrate ability to use all elements of the EMS communication system including: Communications system, Radio configuration, Dispatch, Communications protocols
Demonstrate effective participation in and leadership of the health care team in Public health issues after disasters, Coordination.
Demonstrate the ability to handle situations unique to the trauma patient
Effectively communicate with medical as well non-medical personnel including Volunteers. Discuss special issues associated with these persons and the role of Emergency Medicine Physicians as volunteers.

Professionalism Outcomes:
Discuss the responsibility of Emergency Medicine Physicians in Disaster education, Hospital disaster planning, Disaster drills, Post-disaster injury prevention and surveillance, Disaster medical assistance teams (DMAT), International relief assistance,
Treats patients/family/staff/paraprofessional personnel with respect
Protects staff/family/patient’s interests/confidentiality
Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues
Professionalism Outcomes:
Able to discuss death honestly, sensitively, patiently, and compassionately
Unconditional positive regard for the patient, family, staff, and consultants
Accepts responsibility/accountability
Openness and responsiveness to the comments of other team members, patients, families, and peers

System-Based Practice Outcomes:
Describe local, state and national components of EMS including EMS System Organization System components, Pre-hospital personnel, Emergency department personnel, Transport services, Lead agency and local organizations, Discuss medico legal liability issues relating to EMS.
Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal care to the disaster/EMS patient.
Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal and cost effective care as it relates to Categorization and designation of levels of services, Specialized care centers, Transport vehicles (Ground/Air/Water access).
Discuss the importance of each of the following to effective EMS/disaster management and the ability to practice cost-effective health care and resource allocation that does not compromise quality of care: Medical supply / equipment management, Essential drugs for disasters, Pharmaceutical distribution / control, Role of immunizations. Non-medical emergency responders.
Discuss the Phases of disaster response: Notification, Search and rescue, Triage, Medical care of disaster victims, Disaster communications, Record keeping, Transportation and evacuation, Debriefing/critical incident stress debriefing (CISD) and Recovery.
Discuss issues related to EMS System Operations.
Discuss the development of Patient care protocols to include: Scene triage and treatment, Hospital triage and treatment
Discuss the role of Governmental controls as it relates to: Development and implementation of regulations, Funding, Certification/recertification.
Advocate for and facilitate their patients’ advancement through the health care system.

Osteopathic Principles and Practices:
Among other Understand the interdependence of the musculoskeletal /lymphatic system and other organ systems as they relate to the EMS patient
Understand that the mind, body and spirit all interact in the promotion of health and well being and demonstrate the ability to utilize osteopathic manipulative medicine as a part of their patient care regimen

Objectives:
Participate as an observer or team member in ground and air medical transport systems.
Discuss development of EMS pre-hospital care protocols.
Discuss basic concepts of mass casualties and disaster management.
Demonstrate understanding of appropriate utilization practices for ground and air medical services.
Discuss the process of disaster management notification response, and medical care on a local, state and national level.
Discuss the importance of and methods for medical control in EMS systems.
Discuss the differences in education and skill level of various EMS providers.
Describe common environmental, toxicologic, and biological hazards encountered in the pre-hospital care setting as well as injury prevention techniques.

Educational Goals and Objectives:
This rotation consists of 2 14 day blocks. 2 weeks will be spent working with the Kanawha County Emergency Ambulance Authority on ground and Critical care transport. Two weeks will be spent working with the Health Net air ambulance team, 12-hour shifts. The EM resident is to under the overall supervision of the Chair of the Department of Emergency Medicine and daily supervision of the EMS person to which they are assigned.

Description of didactic experiences:
Description of Clinical Experiences: This program, between Kanawha County Emergency Ambulance Authority; Health Net Aeromedical and the CAMC Emergency Medicine Residency Program, is intended to promote education to the resident as well as a general understanding of Health Net and their ability and/or limitation while working in the
Description of Didactic Objectives:
Successfully complete 4 hours of orientation
Stay within the Scope of Care Operations & Administrative P and Ps 04052007\Scope of Care.doc

Description of didactic experiences:
Activities will be directly supervised by the flight crew. Stay under the supervision of the flight team at all times while on duty.
Maintain orientation status, related to patient care as well.
Maintain a professional attitude at all times, in addition to exhibiting exceptional customer service while representing Health Net.
Maintain aircraft height/weight restrictions and/or limitations.
Have a completed flight crew data sheet on file with Becky Oakley, Program Manager, Health Net, CAMC General Division. Flight Crew Information\EMERGENCY PERSONEL CONTACT SHEET.doc
The resident will review the Charleston area Medical Center Emergency Response Manual at: ERP Main Menu

The resident will attend weekly EM core conferences and monthly journal clubs. Special senior resident conference time will be dedicated to job search, contract principles and financial issues. The resident will also be supplied a reading list for this rotation including review of local EMS protocols.

Evaluation process:
Residents will receive concurrent feedback from the faculty while on the EMS rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their Emergency Medical Service rotation and their progress in achieving ACOGME defined core competencies. The overall evaluation will be developed with input from the Emergency Medical Service faculty and will be placed in the resident’s confidential file. A copy of the written rotation evaluation is given to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.

Feedback mechanisms:
The EM resident will receive verbal and written feedback about their performance. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM faculty and EM resident will communicate the concern immediately to the other party and develop a plan to resolve the issue.

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<th>Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?</th>
<th>Yes</th>
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If no, please explain:
### Rotation: Administration/Research

**Institution:** FACILITY 419 Brooks Street, Office of Emergency Medicine and CAMC

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<tr>
<th>Year of training</th>
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#### Educational Goals:

**Patient Care Goals:** To become knowledgeable and competent in quality assurance and risk management design, function and performance in the Emergency Department. To develop a background in clinical research and statistics.

**Medical Knowledge Goals:** Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to administration of an emergency medicine department and to clinical research.

**Practice-Based Learning Goals:** Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire on the administration rotation and apply the knowledge of clinical research to readings and clinical practice decisions.

**Interpersonal and Communication Skills Goals:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, the families and professional associates and other departments all with diverse backgrounds.

**Professionalism Goals:** To acquire basic administrative information and to develop leadership and administrative skills needed for the practice of Emergency Medicine. Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. It develop research goals and an outline for personal research with literature review and development of outline for the research component of their resident program.

**Systems-Based Practice Goals:** To understand and experience the role of the Emergency Department within the hospital as well as its relationship with other hospital departments. Residents must demonstrate an awareness of and responsiveness to the unique aspects of the healthcare system and be able to effectively call on system resources to provide care and patient follow up that is of optimal value.

**Osteopathic Principles and Practices:** Residents must demonstrate an awareness of the basic tenets of osteopathic philosophy and ability in basic manipulative medicine as well as research in osteopathic medicine when applicable.

#### Objectives:

Through day to day patient contact with Dr. David Seideler and Priemer personnel and with direct supervision from Dr. Seidler for one half the day and each afternoon research lecture or activity will be attended to allow the emergency medicine resident to achieve the following outcomes.

#### Outcomes:

By the completion of this rotation, residents will be able to:

**Patient Care Outcomes:**
- Develop knowledge in the requirements for Certification and Licensure Requirements for Allied health licensure;
- Continuing medical educations; Physician licensure
- Develop understanding of roles and responsibilities of Academic Emergency Medicine, Faculty/staff, Research, Institutional affiliations, Teaching/curriculum, Testing/evaluation, Specialty and subspecialty certification
- Develop an understanding of the function, impact on medical care and role of Information Systems, Departmental Administration, Accreditation, Billing/reimbursement, Budgeting, Cost containment, Equipment and supplies, Facility design, Health care financing, Medical records/documentation, Personnel management, Public relations, Quality improvement
- Be able to describe the role of emergency medicine leadership as well as the individual physician’s responsibility in the development of Clinical Pathways.
Patient Care Outcomes:
Describe the role of emergency medicine leadership to work with other health care professionals to provide patient-focused means of addressing of Ethics: Ethical principles, Beneficence/non-malfeasance, Decision-making capacity, Privacy and confidentiality, Autonomy, Ethical decision-making, Justice, Allocation of health care resources, Life-sustaining treatment, Advance directives, Medical decision surrogates, Academic ethics, Research responsibilities, and Publication ethics
Develop understanding of research techniques and processes

Medical Knowledge Outcomes:
Discuss Certification and Licensure Requirements: allied health licensure, Emergency medical technician, EMT-1/EMT-paramedic, Nurses, Physician extenders/midlevel providers, and how these vary.
Discuss various aspects of Continuing medical education and its use in Physician licensure, Specialty and subspecialty certification.
Discuss the management of Academic Emergency Medicine and it's role in Faculty/staff, Credentials, Career development
Discuss Research, Assessment of new methods and procedures, Testing of new equipment and technologic advances, Data collection/analysis

Practice Based Learning Outcomes:
Describe the relationship of the AOA/ACOGME/ACOEP/ACEP as it relates to CAMC and Institutional affiliations: University, Community, Teaching/curriculum, and Testing/evaluation.
Analyze and assess the role of emergency medicine leadership in the area of Medical Staff and Committees, Credentialing, Disciplinary policy, Structure
Analyze and assess the role of emergency medicine leadership in the development and control of the area of Practice Management. Describe how each of the following effects that management as it relates to department members in the areas of: Benefits, 20.11.2 Contracts, Employee, Group, Hospital, Staff, and Independent contractor, Structure

Interpersonal and Communication Skills Outcomes:
Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences as it relates to emergency medicine leadership.
Demonstrate effective participation in and leadership of the health care team in relation to Hospital Administration: Departmental interaction, Governance, Structure.
Analyze and develop a working knowledge of the role of emergency medicine leadership in the following Skills: Accounting, Management, Negotiations, Physician interpersonal skills, Effective patient-physician communication, Diversity issues, Hostile encounters complaints, Grief reactions.

Professionalism Outcomes:
Discuss the role of the administration of the emergency department including the intra-relationship between various department directors and administrative staff as it effects: Accreditation, National organizations on accreditation of healthcare standards, Billing/reimbursement, Medicaid, Medicare, Insurance, Managed care/capitation, Budgeting, Cost containment principles, Equipment and supplies, Adult, Pediatric, Facility design, Forms, Health care financing, Marketing, Medical records/documentation, Personnel management, Public relations, Quality improvement, Staffing requirements, Policies and procedures, Nursing practice, Interdepartmental relations, Patient flow, Observation units/clinical decision units Infection control, and Security, violence in the emergency department

System-Based Practice Outcomes:
Discuss how the use of various Information Systems can impact (both positively and negatively) Practice and Research.
Discuss the role of emergency medicine leadership in the areas of: Professional relations, Physician-patient, Physician-physician, Peer review, Impairment, Incompetence, Physician-emergency health professional, Physician-hospital, and Physician-societal
Understand, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal Recruitment.
Practice cost-effective health care and resource allocation that does not compromise quality of care Advocate for and facilitate their patients’ advancement through the health care system
Osteopathic Principles and Practices:
While not solely an Osteopathic issue. Describe in terms of mind, body and spirit the role emergency medicine leadership plays in the area of Wellness and the issues of:
Wellness maintenance, Stress management, Unique stressors, Reduction techniques, Debriefing, Shift work, Physician impairment and Family dynamics

Description of clinical experiences:
The EM resident will and under the direct supervision of the Chairman of the Department of Emergency Medicine at CAMC, endeavor to address all the above areas of administration during the rotation. The EM resident may be assigned additional duties as the opportunity presents. These may include but not limited to reviews of charts, policy meetings, and legal agendas.

Description of didactic experiences/Educational objectives:
Discuss the following concepts as they relate to Emergency Medicine: career development, work schedules, contract principles, credentialing, personal finance issues, health care financing, managed care, personnel management, public relations, marketing, hospital administration, and practice management.
Discuss JCAHO requirements relating to the Emergency Department with emphasis on staffing, equipment and supplies; facility, quality assurance and patient transfer regulations.
Discuss hospital and Emergency Department administrative organization.
Discuss liability and malpractice issues as they relate to Emergency Medicine including the difference between occurrence and term malpractice coverage.
Explain the principles of CQI.
Develop and implement a CQI project.
Understand regulatory reporting issues (Assault, Communicable diseases, National Practitioner Data Base) that effect EM practitioners.
Discuss the concepts of confidentiality, consent and refusal of care.
Explain the political and accreditation agencies of as they relate to Emergency Medicine (ACOEP, AOA, ACEP, AAEM, SAEM, EMRA, CORD, EM-RRC, ABEM, and AAPS).

EM residents will attend the residency weekly Emergency Medicine conferences and monthly Journal Club. Dr. Seidler will at his discretion inform the resident of any additional learning opportunities that may present.

Duty Hours:
The EM resident will conform to AOA and CAMC duty hours which include:
Not exceeding 80 hours per week averaged over 4 weeks.
Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At home call cannot be assigned on these free days. Residents must not be scheduled for more than six consecutive nights of night float/call. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
Duty periods of PGY1 residents must not exceed 16 hours in duration.
It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
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.
Under those circumstances, the resident must: 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. The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty. Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods and after in house call. Residents are permitted to return to the hospital while on at home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off duty period”.
Evaluation process:

Evaluation of the resident’s knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACGME/AOA defined core competencies. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident’s confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.

The resident tracks all procedures and completes a rotation evaluation. The EM Residency Program Director will discuss rotation evaluations with the department chair.

Feedback mechanisms:

The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the administration rotation and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Rotation Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described? YES

If no, please explain:
Rotation | Cardiology
---|---
Institution | Charleston Area Medical Center
Year of training | EM1 1 month | EM2 | EM3 | EM4

**Goals:**

**Patient Care Goals:** Residents must be able to provide patient care to patients with cardiovascular illness that is compassionate, appropriate, and effective for the treatment of cardiovascular health problems and advocate for the promotion of cardiovascular and general health in the hospital system.

**Medical Knowledge Goals:** Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognitive sciences associated with cardiovascular disease and must apply this knowledge to the care of patients with acute and chronic cardiovascular illness. Including Pathophysiology; Congenital disorders, 2.1.2 Acquired disorders, and 2.1.3 Effects of aging.

**Practice-Based Learning Goals:** Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire on the cardiac service.

**Interpersonal and Communication Skills Goals:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates all with diverse backgrounds.

**Professionalism Goals:** Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

**Systems-Based Practice Goals:** Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

**Objectives:**

**Patient Care Outcomes:**
- Gather accurate, essential information from the patient’s history and physical examination in a timely manner
- Implement a timely, effective patient management plan
- Competently perform diagnostic and therapeutic procedures, including: central venous catheter placement, transcutaneous and transvenous cardiac pacing, cardioversion, defibrillation and pericardiocentesis
- Demonstrate ability to diagnose and treat cardiovascular illness, including: ST-elevation and non-ST-elevation myocardial infarction, cardiogenic shock, decompensated heart failure, unstable angina, cardiac dysrhythmia, pericarditis, myocarditis, pulmonary embolism, hypertensive emergency, aortic dissection, aortic aneurysm
- Stabilize critical patients

**Medical Knowledge Outcomes:**
- Identify life-threatening conditions, identify the most likely diagnosis, synthesize acquired patient data, and identify how to access current medical information
- Demonstrate the ability to use and interpret data from cardiac monitors, 12 lead ECGs, cardiac outputs, hemodynamic monitoring, arterial blood gases, pulse oximetry, end tidal CO2 monitors and respirators and cardiac pacers
- Understand how to approach the problem of differentiating cardiac chest pain from non-cardiac chest pain in patients with known cardiac risk factors
- Describe the pathophysiology of Diseases of the Myocardium, Acquired including Cardiac failure (High output, Low output, Cor pulmonale, Cardiomyopathy Ischemic heart disease, Ischemic heart disease, Angina Stable, Variant/Unstable/Myocardial infarction/ Cardiogenic shock /Ventricular aneurysm, and Endocarditis.
- Discuss the differential diagnosis of atypical chest pain
- Discuss the sensitivity and specificity of ancillary studies for chest pain presentations including ECG, chest x-ray, cardiac markers, and the various stress tests
Medical Knowledge Outcomes:
Delineate the pharmacological properties, indications, side effects and contraindications of major classes of cardiovascular therapeutics. Thrombolytic therapy; Pharmacological agents, including nitrates, beta blockers, calcium channel blockers, warfarin, heparin, low molecular weight heparin, glycoprotein Ilb/IIIa inhibitors, fibrinolytics, etc.
Discuss the indications for cardiac catheterization
Demonstrate knowledge of AHA recommendation for the treatment of acute ventricular fibrillation, ventricular tachycardia, asystole, pulseless electrical activity, atrial flutter and fibrillation, supraventricular tachycardia, bradycardia, atrio-ventricular blocks and bundle branch blocks
Describe the clinical findings of cardiogenic shock and outline therapy for cardiogenic shock
Describe the clinical presentation for Endocarditis
Describe the clinical presentation for Diseases of the Pericardium; Pericarditis, Pericardial effusion/tamponade and outline the appropriate initial therapy and management
Describe the clinical presentation for Cardiac Transplant Patient and outline the appropriate initial therapy and management
List complications of Valvular heart disease; Aortic insufficiency/stenosis, Mitral insufficiency/stenosis, Pulmonary insufficiency/stenosis, Tricuspid insufficiency/stenosis and prosthetic cardiac valves and appropriate management
Understand the diagnosis and treatment Acquired Diseases of the Circulation, including Arterial Atherosclerosis/insufficiency, Aneurysm, Aortic/iliac, Peripheral arterial, Arteritis, Emboli, Spasm, Thrombosis, Aortic dissection) Venous (Venous insufficiency/varicosities, Thromboembolism, Thrombophlebitis,) and Lymphatics.
Understand the diagnosis and treatment of Hypertension including Acute hypertensive crisis and Chronic hypertension. Differentiate between Essential and Secondary types of hypertension. Differentiate between hypertensive emergencies and urgencies, and understand the treatment of both.
To recognize by the appearance on an EKG or rhythm strip the following: Dysrhythmia, Atrial flutter/fibrillation, Atrial/junctional ectopy, Preexcitation syndromes, Supraventricular tachycardia/bradycardia, Ventricular flutter/fibrillation, Ventricular tachycardia, Ventricular ectopy, QT interval syndrome, Conduction blocks, Sinoatrial block, Sick sinus syndrome, Atrioventricular blocks, Bundle branch blocks
To describe the Emergency treatment of the above dysrhythmia
Understand how to approach problems associated with Myocardial Manifestations of Systemic Diseases including Infections Early (endocarditis sepsis) Late (rheumatic fever group A streptococcal infection and Endocrine and metabolic diseases Rheumatologic Renal, Toxic exposures.
Discuss the etiology of the presentation of patients with Congenital Abnormalities of the Cardiovascular System, Familial/genetically transmitted disorders, Disorders due to anatomic anomalies, Hypertrophic heart disease, Mitral valve prolapsed, Patent foramen ovale.
Recognize and discuss the indications for Cardiac pacemakers, Temporary, Permanent, Surgical interventions, Vascular reconstruction, Angioplasty, Circulatory augmentation, Implantable defibrillators
To recognize patients with Primary Tumors of the Heart

Practice Based Learning:
Analyze and assess their practice experience and perform practice-based improvement
Locate, appraise and utilize scientific evidence related to their patients’ health problems
Apply knowledge of study design and statistical methods to critically appraise the medical literature
Utilize information technology to enhance their education and improve patient care
Facilitate the learning of students and other healthcare professionals

Interpersonal and Communication Skills:
Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences
Demonstrate effective participation in and leadership of the healthcare team
Develop effective written communication skills
Effectively communicate with consultants

Professionalism:
Treats patients, family, staff, and ancillary personnel with respect
Protects staff, family, and patient’s interests and confidentiality
Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues
Discuss death honestly, sensitively, patiently, and compassionately
### Unconditional positive regard for the patient, family, staff, and consultants
Professionalism cont.

- Accepts responsibility and demonstrates accountability
- Exhibit openness and responsiveness to the comments of other team members, patients, families, and peers
- Demonstrate an understanding of the ethical and legal principles applicable to the care of critically ill patients
- Demonstrate an understanding of “Do not resuscitate” orders, advance directives and living wills

### System-Based Practice

- Demonstrate an understanding of the appropriate use of consultants in cardiac patients
- Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal patient care
- Practice cost-effective health care and resource allocation that does not compromise quality of care
- Advocate for and facilitate patient’s advancement through the health care system

### Description of clinical experiences:

The EM resident will see patients that present to Cardiology Department under the direct supervision of the Cardiology Attending. The EM resident will take call and manage Cardiology Inpatients while on call.

### Description of didactic experiences:

EM residents will attend Cardiology/ Internal Medicine Department conferences appropriate for their education as well as weekly Emergency Medicine conferences and Journal Club.

### Duty Hours:

The EM resident will conform to AOA and CAMC duty hours which include:

- Not exceeding **80 hours per week averaged over 4 weeks**.
- Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At home call cannot be assigned on these free days. Residents must not be scheduled for more than six consecutive nights of night float/call. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
- Duty periods of PGY1 residents must not exceed 16 hours in duration.
- It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
- 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.
- Under those circumstances, the resident must: 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. The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty.
- Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods and after in house call. Residents are permitted to return to the hospital while on at home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off duty period”.

### Evaluation process:

- Evaluation of the resident's knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident's clinical performance during their rotation and their progress in achieving ACGME/AOA defined core competencies. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident’s confidential file. A copy of the written rotation..
evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

**Evaluation process:**
At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.
Residents are also evaluated by their performance on the CORD quizzes, ABOEM in training examination and Emergency Medicine Residency Oral examination and ACLS.
The resident tracks all procedures and completes a rotation evaluation. The EM Residency Program Director will discuss rotation evaluations with the Cardiology rotation director.
Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

**Feedback mechanisms:**
The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the Cardiology rotation annually and provide feedback to the Cardiology rotation coordinator. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Cardiology Rotation Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

<table>
<thead>
<tr>
<th>Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?</th>
<th>Yes</th>
</tr>
</thead>
</table>

If no, please explain:
Goals:

Patient Care Goals: Residents must be able to provide patient care to surgical patient that is compassionate, appropriate, and effective for the treatment of health problems and advocate for the promotion of health.

Medical Knowledge Goals: Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to care for surgical patients.

Practice-Based Learning Goals: Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire on the surgical service/unit.

Interpersonal and Communication Skills Goals: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates all with diverse backgrounds.

Professionalism Goals: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Systems-Based Practice Goals: Residents must demonstrate an awareness of and responsiveness to the unique aspects of the healthcare system and be able to effectively call on system resources to provide care and patient follow up that is of optimal value.

Osteopathic Principles and Practices: Residents must demonstrate an awareness of the basic tenets of osteopathic philosophy and ability in basic manipulative medicine and how these relate to the surgical patient.

Objectives:

Through day to day patient contact with patients on the surgery service/unit with direct supervision from senior residents and attending faculty, the emergency medicine resident will achieve the following outcomes.

Outcomes:

By the completion of this rotation, residents will be able to:

Patient Care Outcomes:

Gather accurate, essential information in a timely manner

Generate an appropriate differential diagnosis for the surgical patient.

Implement an effective patient management plan for the surgical patient.

Competently perform the diagnostic and therapeutic procedures specific to the surgical patient

Perform emergency stabilization for the ill surgical patient

Demonstrate ability to determine surgical patients status

Demonstrate ability to perform surgical procedures as would be performed in the emergency room setting. With special efforts to become proficient in the following procedures, Acute Upper Airway, Obstruction, Tracheotomy/complications, Cricothyrotomy, 2 Anesthesia, Local, Regional intravenous anesthesia, Regional nerve blocks, Hemodynamic Techniques, Arterial catheter insertion, Central venous access, Femoral, Jugular, Subclavian, Umbilical, Venous cutdown, Intraosseous infusion, Peripheral venous cutdown, Pulmonary artery catheter insertion, Thoracic, Cardiac pacing, Cutaneous, Transvenous, Defibrillation/cardioversion, Cardiorrhaphy, Pericardiotomy, Thoracostomy, Thoracotomy, Gastric lavage, Incision – drainage, Intestinal tube insertion, Pulse oximetry, Sengstaken-Blakemore tube insertion, Wound closure techniques, Excision of thrombosed hemorrhoids, Foreign body removal, and Conscious sedation.
Patient Care Outcomes:
Demonstrate the ability to assess a surgical patient
Demonstrate ability to evaluate and manage the care of patients with suspected surgical problems or complications, Esophagus, Liver, Gall Bladder and Biliary Tract, Pancreas, Stomach, Small Bowel, Large Bowel, Rectum and Anus, Abdominal Wall, Peritoneum
Discuss the indications for surgical procedures and describe the technique, Surgical interventions, Vascular reconstruction, Angioplasty, Circulatory augmentation, and Implantable defibrillators
Demonstrate ability to diagnose and manage surgical patients

Patient Care Outcomes cont.:
Prioritize and stabilize multiple patients and perform other responsibilities simultaneously
Demonstrate the ability to perform and interpret focused (goal directed) surgical care
Provide health care services aimed at preventing health problems or maintaining health during and after the surgical period
Work with health care professionals to provide patient-focused care

Medical Knowledge Outcomes:
Identify life-threatening conditions that affect the surgical patient, identify the most likely diagnoses, synthesize acquired patient data, and identify how and when to access current medical information
Discuss treatment options in surgical patients
Discuss the signs, symptoms and treatment of the surgical patient
Describe the management of surgical patients
Describe the critical actions in the diagnosis and treatment of the above diagnosis in the surgical patient
Describe the classification scheme for Surgical patient
Describe the relative effectiveness and complications of various surgical procedures
Complete disposition of patients using available resources

Practice Based Learning Outcomes:
Analyze and assess their practice experience and perform practice-based improvement
Locate, appraise and utilize scientific evidence related to their patient’s health problems
Apply knowledge of study design and statistical methods to critically appraise the medical literature
Utilize information technology to enhance their education and improve patient care
Facilitate the learning of students and other health care professionals

Interpersonal and Communication Skills Outcomes:
Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences
Demonstrate effective participation in and leadership of the health care team
Develop effective written communication skills
Demonstrate the ability to handle situations unique to the surgical patient
Effectively communicate with medical as well non-medical personnel

Professionalism Outcomes:
Treats patients/family/staff/paraprofessional personnel with respect
Protects staff/family/patient’s interests/confidentiality
Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues
Able to discuss death honestly, sensitively, patiently, and compassionately
Unconditional positive regard for the patient, family, staff, and consultants
Accepts responsibility/accountability
Openness and responsiveness to the comments of other team members, patients, families, and peers

System-Based Practice Outcomes:
Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal care to the surgical patient
Practice cost-effective health care and resource allocation that does not compromise quality of care
Advocate for and facilitate their patients’ advancement through the health care system

**Osteopathic Principles and Practices:**

*Among other things* understand the interdependence of the musculoskeletal /lymphatic system and other organ systems as they relate to the surgical patient

*Understand that the mind, body and spirit all interact in the promotion of health and well being and demonstrate the ability to utilize osteopathic manipulative medicine as a part of their patient care regimen*

<table>
<thead>
<tr>
<th>Description of clinical experiences:</th>
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</thead>
<tbody>
<tr>
<td>The EM resident will see patients that present to the surgical service/ward under the direct supervision of the attending, surgical senior residents and allied health providers. The EM resident will take call and manage these patients as required by the service policy. While on call, the EM resident will see patient referred to surgical service.</td>
</tr>
</tbody>
</table>

The EM resident will also gain experience in the ED while rotating on the surgical service.

<table>
<thead>
<tr>
<th>Description of didactic experiences:</th>
</tr>
</thead>
<tbody>
<tr>
<td>EM residents will attend surgical Department conferences appropriate for their education as well as weekly Emergency Medicine conferences and Journal Club. The residents will participate in all designated learning activities for the surgery service.</td>
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<table>
<thead>
<tr>
<th>Duty Hours:</th>
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</thead>
<tbody>
<tr>
<td>The EM resident will conform to AOA and CAMC duty hours which include:</td>
</tr>
<tr>
<td>1. Not exceeding <strong>80 hours per week averaged over 4 weeks</strong>.</td>
</tr>
<tr>
<td>2. Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At home call cannot be assigned on these free days. Residents must not be scheduled for more than six consecutive nights of night float/ call. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.</td>
</tr>
<tr>
<td>3. Duty periods of PGY1 residents must not exceed 16 hours in duration.</td>
</tr>
<tr>
<td>4. It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.</td>
</tr>
<tr>
<td>5. 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.</td>
</tr>
<tr>
<td>6. Under those circumstances, the resident must: 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 <strong>every circumstance</strong> to the program director. The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty.</td>
</tr>
<tr>
<td>7. Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods and after in house call. Residents are permitted to return to the hospital while on at home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off duty period”.</td>
</tr>
</tbody>
</table>

**Evaluation process:**

Evaluation of the resident’s knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACGME/AOA defined core competencies. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident’s confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine
Residency Oral examination. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

Evaluation process:
At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.

Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination and ATLS. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

The resident tracks all procedures and completes a rotation evaluation. The EM Residency Program Director will discuss rotation evaluations with the surgical rotation director.

Feedback mechanisms:

The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the surgical rotation and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Rotation Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?  YES

If no, please explain:
<table>
<thead>
<tr>
<th>Rotation</th>
<th>Pediatric Emergency Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institution</td>
<td>Women’s and Children’s Emergency Department</td>
</tr>
<tr>
<td>Year of training</td>
<td></td>
</tr>
<tr>
<td>EM1</td>
<td>1 month</td>
</tr>
<tr>
<td>EM2</td>
<td>1 month</td>
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<tr>
<td>EM3</td>
<td>1 month</td>
</tr>
<tr>
<td>EM4</td>
<td>1 month</td>
</tr>
</tbody>
</table>

**Goals:**

*Patient Care Goals:* Residents must be able to provide patient care to pediatric patient that is compassionate, appropriate, and effective for the treatment of pediatric health problems, and advocate for the promotion of health in the hospital system.

*Medical Knowledge Goals:* Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences associated with pediatric patients, and must apply this knowledge to the care of pediatric patients.

*Practice-Based Learning Goals:* Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire on the Pediatric service.

*Interpersonal and Communications Skills Goals:* Residents must demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patient, their families and professional associates all with diverse backgrounds.

*Professionalism Goals:* Residents must demonstrate a commitment to carrying our professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

*Systems-Based Practice Goals:* Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

*Osteopathic Principles and Practices:* Residents must demonstrate an awareness of the basic tenets of osteopathic philosophy and ability in basic manipulative medicine in the pediatric population.

**Objectives:**

Through day to day contact with pediatric patients on the Pediatric Ward and Nursery under the direct supervision of Attending Pediatric faculty and senior pediatric residents, the emergency medicine resident will achieve the following outcomes:

*Outcomes:*

*Patient Care Outcomes:*
Gather accurate, essential information from the patient and/or caregiver’s history and patient’s physical examination in a timely manner
Implement a timely, effective patient management plans
Competently perform diagnostic and therapeutic procedures, including: venipuncture, Intraosseous needle placement, and administration of appropriate doses of emergency medications
Discuss the differential diagnosis of chest pain in children and adolescents, noting differences from adults, and demonstrating knowledge of proper work-up and treatment
Discuss the differential of congestive failure in the pediatric patient and demonstrate knowledge of appropriate treatment
Work with health care professionals to provide patient-focused care
### Medical Knowledge Outcomes:

- Demonstrate knowledge of the significance of fever in children of various ages, and the ability to perform an work up of the febrile child
- Demonstrate knowledge of common infectious diseases of childhood, including appropriate work-up and treatment of meningitis/encephalitis, pneumonia, urinary tract infection, and bacteremia/sepsis
- Demonstrate ability to properly perform a lumbar puncture on a child
- Demonstrate knowledge of the pathophysiology and manifestations of common and/or serious diseases of the gastrointestinal tract and abdominal cavity of children, including gastroenteritis, intussusceptions, volvulus, Meckel's Diverticulum, and appendicitis
- Discuss the differential and preliminary work-up of abdominal masses found in the pediatric patient
- State the appropriate management of children with seizures, both febrile and afebrile
- Demonstrate knowledge of hydrocephalus, its differential, treatment and the management of neurologic shunt problems
- Calculate fluid and electrolyte requirements for children
- Discuss the diagnostic work-up and disposition when child abuse and/or neglect is suspected
- Demonstrate knowledge of the pathophysiologic differences from adult EKG's
- Discuss the common pediatric dysrhythmia, their diagnosis and treatment
- Discuss the types of congenital cyanotic and noncyanotic heart disease, their complications and treatment
- Demonstrate ability to read pediatric x-rays
- Discuss the etiologies and demonstrate correct management of children with lower and upper airway diseases including asthma, bronchiolitis, cystic fibrosis, epiglottis, pneumonia and respiratory syncytial virus
- Demonstrate correct management of foreign bodies of the upper airway and ability to diagnose and arrange disposition for patients with lower airway foreign bodies
- Demonstrate correct management of the pediatric patient with diabetes and/or diabetic ketoacidosis
- Demonstrate knowledge of the etiologies of anemia in children and the appropriate diagnostic evaluation
- Demonstrate knowledge of the differential diagnosis and work-up of the jaundiced child
- Discuss the differential and required workup for a pediatric patient with a limp
- Demonstrate x-ray interpretation and perform proper splinting principles for pediatric fractures
- Discuss the etiology and treatment of acute soft tissue infections and perform an incision and drainage
- Correctly diagnose common pediatric exanthemas
- Demonstrate knowledge of the differential diagnosis and evaluation of children with petechiae
- 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, neonatal seizures and neonatal sepsis
- Demonstrate knowledge of proper technique for a suprapubic bladder aspiration
- Discuss the findings and disposition of a patient with a suspected autoimmune syndrome such as juvenile arthritis, lupus, or dermatomyositis
- Discuss the differential diagnosis and acute treatment of the weak infant and child
- Demonstrate knowledge of the evaluation and treatment of children with diarrheal illness
- Demonstrate knowledge of the common poisonings of childhood and their treatments
- Manage the care of a child with immersion/drowning
- State the differential diagnosis of a child with upper or lower GI bleeding, and discuss the evaluation and treatment
- Discuss the differential diagnosis and work-up of renal failure or anuria in children
- Demonstrate ability to evaluate children with syncope and discuss its differential diagnosis
- Discuss the signs, symptoms, treatment and complications of Kawasaki disease
- Discuss the risk factors associated with teenage suicide
- Discuss the differential of abnormal vaginal bleeding in childhood and demonstrate ability to perform a genital exam on children
- Demonstrate ability to evaluate and treat a child with altered mental status
Discuss the common pediatric malignant tumors

**Practice Based Learning:**
- Analyze and assess their practice experience and perform practice-based improvement
- Locate, appraise and utilize scientific evidence related to their patients' health problems
- Apply knowledge of study design and statistical methods to critically appraise the medical literature
- Utilize information technology to enhance their education and improve patient care
- Facilitate the learning of students and other healthcare professionals

**Outcomes:**

**Interpersonal and Communication Skills:**
- Develop an effective therapeutic relationship with patients and their families, with respect for diversity, cultural, ethnic, spiritual, emotional, and age-specific differences
- Demonstrate effective participation in and leadership of the healthcare team
- Develop effective written communication skills
- Effectively communicate with consultants

**Professionalism:**
- Treats patients, family, staff, and ancillary personnel with respect
- Protects staff, family, and patient's interests and confidentiality
- Demonstrates sensitivity to patient's pain, emotional state, and gender/ethnicity issues
- Discuss death honestly, sensitively, patiently, and compassionately
- Unconditional positive regard for the patient, family, staff, and consultants

**System-Based Practice:**
- Demonstrate an understanding of the ethical and legal principles applicable to the care of critically ill patients
- Accepts responsibility and demonstrates accountability
- Exhibit openness and responsiveness to the comments of other team members, patients, families, and peers
- Demonstrate an understanding of “Do not resuscitate” orders, advance directives, living wills, and brain death criteria

**Osteopathic Principles and Practices:**
- Among others understand the interdependence of the musculoskeletal /lymphatic system and other organ systems as they relate to the pediatric patient.
- Understand that the mind, body and spirit all interact in the promotion of health and well being and demonstrate the ability to utilize osteopathic manipulative medicine as a part of their patient care regimen.

<table>
<thead>
<tr>
<th>Description of clinical experiences:</th>
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<tbody>
<tr>
<td>EM residents will care, assess and treat pediatric patients that present to the emergency department at all three facilities. A 4-week block will be protected during each year solely for Women's and Children's Emergency Department. Additional shifts will be scheduled as needed for competency. EM residents will also assist in deliveries and care for neonates in the Emergency Department.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Description of didactic experiences:</th>
</tr>
</thead>
<tbody>
<tr>
<td>EM residents will attend Pediatric Department educational conferences while on service and participate in daily teaching rounds as patient care allows. In addition, EM residents will participate in weekly Emergency Medicine conferences, as well as Journal Clubs.</td>
</tr>
</tbody>
</table>
Duty Hours:
The EM resident will conform to AOA and CAMC duty hours which include:
Not exceeding 60 hours per week averaged over 4 weeks.
Duty periods of PGY1-4 residents must not exceed 12 hours in duration when rotating in the emergency department.
It is essential for patient safety and resident education that effective transitions in care occur.
Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional 30 minutes.
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.
Under those circumstances, the resident must: 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. The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty.
Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods, and 12 hours off after any 12-hour shift in the ED.

Evaluation process:
EM residents are expected to take Pediatric Advance Life Support (PALS). Resident's knowledge of neonatal and pediatric life support is evaluated as a part of PALS using MCQ and simulations. Residents will receive concurrent feedback from the faculty while on the Pediatrics rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident's clinical performance during their rotation and their progress in achieving ACGME/AAO defined core competencies. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident's confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.
Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.
The resident tracks all procedures and completes a rotation evaluation. The EM Residency Program Director will discuss rotation evaluations with the Pediatrics rotation director. At the annual program review, the residents and EM faculty will also discuss the rotation.
Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

Feedback mechanisms:
The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents' evaluations of the rotation and annually give feedback to the Mt. State OPTI and the quarterly to EM residency curriculum committee and as required to the CHERI/GME committee at CAMC. If an area of concern is noted at any point with respect to a specific resident or the rotation, the EM Residency Program Director, EM resident and Pediatric Rotation Coordinator will communicate the concern immediately and develop a plan to resolve the issue.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described? Yes

If no, please explain:
<table>
<thead>
<tr>
<th>Rotation</th>
<th>Emergency Medicine PGL 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institution</td>
<td>Charleston Area Medical Center- Memorial</td>
</tr>
<tr>
<td>Year of training</td>
<td>OEM1 3 months OEM2 OEM3 OEM4</td>
</tr>
</tbody>
</table>

These training objectives provide a reasonable set of expectations for various levels of residents. They are not meant to be restrictive in the separation of responsibility. Residents who exceed the expectations for the training year are permitted to assume greater responsibility, provided that they are not competing with the senior resident's responsibilities. Many of our residents can perform at levels higher than those dictated by the training objectives for the year. This well-defined responsibility, based on year of training serves to provide organization and direction to the Emergency Department and makes optimal use of skills previously acquired by the resident.

PGL-1:
The first year of the Emergency Medicine training concentrates on developing skills in individual patient evaluation. The resident should begin to go from novice to advanced beginner. Focusing on the basic principles of decision making in Emergency Medicine, and acquiring the central knowledge base are the primary educational objectives. The resident should become thorough and efficient in the performance of the history and physical exam, and should begin to develop skills in the use of diagnostic tests, initiating treatment, requesting consultation, developing a treatment plan and arranging appropriate follow-up. The focus is on providing high quality care, with an Emergency Medicine approach to patient complaints to avoid the misdiagnosis, or delayed diagnosis of life threatening conditions. The residents are expected to see a reasonable number of patients, and begin to develop efficiency as they acquire the basic familiarity with common Emergency Department presentation. The first year residents are not primarily responsible for the care of critically ill patients. The focus of their effort is not on the volume of patients, but the efficacy and accuracy of patient evaluation. They are expected to learn appropriate medical record keeping and documentation. Basic procedural skills are acquired with encouragement to use the resources available in the simulation lab, as well as from direct bedside supervision.

Privalages:
PGL-1 and 2:
Senior level residents or faculty will closely supervise individuals in the PGL1 and 2 years. Residents entering this level of training are expected to present each patient case directly to the attending emergency physician or senior emergency medicine resident prior to the initiation of any diagnostic and/or therapeutic orders. The benefit of this immediate discussion of the patient management plan (including differential diagnoses, ancillary testing required and potential disposition) to the resident is real-time medical education. The patient benefits as the attending physician is made aware of his/her presenting complaint soon after the resident takes the history and physical. Therefore, the attending physician actively participates in the patient management from the onset. The emergency department and ancillary departments benefit as the patient workup is ordered with the knowledge and assent of the attending physician.

Goals:
Patient Care Goals: Residents must be able to provide patient care to emergency medicine patient that is compassionate, appropriate, and effective for the treatment of health problems and advocate for the promotion of health in the medical system.

Medical Knowledge Goals: Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to patient care.

Practice-Based Learning Goals: Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire in the emergency medicine department.

Interpersonal and Communication Skills Goals: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates all with diverse backgrounds.
Professionalism Goals: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Systems-Based Practice Goals: Residents must demonstrate an awareness of and responsiveness to the unique aspects of the CAMC system and be able to effectively call on system resources to provide care and patient follow up that is of optimal value.

Objectives:
Through day to day patient contact with patients in the emergency department and attending supervision, the emergency medicine resident will achieve the following outcomes.

Outcomes:
By the completion of this rotation, residents will be able to:

Patient Care Outcomes:
Gather accurate, essential information from the patient's history and physical examination in a timely manner
Focusing on the basic principles of decision making in Emergency Medicine and acquiring the central knowledge base are the primary educational objectives.
Implement a timely; effective patient management plans for the emergency medicine patient.
Competently perform diagnostic and therapeutic procedures as required to care for the emergency patient
Demonstrate ability to diagnose and treat shock, sepsis, fluid and electrolyte abnormalities, cardiac failure, cardiac dysrhythmia, renal failure, and hepatic failure in critically ill emergency patient patients.
Stabilize critical patients
Prioritize and stabilize multiple patients and perform other responsibilities simultaneously
Work with health care professionals to provide patient-focused care

Medical Knowledge Outcomes:
Identify life-threatening conditions, the most likely diagnosis, synthesize acquired patient data, and identify how and when to access current medical information
To learn the basic procedural skills used in the treatment of Emergency Department patients. Special emphasis is placed on wound and airway management.
Provide high quality care, with an Emergency Medicine approach to patient complaints to avoid the misdiagnosis or delayed diagnosis of life threatening conditions.
Learn to be efficacy and accuracy of patient evaluation without focus on patient volumes.
Learn appropriate medical record keeping and documentation.
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.
Demonstrate the ability to manage a patient on a ventilator.
Complete disposition of patients using available resources
Learn the indications, contraindications, complications and techniques for wound management and airway management.
Perform these skills in the training laboratory and when available in the ED
Learn the presenting signs and symptoms of common ED complaints and gain an understanding of the diagnostic and therapeutic approach to these complaints. The following complaints will be specifically addressed: Approach to the Emergency Department patient, Approach to the dyspneic patient, Approach to the patient with chest pain, Approach to the trauma patient, Approach to gynecologic disorders, A review of Pediatric Advanced Life Support, A review of Advanced Cardiac Life Support, Rapid Sequence Intubation, Procedural Sedation, Communication Skills, giving bad news, Professionalism in Emergency Medicine, Hands on Suture Lab/Wound Care Basics, Introduction to Ultrasound, Wellness /recognition of fatigue and related topics, Code and Critical Scenario Etiquette, Common ENT Presentations, Slit lamp Clinic and common Ophthalmologic presentations, Base Station - EMS Review, General Program Orientation, Honor Code, Approach to the Pediatric Patient, Common orthopedic injuries/splinting clinic, Use of Observation/CRDC/Admission Criteria EMTALA Review
**Practice Based Learning Outcomes:**
- Analyze and assess their practice experience and perform practice-based improvement
- Locate, appraise and utilize scientific evidence related to their patient’s health problems
- Apply knowledge of study design and statistical methods to critically appraise the medical literature
- Utilize information technology to enhance their education and improve patient care
- Facilitate the learning of students and other healthcare professionals
- Successfully complete the following courses in the first year of training, however, an overview of each of these will occur during the orientation month: ACLS Provider Course, Pediatric Advanced Life Support Course, Advanced Trauma Life Support Provider Course

**Interpersonal and Communication Skills Outcomes:**
- Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences
- Demonstrate effective participation in and leadership of the healthcare team
- Develop effective written communication skills
- Demonstrate the ability to handle situations unique to the practice of emergency medicine
- Effectively communicate with out-of-hospital personnel as well as non-medical personnel

**Professionalism Outcomes:**
- Treats patients, family, staff, and ancillary personnel with respect
- Protects staff, family, and patient’s interests and confidentiality
- Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues
- Able to discuss death honestly, sensitively, patiently, and compassionately
- Unconditional positive regard for the patient, family, staff, and consultants
- Accepts responsibility and demonstrates accountability
- Openness and responsiveness to the comments of other team members, patients, families, and peers
- Demonstrate an understanding of the ethical and legal principles applicable to the care of critically ill patients.
- Demonstrate understanding of “Do not resuscitate” orders, advance directives, living wills, and brain dead criteria

**System-Based Practice Outcomes:**
- Demonstrate an understanding of the appropriate use of consultants in emergency medicine patients
- Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal patient care
- Practice cost-effective health care and resource allocation that does not compromise quality of care
- Advocate for and facilitate patient’s advancement through the health care system
- To become familiar with the Department and Residency’s Policies and Procedures

**Description of clinical experiences:**
The EM resident will see patients that present to the emergency department under the direct supervision of the of the emergency department attending.

**Description of didactic experiences:**
EM residents will attend emergency department conferences appropriate for their education as well as weekly Emergency Medicine conferences and Journal Club.

**Duty Hours:**
The EM resident will conform to AOA and CAMC duty hours which include:
Not exceeding 60 hours per week averaged over 4 weeks.
Duty periods of PGY1 residents must not exceed 12 hours in duration when rotating in the emergency department.
It is essential for patient safety and resident education that effective transitions in care occur.
Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional 30 minutes.
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.

Under those circumstances, the resident must: 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. The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty.

Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods, and 12 hours off after any 12-hour shift in the ED.

**Evaluation process:**

Evaluation of the resident's knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACGME/AOA defined core competencies using the daily evaluation form. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident’s confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination, ACLS, PALS, ATLS and other training modules as directed by the PD. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.

The resident tracks all procedures and completes a rotation evaluation. The EM Residency Program Director will discuss rotation evaluations with the Trauma/Surgical Intensive Care Unit Coordinator. At the annual program review, the residents and EM faculty will also discuss the rotation.

**Feedback mechanisms:**

The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the emergency department rotation and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Emergency Medicine Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

| Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described? | Yes |
| If no, please explain: |
These training objectives provide a reasonable set of expectations for various levels of residents. They are not meant to be restrictive in the separation of responsibility. Residents who exceed the expectations for the training year are permitted to assume greater responsibility, provided that they are not competing with the senior resident's responsibilities. Many of our residents can perform at levels higher than those dictated by the training objectives for the year. This well-defined responsibility, based on year of training serves to provide organization and direction to the Emergency Department and makes optimal use of skills previously acquired by the resident.

As residents progress into the second year of residency it is expected that an increasing level of independence will be warranted. It is at this level that the resident is expected to go from advanced beginner to competent. The PGL2 resident will be expected to not only increase in medical knowledge, but also in procedural expertise. Continued use of the simulation lab is encouraged as new skills and procedures are added to your knowledge base. The PGL2 is also encouraged to use this resource to review and practice those skills learned in the PGY1 year. Advancing to this level also carries with it added responsibilities. The resident will be assigned increasing duties to teach. These will include presentations in the new resident orientation and, if selected, instructorship in the American Heart Association courses, as well as ATLS. Other opportunities will present, and should be welcomed as a means to develop these important skills, not the least of which will include the opportunity to assist, (while not supervising), the intern class. PGL2 level residents will participate on an ICU and Trauma month at General Hospital in order to gain exposure to critically ill and injured patients. This is also an opportunity to gain some procedural expertise. PGL2 residents will also be tracked as to their proficiency in managing patients. Progress in the number of patients seen will be monitored through the patient logs and Premier (ED) statistics. It is at this level that life-long skills in communication and disposition are beginning to be developed.

Privileges
PGL-1 and 2:
Senior level residents or faculty will closely supervise individuals in the PGL1 and 2 years. Residents entering this level of training are expected to present each patient case directly to the attending emergency physician or senior emergency medicine resident prior to the initiation of any diagnostic and/or therapeutic orders. The benefit of this immediate discussion of the patient management plan (including differential diagnoses, ancillary testing required and potential disposition) to the resident is real-time medical education. The patient benefits as the attending physician is made aware of his/her presenting complaint soon after the resident takes the history and physical. Therefore, the attending physician actively participates in the patient management from the onset. The emergency department and ancillary departments benefit as the patient workup is ordered with the knowledge and assent of the attending physician.

Goals:
Patient Care Goals: Residents must be able to provide patient care to emergency medicine patient that is compassionate, appropriate, and effective for the treatment of health problems and advocate for the promotion of health in the medical system.

Medical Knowledge Goals: Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to patient care.

Practice-Based Learning Goals: Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire in the emergency medicine department.

Interpersonal and Communication Skills Goals: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates all with diverse backgrounds.
Professionalism Goals: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Systems-Based Practice Goals: Residents must demonstrate an awareness of and responsiveness to the unique aspects of the CAMC system and be able to effectively call on system resources to provide care and patient follow up that is of optimal value.

Objectives:

Through day to day patient contact with patients in the emergency department and attending supervision, the emergency medicine resident will achieve the following outcomes.

Outcomes:

By the completion of this rotation, residents will be able to:

Patient Care Outcomes:
- Gather accurate, essential information from the patient’s history and physical examination in a timely manner
- Work towards increasing level of independence
- Implement a timely, effective patient management plans for the emergency medicine patient
- Competently perform diagnostic and therapeutic procedures as required to care for the emergency patient
- Demonstrate ability to diagnose and treat shock, sepsis, fluid and electrolyte abnormalities, cardiac failure, cardiac dysrhythmia, renal failure, and hepatic failure in critically ill emergency patient patients
- Stabilize critical patients
- Prioritize and stabilize multiple patients and perform other responsibilities simultaneously
- Progress in the number of patients seen
- Work with health care professionals to provide patient-focused care

Medical Knowledge Outcomes:
- Identify life-threatening conditions, the most likely diagnosis, synthesize acquired patient data, and identify how and when to access current medical information
- To learn the basic procedural skills used in the treatment of Emergency Department patients. Special emphasis is placed on wound and airway management.
- The focus is on providing high quality care, with an Emergency Medicine approach to patient complaints to avoid the misdiagnosis or delayed diagnosis of life threatening conditions.
- Accept increased assignments to teach.
- Gain exposure to management of critically ill and injured patients
- 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.
- Demonstrate the ability to manage a patient on a ventilator.
- Complete disposition of patients using available resources
- The resident will learn the indications, contraindications, complications and techniques for wound management and airway management. The resident will perform these skills in the training laboratory and when available in the ED
- The resident will learn the presenting signs and symptoms of common ED complaints and gain an understanding of the diagnostic and therapeutic approach to these complaints. Typically, the following complaints will be specifically addressed: Approach to the Emergency Department patient, Approach to the dyspneic patient, Approach to the patient with chest pain, Approach to the trauma patient, Approach to gynecologic disorders, A review of Pediatric Advanced Life Support, A review of Advanced Cardiac Life Support, Rapid Sequence Intubation, Procedural Sedation, Communication Skills, giving bad news, Professionalism in Emergency Medicine, Hands on Suture Lab/Wound Care Basics, Introduction to Ultrasound, Wellness/recognition of fatigue and related topics, Code and Critical Scenario Etiquette, Common ENT Presentations, Slit lamp Clinic and common Ophthalmologic presentations, Base Station - EMS Review, General Program Orientation, Honor Code, Approach to the Pediatric Patient, Common orthopedic injuries/splinting clinic, Use of Observation/CRDC/Admission Criteria EMTALA Review

Practice Based Learning Outcomes:
- Analyze and assess their practice experience and perform practice-based improvement
- Locate, appraise and utilize scientific evidence related to their patient’s health problems
- Apply knowledge of study design and statistical methods to critically appraise the medical literature
Utilize information technology to enhance their education and improve patient care

**Practice Based Learning Outcomes:**
- Facilitate the learning of students and other healthcare professionals
- The resident will successfully complete the following courses in the first year of training, however, an overview of each of these will occur during the orientation month. ACLS Provider Course, Pediatric Advanced Life Support Course, Advanced Trauma Life Support Provider Course

**Interpersonal and Communication Skills Outcomes:**
- Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences
- Demonstrate effective participation in and leadership of the healthcare team
- Develop effective written communication skills
- Demonstrate the ability to handle situations unique to the practice of emergency medicine
- Effectively communicate with out-of-hospital personnel as well as non-medical personnel

**Professionalism Outcomes:**
- Treats patients, family, staff, and ancillary personnel with respect
- Protects staff, family, and patient's interests and confidentiality
- Demonstrates sensitivity to patient's pain, emotional state, and gender/ethnicity issues
- Able to discuss death honestly, sensitively, patiently, and compassionately
- Unconditional positive regard for the patient, family, staff, and consultants
- Accepts responsibility and demonstrates accountability
- Openness and responsiveness to the comments of other team members, patients, families, and peers
- Demonstrate an understanding of the ethical and legal principles applicable to the care of critically ill patients.
- Demonstrate understanding of "Do not resuscitate" orders, advance directives, living wills, and brain dead criteria

**System-Based Practice Outcomes:**
- Demonstrate an understanding of the appropriate use of consultants in emergency medicine patients
- Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal patient care
- Practice cost-effective health care and resource allocation that does not compromise quality of care
- Advocate for and facilitate patient's advancement through the health care system
- To become familiar with the Department and Residency's Policies and Procedures

**Description of Clinical Experiences:**
- The EM resident will see patients that present to the emergency department under the direct supervision of the emergency department attending.

**Description of Didactic Experiences:**
- EM residents will attend emergency department conferences appropriate for their education as well as weekly Emergency Medicine conferences and Journal Club.

**Duty Hours:**
- The EM resident will conform to AOA and CAMC duty hours which include:
  - Not exceeding 60 hours per week averaged over 4 weeks.
  - Duty periods of PGY2 residents must not exceed 12 hours in duration when rotating in the emergency department.
  - It is essential for patient safety and resident education that effective transitions in care occur.
  - Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional 30 minutes.
  - 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.
  - Under those circumstances, the resident must: 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. The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty. Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods, and 12 hours off after any 12-hour shift in the ED.

**Evaluation process:**
Evaluation of the resident’s knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACGME/AAO defined core competencies using the daily evaluation form. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident's confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination, ACLS, PALS, ATLS and other training modules as directed by the PD. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.

The resident tracks all procedures and completes a rotation evaluation. The EM Residency Program Director will discuss rotation evaluations with the Trauma/Surgical Intensive Care Unit Coordinator. At the annual program review, the residents and EM faculty will also discuss the rotation.

**Feedback mechanisms:**
The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the emergency department rotation and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Emergency Medicine Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

| Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described? | Yes |
| If no, please explain: |   |
These training objectives provide a reasonable set of expectations for various levels of residents. They are not meant to be restrictive in the separation of responsibility. Residents who exceed the expectations for the training year are permitted to assume greater responsibility, provided that they are not competing with the senior resident’s responsibilities. Many of our residents can perform at levels higher than those dictated by the training objectives for the year. This well-defined responsibility, based on year of training serves to provide organization and direction to the Emergency Department and makes optimal use of skills previously acquired by the resident.

PGL-3:
The third year Emergency Medicine Resident concentrates on expanding and refining patient care skills. It is at this level that the resident is expected to go from competent to proficient. The resident begins to focus on developing an efficient approach to patient care, and learns the skills needed to manage several patients simultaneously. He/she is expected to see a larger number of patients to broaden the base of experience. Participation in major medical and trauma resuscitations is expected. The third year resident is introduced to advanced procedural skills and encouraged not only to avail themselves of the simulation lab for review and development of these skills, but also to teach and assist junior residents to develop their skills. Residents will participate on an EMS/AIR AMBULANCE rotation to gain exposure to the vital role played by EMS in the field in emergency situations. PGL3 residents will also participate on an ICU service at General Hospital. As they have now begun to gain increased autonomy and knowledge, it is expected that the resident at this level will assume increasing responsibility while on service. The residents develop skills in problem-solving, patient disposition, efficient delivery of emergency medical care and teaching. Increasing teaching responsibilities occur at this level and include presenting lectures, supervising junior residents, and assisting with procedures and medical management of emergency cases. Leadership abilities should be developed at or before this level. It is expected by the third year of post-graduate training the resident will have become a model for more junior residents, exemplifying those qualities so sought after in our profession.

PGL-3: Privileges
Individuals in the third postgraduate year are expected to perform independently the duties learned in the first two years and may supervise the routine activities of the PGL 1 and 2 year residents. Residents at this level of training should have progressed in independent responsibility as outlined and approved by the emergency medicine residency faculty. The resident should take a leadership role in teaching the more junior residents and medical students the practical aspects of patient care, and be able to explain complex diagnostic and therapeutic procedures to the patient and family. The PGL3 resident should be able to incorporate ethical concepts into patient care, and discuss these with the patient, family, and other members of the health care team.

Goals:

Patient Care Goals: Residents must be able to provide patient care to emergency medicine patient that is compassionate, appropriate, and effective for the treatment of health problems and advocate for the promotion of health in the medical system.

Medical Knowledge Goals: Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to patient care.

Practice-Based Learning Goals: Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire in the emergency medicine department.

Interpersonal and Communication Skills Goals: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates all with diverse backgrounds.

Professionalism Goals: Residents must demonstrate a commitment to carrying out professional responsibilities,
adherence to ethical principles, and sensitivity to a diverse patient population.

**Systems-Based Practice Goals:** Residents must demonstrate an awareness of and responsiveness to the unique aspects of the CAMC system and be able to effectively call on system resources to provide care and patient follow up that is of optimal value.

**Objectives:**
Through day to day patient contact with patients in the emergency department and attending supervision, the emergency medicine resident will achieve the following outcomes.

**Outcomes:**
By the completion of this rotation, residents will be able to:

**Patient Care Outcomes:**
- Gather accurate, essential information from the patient’s history and physical examination in a timely manner
- Work towards increasing level of independence
- Implement a timely; effective patient management plans for the emergency medicine patient.
- Competently perform diagnostic and therapeutic procedures as required to care for the emergency patient
- Demonstrate ability to diagnose and treat shock, sepsis, fluid and electrolyte abnormalities, cardiac failure, cardiac dysrhythmia, renal failure, and hepatic failure in critically ill emergency patient patients.
- Stabilize critical patients
- Prioritize and stabilize multiple patients and perform other responsibilities simultaneously
- See a larger number of patients to broaden the base of experience.
- Work with health care professionals to provide patient-focused care

**Medical Knowledge Outcomes:**
- Identify life-threatening conditions, the most likely diagnosis, synthesize acquired patient data, and identify how and when to access current medical information
- Participation in major medical and trauma resuscitations
- To learn the basic procedural skills used in the treatment of Emergency Department patients. Special emphasis is placed on wound and airway management.
- The focus is on providing high quality care, with an Emergency Medicine approach to patient complaints to avoid the misdiagnosis or delayed diagnosis of life threatening conditions.
- Accept increased assignments to teach.
- Gain exposure to management of critically ill and injured patients
- 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.
- Demonstrate the ability to manage a patient on a ventilator.
- Complete disposition of patients using available resources
- Develop skills in problem-solving, patient disposition, efficient delivery of emergency medical care and teaching
- Learn the indications, contraindications, complications and techniques for wound management and airway management.
- Perform these skills in the training laboratory and when available in the ED
- Learn the presenting signs and symptoms of common ED complaints and gain an understanding of the diagnostic and therapeutic approach to these complaints. Typically, the following complaints will be specifically addressed: Approach to the Emergency Department patient, Approach to the dyspneic patient, Approach to the patient with chest pain, Approach to the trauma patient, Approach to gynecologic disorders, A review of Pediatric Advanced Life Support, A review of Advanced Cardiac Life Support, Rapid Sequence Intubation, Procedural Sedation, Communication Skills, giving bad news, Professionalism in Emergency Medicine, Hands on Suture Lab/Wound Care Basics, Introduction to Ultrasound, Wellness /recognition of fatigue and related topics, Code and Critical Scenario Etiquette, Common ENT Presentations, Slit lamp Clinic and common Ophthalmologic presentations, Base Station - EMS Review, General Program Orientation, Honor Code, Approach to the Pediatric Patient, Common orthopedic injuries/splinting clinic, Use of Observation/CRDC/Admission Criteria EMTALA Review
- Participate on an EMS/AIR AMBULANCE rotation to gain exposure to the vital role played by EMS in the field in emergency situations.
Practice Based Learning Outcomes:
Analyze and assess their practice experience and perform practice-based improvement
Locate, appraise and utilize scientific evidence related to their patient’s health problems
Apply knowledge of study design and statistical methods to critically appraise the medical literature
Utilize information technology to enhance their education and improve patient care
Facilitate the learning of students and other healthcare professionals
The resident will successfully complete the following courses in the first year of training, however, an overview of each of these will occur during the orientation month. ACLS Provider Course, Pediatric Advanced Life Support Course, Advanced Trauma Life Support Provider Course
Present lectures, supervising junior residents, and assisting with procedures and medical management of emergency cases.

Interpersonal and Communication Skills Outcomes:
Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences
Demonstrate effective participation in and leadership of the healthcare team
Develop effective written communication skills
Demonstrate the ability to handle situations unique to the practice of emergency medicine
Effectively communicate with out-of-hospital personnel as well as non-medical personnel
Incorporate ethical concepts into patient care and discuss these with the patient, family, and other members of the healthcare team.

Professionalism Outcomes:
Treats patients, family, staff, and ancillary personnel with respect
Protects staff, family, and patient’s interests and confidentiality
Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues
Able to discuss death honestly, sensitively, patiently, and compassionately
Unconditional positive regard for the patient, family, staff, and consultants
Accepts responsibility and demonstrates accountability
Openness and responsiveness to the comments of other team members, patients, families, and peers
Demonstrate an understanding of the ethical and legal principles applicable to the care of critically ill patients.
Demonstrate understanding of “Do not resuscitate” orders, advance directives, living wills, and brain dead criteria
Become a model for more junior residents, exemplifying those qualities so sought after in our profession.

System-Based Practice Outcomes:
Demonstrate an understanding of the appropriate use of consultants in emergency medicine patients
Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal patient care
Practice cost-effective health care and resource allocation that does not compromise quality of care
Advocate for and facilitate patient’s advancement through the health care system
To become familiar with the Department and Residency’s Policies and Procedures

Description of clinical experiences:
The EM resident will see patients that present to the emergency department under the direct supervision of the of the emergency department attending.

Description of didactic experiences:
EM residents will attend emergency department conferences appropriate for their education as well as weekly Emergency Medicine conferences and Journal Club.

Duty Hours:
The EM resident will conform to AOA and CAMC duty hours which include:
Not exceeding 60 hours per week averaged over 4 weeks.
Duty periods of PGY3 residents must not exceed 12 hours in duration when rotating in the emergency department.
It is essential for patient safety and resident education that effective transitions in care occur.
Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional 30 minutes. 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.

Under those circumstances, the resident must: 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. The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty. Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods, and 12 hours off after any 12-hour shift in the ED.

**Evaluation process:**

Evaluation of the resident’s knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACGME/AAO defined core competencies using the daily evaluation form. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident’s confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination, ACLS, PALS, ATLS and other training modules as directed by the PD. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.

The resident tracks all procedures and completes a rotation evaluation. The EM Residency Program Director will discuss rotation evaluations with the Trauma/Surgical Intensive Care Unit Coordinator. At the annual program review, the residents and EM faculty will also discuss the rotation.

**Feedback mechanisms:**

The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the emergency department rotation and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Emergency Medicine Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

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<tr>
<th>Have the service directors for all rotations in the Emergency Department at the primary institution reviewed and agreed to the rotations as described?</th>
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If no, please explain:
Rotation | Emergency Medicine PGL 4  
---|---
Institution | Charleston Area Medical Center- Memorial  
Year of training | OEM1 | OEM2 | OEM3 | OEM4 | 9 months  

These training objectives provide a reasonable set of expectations for various levels of residents. They are not meant to be restrictive in the separation of responsibility. Residents who exceed the expectations for the training year are permitted to assume greater responsibility, provided that they are not competing with the senior resident's responsibilities. Many of our residents can perform at levels higher than those dictated by the training objectives for the year. This well-defined responsibility, based on year of training serves to provide organization and direction to the Emergency Department and makes optimal use of skills previously acquired by the resident.

PGL-4:
The fourth year Emergency Medicine Resident concentrates on broadening exposure and developing efficiency. It is at this level that the resident is expected to concentrate on those skills lacking proficiency and begin to develop expert standing. Life-long learning practices and habits, which will have been introduced earlier in training, now become individually resident-driven. The resident will increasingly share experience and knowledge with junior residents and medical students. The resident is primarily responsible for the most critically ill patients in the Emergency Department, and directs and assists junior residents with medical resuscitations. This should include demonstrations of mastery in clinical procedures, as well as the ability and willingness to teach those that follow, both at the bedside and in the lab. The PGL4 resident functions as an integral member of the ICU and Trauma resuscitation team. The PGL4 residents assume ever-increasing academic responsibilities, providing lectures and conferences as part of their regular academic activities. The resident continues to develop skills and confidence in problem-solving, patient disposition, efficient delivery of emergency medical care and teaching. Overseeing the operation of the Emergency Department and ensuring that all patients receive appropriate care are of paramount importance. The PGL4 residents will be afforded greater opportunity to provide lectures, presentations, and conferences to the faculty and junior residents as part of their regular academic activities. Leadership roles are expanded to include scheduling of resident shifts and lectures.

Privileges PGL-4:
In the fourth emergency medicine training year, the resident should be capable of managing patients with virtually any routine or complicated condition, and of supervising junior residents, practitioners, and medical students in their daily activities. The resident is responsible for coordinating the care of multiple patients on the assigned team. The delineation of privileges is designed as an outline for the purpose of determining the appropriate level of individual resident supervision. As with any group learning process, individuals may exceed or fall below the expected level of independence. Those residents who exceed the learning and procedural expectations for their given year may be approved by faculty consensus to increase their independent level of responsibility ahead of their peers. Those residents not meeting the determined level of independent responsibility as decided by faculty consensus will not be approved to increase their level of responsibility until such time as the faculty believes these educational requirements are met.

Goals:

**Patient Care Goals:** Residents must be able to provide patient care to emergency medicine patient that is compassionate, appropriate, and effective for the treatment of health problems and advocate for the promotion of health in the medical system.

**Medical Knowledge Goals:** Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to patient care.

**Practice-Based Learning Goals:** Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire in the emergency medicine department.

**Interpersonal and Communication Skills Goals:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates all with diverse backgrounds.
Professionalism Goals: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Systems-Based Practice Goals: Residents must demonstrate an awareness of and responsiveness to the unique aspects of the CAMC system and be able to effectively call on system resources to provide care and patient follow up that is of optimal value.

Objectives: Through day to day patient contact with patients in the emergency department and attending supervision, the emergency medicine resident will achieve the following outcomes.

Outcomes: By the completion of this rotation, residents will be able to:

Patient Care Outcomes:
Gather accurate, essential information from the patient’s history and physical examination in a timely manner
Work towards increasing level of independence
Implement a timely; effective patient management plans for the emergency medicine patient.
Competently perform diagnostic and therapeutic procedures as required to care for the emergency patient
Demonstrate ability to diagnose and treat shock, sepsis, fluid and electrolyte abnormalities, cardiac failure, cardiac dysrhythmia, renal failure, and hepatic failure in critically ill emergency patient patients.
Stabilize critical patients
Prioritize and stabilize multiple patients and perform other responsibilities simultaneously
Work with health care professionals to provide patient-focused care
Primarily responsible for the most critically ill patients in the Emergency Department and directs and assists junior residents with medical resuscitations

Medical Knowledge Outcomes:
Identify life-threatening conditions, the most likely diagnosis, synthesize acquired patient data, and identify how and when to access current medical information
Be capable of managing patients with virtually any routine or complicated condition and of supervising junior residents, practitioners and medical students in their daily activities.
Participation in major medical and trauma resuscitations
Learn the basic procedural skills used in the treatment of Emergency Department patients. Special emphasis is placed on wound and airway management.
Focus is on providing high quality care, with an Emergency Medicine approach to patient complaints to avoid the misdiagnosis or delayed diagnosis of life threatening conditions.
Accept increased assignments to teach.
Gain exposure to management of critically ill and injured patients
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.
Demonstrate the ability to manage a patient on a ventilator.
Complete disposition of patients using available resources
Develop skills in problem-solving, patient disposition, efficient delivery of emergency medical care and teaching
Learn the indications, contraindications, complications and techniques for wound management and airway management.
Perform these skills in the training laboratory and when available in the ED
Learn the presenting signs and symptoms of common ED complaints and gain an understanding of the diagnostic and therapeutic approach to these complaints. Typically, the following complaints will be specifically addressed: Approach to the Emergency Department patient, Approach to the dyspneic patient, Approach to the patient with chest pain, Approach to the trauma patient, Approach to gynecologic disorders, A review of Pediatric Advanced Life Support, A review of Advanced Cardiac Life Support, Rapid Sequence Intubation, Procedural Sedation, Communication Skills, giving bad news, Professionalism in Emergency Medicine, Hands on Suture Lab/Wound Care Basics, Introduction to Ultrasound, Wellness/recognition of fatigue and related topics, Code and Critical Scenario Etiquette, Common ENT Presentations, Medical Knowledge Outcomes:
Slit lamp Clinic and common Ophthalmologic presentations, Base Station - EMS Review, General Program Orientation,
Honor Code, Approach to the Pediatric Patient, Common orthopedic injuries/splinting clinic, Use of Observation/CRDC/Admission Criteria EMTALA Review
Participate on an EMS/AIR AMBULANCE rotation to gain exposure to the vital role played by EMS in the field in emergency situations.

Practice Based Learning Outcomes:
Analyze and assess their practice experience and perform practice-based improvement
Locate, appraise and utilize scientific evidence related to their patient’s health problems
Apply knowledge of study design and statistical methods to critically appraise the medical literature
Utilize information technology to enhance their education and improve patient care
Facilitate the learning of students and other healthcare professionals
The resident will successfully complete the following courses in the first year of training, however, an overview of each of these will occur during the orientation month. ACLS Provider Course, Pediatric Advanced Life Support Course, Advanced Trauma Life Support Provider Course
Present lectures, supervising junior residents, and assisting with procedures and medical management of emergency cases.

Interpersonal and Communication Skills Outcomes:
Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences
Demonstrate effective participation in and leadership of the healthcare team
Develop effective written communication skills
Demonstrate the ability to handle situations unique to the practice of emergency medicine
Effectively communicate with out-of-hospital personnel as well as non-medical personnel
Incorporate ethical concepts into patient care and discuss these with the patient, family, and other members of the health care team.
Supervising junior residents, practitioners and medical students in their daily activities.

Professionalism Outcomes:
Treats patients, family, staff, and ancillary personnel with respect
Protects staff, family, and patient’s interests and confidentiality
Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues
Able to discuss death honestly, sensitively, patiently, and compassionately
Unconditional positive regard for the patient, family, staff, and consultants
Accepts responsibility and demonstrates accountability
Openness and responsiveness to the comments of other team members, patients, families, and peers
Demonstrate an understanding of the ethical and legal principles applicable to the care of critically ill patients.
Demonstrate understanding of “Do not resuscitate” orders, advance directives, living wills, and brain dead criteria
Become a model for more junior residents, exemplifying those qualities so sought after in our profession.

System-Based Practice Outcomes:
Demonstrate an understanding of the appropriate use of consultants in emergency medicine patients
Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal patient care
Advocate for and facilitate patient’s advancement through the health care system
To become familiar with the Department and Residency’s Policies and Procedures
Overseeing the operation of the Emergency Department and ensuring that all patients receive appropriate care

Description of clinical experiences:
The EM resident will see patients that present to the emergency department under the direct supervision of the of the emergency department attending. Additionally, PGY4 residents will spend 2 half-day sessions every 4 weeks at the WV Regional Toxicology Center. See Toxicology Curriculum
**Description of didactic experiences:**

EM residents will attend emergency department conferences appropriate for their education as well as weekly Emergency Medicine conferences and monthly Journal Club.

**Duty Hours:**

The EM resident will conform to AOA and CAMC duty hours which include:

- Not exceeding *60 hours per week averaged over 4 weeks*.

Duty periods of PGY4 residents must not exceed 12 hours in duration when rotating in the emergency department. It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional 30 minutes.

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.

Under those circumstances, the resident must: 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. The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty.

Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods, and 12 hours off after any 12-hour shift in the ED.

**Evaluation process:**

Evaluation of the resident's knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident's clinical performance during their rotation and their progress in achieving ACGME/AOA defined core competencies using the daily evaluation form. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident's confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination, ACLS, PALS, ATLS and other training modules as directed by the PD. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.

The resident tracks all procedures and completes a rotation evaluation. The EM Residency Program Director will discuss rotation evaluations with the Trauma/Surgical Intensive Care Unit Coordinator. At the annual program review, the residents and EM faculty will also discuss the rotation.

**Feedback mechanisms:**

The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents' evaluations of the emergency department rotation and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Emergency Medicine Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?  

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<td><img src="true" alt="Yes" /></td>
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If no, please explain:
Goals:

Patient Care Goals: Residents must be able to provide patient care to patients that are compassionate, appropriate, and effective for the treatment of health problems and advocate for the promotion of health as it relates to the radiology service.

Medical Knowledge Goals: Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to the science of radiologic imagining.

Practice-Based Learning Goals: Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire in the radiology department.

Interpersonal and Communication Skills Goals: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates all with diverse backgrounds.

Professionalism Goals: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Systems-Based Practice Goals: Residents must demonstrate an awareness of and responsiveness to the unique aspects of the healthcare system and be able to effectively call on system resources to provide care and patient follow up that is of optimal value.

Osteopathic Principles and Practices: Residents must demonstrate an awareness of the basic tenets of osteopathic philosophy and ability in basic manipulative medicine.

Objectives:
With direct supervision from senior residents and attending faculty, the emergency medicine resident will upon successful completion of this rotation achieve the following outcomes.

Outcomes:
By the completion of this rotation, residents will be able to:

Patient Care Outcomes:
Gather accurate, essential information in a timely manner
Generate an appropriate differential diagnosis for the patient
Implement an effective patient management plan as it relates to the care of the imaged patient
Demonstrate ability to determine appropriate and cost effective approach to imagining emergency patients
Demonstrate the ability to assess radiologic studies common to the emergency department patient
Demonstrate ability to evaluate plain film radiographic studies, ventilation perfusion scans, CTA of the chest, radiographic studies of the nervous system, radiographic studies of the musculoskeletal system, barium enemas, ultrasonography studies pertinent to emergency medicine patients
Discuss the indications for each of the above and identify proper technique
Provide health care services aimed at preventing health problems or maintaining health during and after radiologic examination
Work with health care professionals to provide patient-focused care
Medical Knowledge Outcomes:
Describe the fundamentals of plain film radiography including the concepts of proper patient positioning, adequate penetration, and technique
Recite the critical steps involved in plain film radiography as it relates to cardio pulmonary imagining
Differentiate pneumonia from other intrathoracic processes and describe these processes by location and appearance
Site the distinguishing plain film characteristics of histoplasmosis, pneumoconiosis, sarcoid, pulmonary edema, "atypical" pneumonia, pulmonary fibrosis, and tuberculosis
Summarize the distinguishing characteristics of pneumonia with AIDS
Identify plural effusion and hemothorax
Identify pneumothorax and pneumomediastinum
Differentiate radiographically the stages of congestive heart failure
Explain the fundamentals of performing and interpretation of ventilation - perfusion scans for detection of pulmonary emboli. Explain the advantages and disadvantages of CTA for detection of pulmonary emboli
Name the indications for plain film radiology in gastrointestinal imaging
Identify the indications for barium enemas
Describe the fundamentals of abdominal CT and indicate appropriate methodology for various emergency conditions
Select appropriate neuroimaging techniques and describe limitations of each
Identify and recognize the classic finding of ischemic stroke both acute and sub acute
List the common risks and associated patient preparation related to contrast studies
Describe major differences between the radiographic anatomy of the pediatric patient, adults patients and elderly patients

Practice Based Learning Outcomes:
Correctly interpret abdominal radiographs demonstrating small bowel obstruction, large bowel obstruction and ileus
State the classic findings of intussusceptions volvulus on pediatric barium enemas
Differentiate classic abdominal CT findings for trauma, appendicitis, diverticulitis, AAA, and pancreatitis
Demonstrate ultrasound techniques for cholecystitis, FAST, AAA
Analyze pelvic ultrasonography findings for normal early pregnancy, ectopic pregnancy, third trimester bleeding and ovarian torsion
Recognize radiographic findings for cerebral contusions, subdural hematoma, epidural hematoma, subarachnoid hemorrhage, intraparenchymal hemorrhage intracranial masses and stroke
Demonstrate and understanding of the principals and applications of MRI in the emergency setting
Locate, appraise and utilize scientific evidence related to their patient’s health problems
Apply knowledge of study design and statistical methods to critically appraise the medical literature
Utilize information technology to enhance their education and improve patient care
Locate and identify the radio graphically demonstrated bony anatomy of the spine, upper and lower extremities.
Interpret major abnormalities associated with these findings

Interpersonal and Communication Skills Outcomes:
Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences
Demonstrate effective participation in and leadership of the health care team
Develop effective written communication skills
Effectively communicate with medical as well non-medical personnel

Professionalism Outcomes:
Treats patients/family/staff/paraprofessional personnel with respect
Protects staff/family/patient’s interests/confidentiality
Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues
Able to discuss death honestly, sensitively, patiently, and compassionately
Unconditional positive regard for the patient, family, staff, and consultants
Accepts responsibility/accountability
Openness and responsiveness to the comments of other team members, patients, families, and peers
### System-Based Practice Outcomes:
Demonstrate an understanding of, appropriate utilization and evaluation of the available radiological resources, providers, and systems
Practice cost-effective health care and resource allocation that does not compromise quality of care
Advocate for and facilitate their patients’ advancement through the health care system

### Osteopathic Principles and Practices:
Among others demonstrate and understanding of the interdependence of the musculoskeletal/lymphatic system and other organ systems as they relate to the radiographic patient
Understand that the mind, body and spirit all interact in the promotion of health and well being and demonstrate the ability to utilize osteopathic manipulative medicine as a part of their patient care regimen

### Description of clinical experiences:
The EM resident will see patients that present to the radiology department under the direct supervision of the assigned attending radiologist and allied health providers as designated by the department. The EM resident will take call as necessary and manage these patients as required by the Radiology department policy.

### Description of didactic experiences:
EM residents will attend any Radiology department conferences appropriate for their education as well as weekly Emergency Medicine conferences and Journal Club. The residents will also be given additional reading assignments and Emergency Department radiographic teaching files to review.

### Evaluation process:

#### Duty Hours:
The EM resident will conform to AOA and CAMC duty hours which include:
- Not exceeding *80 hours per week averaged over 4 weeks*.
- Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At home call cannot be assigned on these free days. Residents must not be scheduled for more than six consecutive nights of night float/call. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
- Duty periods of PGY1 residents must not exceed 16 hours in duration.
- It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
- 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.
  - Under those circumstances, the resident must: 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. The program director must review each submission of additional service and track both individual resident and program wide episodes of additional duty.
  - Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods and after in house call. Residents are permitted to return to the hospital while on at home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off duty period".

#### Evaluation process:
Evaluation of the resident’s knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACGME/AOA defined core competencies. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident’s confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.
**Evaluation process:**
Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.
The resident tracks all procedures and completes a rotation evaluation. The EM Residency Program Director will discuss rotation evaluations with the Radiology rotation director.

**Feedback mechanisms:**
The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the Radiology rotation and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Rotation Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

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<th>Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?</th>
<th>YES</th>
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If no, please explain:
Goals:

Patient Care Goals: Residents must be able to provide patient care to patients that are compassionate, appropriate, and effective for the treatment of health problems and advocate for the promotion of health as it relates to the neurology service.

Medical Knowledge Goals: Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to the science of neurology.

Practice-Based Learning Goals: Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire in the neurology department.

Interpersonal and Communication Skills Goals: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates all with diverse backgrounds.

Professionalism Goals: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Systems-Based Practice Goals: Residents must demonstrate an awareness of and responsiveness to the unique aspects of the healthcare system and be able to effectively call on system resources to provide care and patient follow up that is of optimal value.

Osteopathic Principles and Practices: Residents must demonstrate an awareness of the basic tenets of osteopathic philosophy and ability in basic manipulative medicine.

Objectives:
With direct supervision from senior residents and attending faculty, the emergency medicine resident will upon successful completion of this rotation achieve the following outcomes.

Outcomes:
By the completion of this rotation, residents will be able to:

Patient Care Outcomes:
Gather accurate, essential information in a timely manner
Generate an appropriate differential diagnosis for the patient
Implement an effective patient management plan as it relates to the care of the neurology patient
Demonstrate ability to determine appropriate and cost effective approach to neurology emergency patients
Demonstrate the ability to evaluate patients with neurologic complaints and understand the pathophysiology process, diagnosis and management of: Cerebral aneurysm, Arteriovenous malformation, Hemorrhagic stroke, Ischemic stroke, Verteobasilar insufficiency, Transient Ischemic attack, Subarachnoid hemorrhage, Bell’s Palsy, Trigeminal neuralgia, Amyotrophic lateral sclerosis, Multiple sclerosis, Intracranial abscess, Encephalitis, Meningitis, Myelitis, Neuritis, Landry-Guillain-Barre, Myasthenia gravis, Peripheral neuropathy, Spinal cord compression, CNS shunt malfunction, Seizure disorders, Headache, Pseudotumor cerebri, Normal pressure hydrocephalus
Demonstrate ability to evaluate indications and contradictions for implementing the following diagnostic tests and procedures: Lumbar puncture, CAT scan, Magnetic resonance imaging, Electroencephalography, Electromyelography, Pharmacologic intervention for Acute neurologic disease
Discuss the indications for each of the above and identify proper technique
Provide health care services aimed at preventing health problems or maintaining health during and after neurologic examination
Work with health care professionals to provide patient-focused care
Medical Knowledge Outcomes:
Describe the fundamentals of neurology
Describe the fundamentals of abdominal CT and indicate appropriate methodology for various emergency conditions
Select appropriate neuroimaging techniques and describe limitations of each
Identify and recognize the classic finding of ischemic stroke both acute and sub acute
List the common risks and associated patient preparation related to contrast studies

Practice Based Learning Outcomes:
Recognize radiographic findings for cerebral contusions, subdural hematoma, epidural hematoma, subarachnoid hemorrhage, intraparenchymal hemorrhage intracranial masses and stroke
Demonstrate and understanding of the principals and applications of neurology in the emergency setting
Analyze and assess their practice experience and perform practice-based improvement
Locate, appraise and utilize scientific evidence related to their patient’s health problems
Apply knowledge of study design and statistical methods to critically appraise the medical literature
Use information technology to enhance their education and improve patient care
Facilitate the learning of students and other health care professionals

Interpersonal and Communication Skills Outcomes:
Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences
Demonstrate effective participation in and leadership of the health care team
Develop effective written communication skills
Effectively communicate with medical as well non-medical personnel

Professionalism Outcomes:
Treats patients/family/staff/paraprofessional personnel with respect
Protects staff/family/patient’s interests/confidentiality
Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues
Able to discuss death honestly, sensitively, patiently, and compassionately
Unconditional positive regard for the patient, family, staff, and consultants
Accepts responsibility/accountability
Openness and responsiveness to the comments of other team members, patients, families, and peers

System-Based Practice Outcomes:
Demonstrate an understanding of, appropriate utilization and evaluation of the available neurological resources, providers, and systems
Practice cost-effective health care and resource allocation that does not compromise quality of care
Advocate for and facilitate their patients’ advancement through the health care system

Osteopathic Principles and Practices:
Among others demonstrate and understanding of the interdependence of the musculoskeletal /lymphatic system and other organ systems as they relate to the neurologic patient
Understand that the mind, body and spirit all interact in the promotion of health and well being and demonstrate the ability to utilize osteopathic manipulative medicine as a part of their patient care regimen

Description of clinical experiences:
The resident will rotate for two to four weeks at the PGL-2 level on the neurology service. The resident will work under the supervision of the attending neurologist.
Instruction in the proper method of neurologic examination and usage of diagnostic tests will be provided by the Neurology service to the neurologist.
The resident will examine and treat patients in both the hospital and Neurology office and clinic under the supervision of the attending neurologist.
The resident will perform neurology consultations for patients who present to the Emergency Department with acute neurologic complaints.

Description of didactic experiences:
The resident will attend all educational conferences and meetings while on the Neurology service.
The resident will be responsible for the list of suggested readings for the Neurology Rotation in addition to any provided by the Neurology service. The resident will attend all Emergency Medicine didactic sessions while on Neurology service.

### Duty Hours:
The EM resident will conform to AOA and CAMC duty hours which include:

- Not exceeding **80 hours per week averaged over 4 weeks**.
- Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At home call cannot be assigned on these free days. Residents must not be scheduled for more than six consecutive nights of night float/call. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
- Duty periods of PGY1 residents must not exceed 16 hours in duration.

It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

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.

Under those circumstances, the resident must: 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. The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty. Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods and after in house call. Residents are permitted to return to the hospital while on at home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off duty period”.

### Evaluation process:
Evaluation of the resident’s knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACGME/AOA defined core competencies. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident’s confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendations if necessary.

### Feedback mechanisms:
The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the Neurology rotation and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Rotation Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described? **YES**

If no, please explain:
Goals: Ultrasound Educational Objectives: With direct supervision from senior residents and the Ultrasound faculty, the emergency medicine resident will upon successful completion of this rotation achieve the following outcomes. By the completion of this rotation, residents will be able to:

Medical Knowledge-
1. To gain a basic understanding of ultrasound physics and how images are acquired.
2. To learn image acquisition and interpretation of Emergency Medicine Bedside Ultrasound (EMBU) for the following studies:
   a. Aorta
   b. Cardiac
   c. FAST
   d. Gallbladder
   e. Lower Extremity DVT
   f. Early Obstetrical (transabdominal and transvaginal)
   g. Renal/Bladder
   h. Soft Tissue
3. To critically review the EMBU literature, both supporting and refuting ED US use.

Patient Care-
1. To appreciate the utility of Ultrasound in the Emergency Department, both as a diagnostic tool and as a procedural aide, in the improvement of efficiency, patient satisfaction and overall patient care.
2. To become facile with Ultrasound as a procedural aide for the following procedures:
   a. Peripheral intravenous access
   b. Central venous access
   c. Thoracentesis
   d. Paracentesis
   e. Arthrocentesis
   f. Abscess localization and drainage
   g. Foreign body localization and removal

Professionalism-
1. To obtain an appreciation for ultrasound and the invasiveness of these scans/procedures and to take the need for privacy and appropriate draping into account while performing the scans.
2. To always maintain a high level of professionalism while performing ultrasound scans/procedures.

Interpersonal and Communication Skills-
1. To learn how to explain the ultrasound scan/procedure in terminology appropriate for patients, colleagues and consultants.

Practice-Based Learning-
1. To garner proficiency in ultrasound by performing multiple scans/procedures throughout the month.
   a. Each scan/procedure is different and will prepare the resident for the next opportunity.
   b. Residents will need to scan, scan, scan and then scan some more.

Systems-Based Practice-
1. To gain an appreciation how EMBU can greatly improve patient flow and care by giving immediate answers to clinical questions.
2. To understand ultrasound guided procedures have greater success rates are quicker and associated with improved patient satisfaction and decreased complications.
**Osteopathic Principles and Practices:**

Understand that the mind, body and spirit all interact in the promotion of health and well being and demonstrate the ability to utilize osteopathic manipulative medicine as a part of their patient care regimen.

**Description of clinical experiences:**

The resident will rotate for two to four weeks with the ultrasound technologist at CAMC. The resident will work under the supervision of the ultrasound technologist but is responsible to the supervising physician which shall be the Program Director of his designee.

Instruction in the proper method of ultrasound examination and usage of diagnostic tests will be provided by the ultrasound technologist at CAMC.

The resident will examine and treat patients in both the CAMC hospital system.

The resident will perform ultrasound consultations for patients who present to the Emergency Department with acute complaints.

**Description of didactic experiences:**

The resident will attend all educational conferences and meetings while on the Neurology service.

**Duty Hours:**

The EM resident will conform to AOA and CAMC duty hours which include:

- Not exceeding **80 hours per week averaged over 4 weeks**.
- Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At home call cannot be assigned on these free days. Residents must not be scheduled for more than six consecutive nights of night float/call. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
- Duty periods of PGY1 residents must not exceed 16 hours in duration.

It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

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.

Under those circumstances, the resident must:

- 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. The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty. Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods and after in house call. Residents are permitted to return to the hospital while on at home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off duty period”.

**Evaluation process:**

Evaluation of the resident’s knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACGME/AOA defined core competencies. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident’s confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.
Evaluation process:
Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.

Feedback mechanisms:
The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the ultrasound rotation at CAMC and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Rotation Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described? | YES
---|---
If no, please explain:
Goals: Medical simulation objectives: With direct supervision from the LSTC faculty the Emergency Medicine resident will upon successful completion of this rotation achieve the outcomes listed below.

Medical Knowledge:
To gain a basic understanding of the concepts of medical simulation and its application to emergency medicine training
To become competent in the operation of a simulation program as it applies to the following:
- ACLS
- PALS
- Adult sepsis
- Pediatric sepsis
- Simulation scenario development and design

Patient Care:
To employ the use of medical simulation as a training and educational tool for advancing patient care
To become familiar and complete required procedure logs in the medical simulation of:
- IV access (central and peripheral)
- Interosseous access
- Advanced airways
- Medical procedures
- Surgical procedures
- Pharmacologic therapeutics
- Ultrasound techniques

Professionalism:
To obtain an appreciation for simulation and the direction of a simulation program
To always maintain an exemplary professional manner while engaged in duties

Interpersonal and Communication Skills:
- Teaching critical teaching skills
- Teaching teamwork
- Teaching crisis management
- Develop debriefing skills

Practice-Based Learning:
To become proficient in medical simulation
To work within a collaborative environment

Systems-Based Practice:
Advancing simulation within the institution

Osteopathic Principles and Practices:
Understand that the mind, body and spirit all interact in the promotion of health and well being and demonstrate osteopathic manipulative technique on simulation patients.
Description of clinical experiences:

4 week rotation
- Monday, Tuesday, Thursday and Friday 7:30am
- Wednesday 1:00pm
- 1st Wednesday of each calendar month is mock code review for off service residents and rotators.
- 2nd Wednesday of each calendar month is adult sepsis training program
- 3rd Wednesday of each calendar month is pediatric sepsis training program
- 4th Wednesday of each month is reserved for the rotating Emergency Medicine resident in medical simulation to run the simulation scenario that s/he developed for the off service and rotating residents.

The resident completing their medical simulation rotation shall develop uniform debriefing methods with the anchor faculty of the simulation center.

The resident completing their medical simulation rotation shall incorporate TEAM STEPS into teaching scenarios, briefing and debriefing.

Description of didactic experiences:

The resident will attend all educational conferences and meetings while on the Medical Simulation rotation.

Duty Hours:

The EM resident will conform to AOA and CAMC duty hours which include:
- Not exceeding 80 hours per week averaged over 4 weeks.
- Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At home call cannot be assigned on these free days. Residents must not be scheduled for more than six consecutive nights of night float/call. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

Duty periods of PGY1 residents must not exceed 16 hours in duration.

It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

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.

Under those circumstances, the resident must: 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. The program director must review each submission of additional service, and track both individual resident and program wide episodes of additional duty. Adequate time for rest and personal activities must be provided. This will consist of a minimum of a 10-hour time period provided between all daily duty periods and after in house call. Residents are permitted to return to the hospital while on at home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off duty period”.

Evaluation process:

Evaluation of the resident’s knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACGME/AOA defined core competencies. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident’s confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.
Evaluation process:
Residents are also evaluated by their performance on the ABOEM in training examination and Emergency Medicine Residency Oral examination. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.

Feedback mechanisms:
The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents’ evaluations of the ultrasound rotation at CAMC and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Rotation Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?  

| YES |

If no, please explain:
## Rotation

**Pediatric Intensive Care Unit**

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### Goals:

**Patient Care Goals:** Residents must be able to provide patient care to the pediatric intensive care patient that is compassionate, appropriate, and effective for the treatment of health problems and advocate for the promotion of health in the CAMC medical system.

**Medical Knowledge Goals:** Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the appropriate application of this knowledge to patient care.

**Practice-Based Learning Goals:** Residents must be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices and speed based on the knowledge and experience they acquire in the CAMC Medical, Neurological, Surgical or Cardiac Intensive Care Units.

**Interpersonal and Communication Skills Goals:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates all with diverse backgrounds.

**Professionalism Goals:** Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

**Systems-Based Practice Goals:** Residents must demonstrate an awareness of and responsiveness to the unique aspects of the CAMC system and be able to effectively call on system resources to provide care and patient follow up that is of optimal value.

**Osteopathic Principles and Practices:** Residents must demonstrate an awareness of the basic tenets of osteopathic philosophy and ability in basic manipulative medicine.

### Objectives:

Through day to day patient contact with patients in the Pediatric Intensive Care Unit and attending supervision, the emergency medicine resident will achieve the following outcomes.

### Outcomes:

By the completion of this rotation, residents will be able to:

**Patient Care Outcomes:**
- Gather accurate, essential information from the patient’s history and physical examination in a timely manner
- Implement a timely, effective patient management plans
- Competently perform diagnostic and therapeutic procedures
- Demonstrate ability to diagnose and treat patients with the more common acute cardiac conditions including: cardiac failure (high output and low output), myocardial infarction, arrhythmias.
- Stabilize critical patients
- Prioritize and stabilize multiple patients and perform other responsibilities simultaneously
- Work with health care professionals to provide patient-focused care

**Medical Knowledge Outcomes:**
- Identify life-threatening conditions, the most likely diagnosis, synthesize acquired patient data, and identify how and when to access current medical information
- Demonstrate the ability to use and interpret data from electrocardiography (ECG monitors and 12 lead ECGs), cardiac outputs, hemodynamic monitoring, arterial blood gas sampling, pulse oximetry, end tidal CO2 monitors and respirators.
- Demonstrate the ability to manage a patient with an arterial catheterization including indications contraindications and complications of the treatment modality.
**Medical Knowledge Outcomes:**

Demonstrate the ability to manage a patient with central venous catheterization including indications and contraindications and complications of the treatment modality.

Discuss the critical steps in the implementation of a swan-ganz catheterization, cardiac pacing. Demonstrate the ability to manage a patient needing defibrillation/cardioversion including indications and contraindications and complications of the treatment modality.

Demonstrate the ability to manage a patient on mechanical ventilation including indications and contraindications and complications of the treatment modality.

Discuss the differential and preliminary work-up myocarditis, pericardial effusion/tamponade, pericarditis and endocarditis.

Discuss the differential and preliminary work-up cardiogenic shock.

Demonstrate knowledge of aortic insufficiency/stenosis, mitral insufficiency/stenosis, and pulmonary insufficiency/stenosis.

Demonstrate knowledge of the pathophysiology and manifestations arterial emboli, arterial spasm, arterial thrombosis, venous insufficiency/varicosities, venous thromboembolism, and venous thrombophlebitis.

Demonstrate knowledge of the significance and correct treatment of acute hypertensive crisis, essential hypertension, and secondary hypertension.

Discuss the differential and preliminary work-up of and the appropriate management of: cardiovascular surgery, mechanical assistance, primary tumors of the heart, myocardial manifestations of systemic disease, and transplantation.

Demonstrate knowledge of the pathophysiology and manifestations of mitral valve prolapse, patent foramen ovale, congenital abnormalities, tricuspid insufficiency/stenosis and hypertrophic heart disease.

The resident will demonstrate knowledge of the indications and counter indications for thrombolytic therapy and other interventional techniques and experience their use.

Complete disposition of patients using available resources

Analyze and assess their practice experience and perform practice-based improvement

Locate, appraise and utilize scientific evidence related to their patient’s health problems

Apply knowledge of study design and statistical methods to critically appraise the medical literature

Utilize information technology to enhance their education and improve patient care

Facilitate the learning of students and other healthcare professionals

**Interpersonal and Communication Skills Outcomes:**

Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences

Demonstrate effective participation in and leadership of the healthcare team

Develop effective written communication skills

Demonstrate the ability to handle situations unique to the practice of emergency medicine

Effectively communicate with out-of-hospital personnel as well as non-medical personnel

**Professionalism Outcomes:**

Treats patients, family, staff, and ancillary personnel with respect

Protects staff, family, and patient’s interests and confidentiality

Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues

Able to discuss death honestly, sensitively, patiently, and compassionately

Unconditional positive regard for the patient, family, staff, and consultants

Accepts responsibility and demonstrates accountability

Openness and responsiveness to the comments of other team members, patients, families, and peers

Demonstrate an understanding of the ethical and legal principles applicable to the care of critically ill patients

Demonstrate understanding of “Do not resuscitate” orders, advance directives, living wills, and brain dead criteria

**System-Based Practice Outcomes:**

Demonstrate an understanding of the appropriate use of consultants in critically ill patients

Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal patient care

Practice cost-effective health care and resource allocation that does not compromise quality of care

Advocate for and facilitate patient’s advancement through the health care system
Osteopathic Principles and Practices:
Among other understand the interdependence of the musculoskeletal /lymphatic system and other organ systems as they relate to the critically ill patient
Understand that the mind, body and spirit all interact in the promotion of health and well being and demonstrate the ability to utilize osteopathic manipulative medicine as a part of their patient care regimen

Description of clinical experiences:
The EM resident will see patients that present to the Pediatric Intensive Care Unit under the direct supervision of the of the Pediatric Intensive Care Unit attending. The EM resident will take call and manage Pediatric Intensive Care Unit patients while on call.

Description of didactic experiences:
EM residents will attend PICU conferences appropriate for their education as well as weekly Emergency Medicine conferences and Journal Club as scheduled.

Duty Hours:
The EM resident will conform to AOA and CAMC duty hours which include:
Not exceeding 80 hours per week averaged over 4 weeks.
Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At home call cannot be assigned on these free days. Residents must not be scheduled for more than six consecutive nights of night float/ call. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
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Evaluation process:
Evaluation of the resident’s knowledge and skills by direct supervision of the care given to patients on this rotation. Residents will receive concurrent feedback from the faculty while on this rotation. At the end of the rotation, the resident will be evaluated in writing. The evaluation will document the EM resident’s clinical performance during their rotation and their progress in achieving ACGME/ AOA defined core competencies. The ACGME/ABMS Toolbox of Assessment Methods will be used as evaluations posted on New-Innovations. The overall evaluation will be developed with input from the Emergency Medicine faculty and will be placed in the resident’s confidential file. A copy of the written rotation evaluation is to be available to the resident. The EM Program Director or designee reviews all evaluations with the EM resident at least semi-annually.

At the annual program review, the residents and EM faculty will also discuss the rotation and make recommendation for changes if necessary.
Residents are also evaluated on their performance through the use of the ABOEM in training examination, CORD On-Line tests, Simulation scenarios and Emergency Medicine Residency Oral examination and ACLS. Any deficiencies noted are corrected with a focused remediation program designed by the EM Residency Program Director, EM Faculty and EM resident.
The resident tracks all procedures and completes a rotation evaluation. The EM Residency Program Director will discuss rotation evaluations with the Pediatric Intensive Care Unit Faculty.

Feedback mechanisms:
The EM resident will receive verbal and written feedback as well as patient follow-up information to aid in their education. The EM Program Director will summarize all the residents' evaluations of the PICU rotation and provide feedback to the rotation coordinator on an annual basis. If an area of concern is noted at any point with respect to a specific resident or the rotation itself, the EM Residency Program Director, EM resident and Pediatric Intensive Care Unit Rotation Coordinator will communicate the concern immediately to the other party and develop a plan to resolve the issue.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?  ✓

If no, please explain: